# MISSISSIPPI

## Workers' Compensation Medical Fee Schedule

*Effective July 1, 2007*

INGENIX®

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# Introduction

Pursuant to Mississippi Code Annotated (MCA), section 71-3-15(3)(Rev. 2000), the following Fee Schedule, including Cost Containment and Utilization Management rules and guidelines, is hereby established in order to implement a medical cost containment program. This Fee Schedule, and accompanying rules and guidelines, applies to medical services rendered after the effective date of July 1, 2007. This Fee Schedule establishes the maximum level of medical and surgical reimbursement for the treatment of work-related injuries and/or illnesses, which the Mississippi Workers' Compensation Commission deems to be fair and reasonable.

This Fee Schedule shall be used by the Workers' Compensation Commission, insurance payers, and self-insurers for approving and paying medical charges of physicians, surgeons, and other health care providers for services rendered under the Mississippi Workers' Compensation Law. This Fee Schedule applies to all medical services provided to injured workers by physicians, and also covers other medical services arranged for by a physician. In practical terms, this means professional services provided by hospital-employed physicians, as well as those physicians practicing independently, are reimbursed under this Fee Schedule.

The Commission will require the use of the most current version of the CPT book and HCPCS codes and modifiers in effect at the time services are rendered. All coding, billing and other issues, including disputes, associated with a claim, shall be determined in accordance with the CPT rules and guidelines in effect at the time service is rendered, unless otherwise provided in this Fee Schedule or by the Commission. As used in this Fee Schedule, CPT refers to the American Medical Association's *Current Procedural Terminology* codes and nomenclature. CPT is a registered trademark of the American Medical Association. HCPCS is an acronym for the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System and includes codes for procedures, equipment, and supplies not found in the CPT book. However, the inclusion of a service, product or supply in the CPT book or HCPCS book does not necessarily imply coverage, reimbursement or endorsement.

## I. Format

This Fee Schedule is comprised of the following sections: Introduction; General Rules; Billing and Reimbursement Rules; Medical Records Rules; Dispute Resolution Rules; Utilization Review Rules; Rules for Modifiers and Code Exceptions; Pharmacy Rules; Nurse Practitioner and Physcian Assistant Rules; Home Health Rules; Skilled Nursing Facility Rules; Evaluation and Management; Anesthesia; Pain Management; Surgery; Radiology; Pathology and Laboratory; Medicine Services; Physical Medicine; Dental; Durable Medical Equipment (DME), Orthotics, Prosthetics and Other HCPCS Codes; Inpatient Hospital Payment Schedule and Rules; and Forms. Each section listed above has specific instructions (rules/guidelines). The Fee Schedule is divided into these sections for structural purposes only. Providers are to use the specific section(s) that contains the procedure(s) they perform or the service(s) they render. **In the event a rule/guideline contained in one of the specific service sections conflicts with a general rule/guideline, the specific section rule/guideline will supercede.**

This Fee Schedule utilizes *Current Procedural Terminology* (CPT) codes and guidelines under copyright agreement with the American Medical Association. The descriptions included are full procedure descriptions. A complete list of modifiers is included in a separate section for easy reference.

## II. Scope

The *Mississippi Workers' Compensation Medical Fee Schedule* does the following:

A. Establishes rules/guidelines by which the employer shall furnish, or cause to be furnished, to an employee who suffers a bodily injury or occupational disease covered by the Mississippi Workers' Compensation Law, reasonable and necessary medical, surgical, and hospital services medicines, supplies or other attendance or treatment as necessary. The employer shall provide to the injured employee such medical or dental surgery, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances which are reasonable and necessary to treat, cure, and/or relieve the employee

from the effects of the injury/illness, in accordance with MCA §71-3-15 (Rev. 2000), as amended.

B. Establishes a schedule of maximum reimbursement allowances (MRA) for such treatment, attendance, service, device, apparatus, or medicine.

C. Establishes rules/guidelines by which a health care provider shall be paid the lesser of (a) the provider's total billed charge, or (b) the maximum reimbursement allowance (MRA) established under this Fee Schedule.

D. Establishes rules for cost containment to include utilization review of health care and health care services, and provides for the acquisition by an employer/payer, other interested parties, and the Mississippi Workers' Compensation Commission, of the necessary records, medical bills, and other information concerning any health care or health care service under review.

E. Establishes rules for the evaluation of the appropriateness of both the level and quality of health care and health care services provided to injured employees, based upon medically accepted standards.

F. Authorizes employers/payers to withhold payment from, or recover payment from, health facilities or health care providers that have made excessive charges or which have provided unjustified and/or unnecessary treatment, hospitalization, or visits.

G. Provides for the review by the employer/payer or Commission any health facility or health care provider records and/or medical bills that have been determined not to be in compliance with the schedule of charges established herein.

H. Establishes that a health care provider or facility may be required by the employer/payer to explain in writing the medical necessity of health care or health care service that is not usually associated with, is longer and/or more frequent than, the health care or health care service usually accompanying the diagnosis or condition for which the patient is being treated.

I. Provides for medical cost containment review and decision responsibility. The rules and definitions hereunder are not intended to supersede or modify the Workers' Compensation Act, the administrative rules of the Commission, or court decisions interpreting the Act or the Commission's administrative rules.

J. Provides for the monitoring of employer/payers to determine their compliance with the criteria and standards established by this Fee Schedule.

K. Establishes deposition/witness fees.

L. Establishes fees for medical reports.

M. Provides for uniformity in billing of provider services.

N. Establishes rules/guidelines for billing.

O. Establishes rules/guidelines for reporting medical claims for service.

P. Establishes rules/guidelines for obtaining medical services by out-of-state providers.

Q. Establishes rules/guidelines for Utilization Review to include pre-certification, concurrent review, discharge planning and retrospective review.

R. Establishes rules for dispute resolution which includes an appeal process for determining disputes which arise under this Fee Schedule.

S. Establishes a Peer Review system for determining medical necessity. Peer review is conducted by professional practitioners of the same specialty as the treating medical provider on a particular case.

T. Establishes the list of health care professionals who are considered authorized providers to treat employees under the Mississippi Workers' Compensation Law; and who, by reference in this rule, will be subject to the rules, guidelines and maximum reimbursement limits in this Fee Schedule.

U. Establishes financial and other administrative penalties to be levied against payers or providers who fail to comply with the provisions of the Fee Schedule, including but not limited to interest charges for late billing or payment, percentage penalties for late billing or payment, and additional civil penalties for practices deemed unreasonable by the Commission.

## III. Medical Necessity

The concept of medical necessity is the foundation of all reimbursement made under the provision of section 71-3-15, Mississippi Code of 1972, as amended. For reimbursement to be made, services and supplies must meet the definition of "medically necessary."

A. For the purpose of the Workers' Compensation Program, any reasonable medical service or supply used to identify or treat a work-related injury/illness which is appropriate to the patient's diagnosis, is based upon accepted standards of the health care specialty involved, represents an appropriate level of care given the location of service, the nature and seriousness of the condition, and the frequency and duration of services, is not experimental or investigational, and is consistent with or comparable to the treatment of like or similar non-work related injuries, is considered "medically necessary." The service must be widely accepted by the practicing peer group, based on scientific criteria, and determined to be reasonably safe. It must not be

experimental, investigational, or research in nature except in those instances in which prior approval of the payer has been obtained. For purposes of this provision, "peer group" is defined as similarly situated physicians of the same specialty, licensed in the State of Mississippi, and qualified to provide the services in question.

B. Services for which reimbursement is due under this Fee Schedule are those services meeting the definition of "medically necessary" above and which are required to determine or diagnose whether a work-related injury or illness has been sustained, or which are required for the remedial treatment or diagnosis of an on-the-job injury, a work-related illness, a pre-existing condition affected by the injury or illness, or a complication resulting from the injury or illness, and which are provided for such period as the nature of the injury or process of recovery may require.

C. Treatment of conditions unrelated to the injuries sustained in an industrial accident may be denied as unauthorized if the treatment is directed toward the non-industrial condition or if the treatment is not deemed medically necessary for the patient's rehabilitation from the industrial injury.

## IV. Definitions

**Act** means Mississippi Workers' Compensation Law, Mississippi Code Annotated (MCA), section 71-3-1 et seq (Rev. 2000 as amended).

**Adjust** means that a payer or a payer's agent reduces or otherwise alters a health care provider's request for payment.

**Appropriate care** means health care that is suitable for a particular patient, condition, occasion, or place.

**Bill** means a claim submitted by a provider to a payer for payment of health care services provided in connection with a covered injury or illness.

**Bill adjustment** means a reduction of a fee on a provider's bill, or other alteration of a provider's bill.

**By report (BR)** means that the procedure is new, or is not assigned a maximum fee, and requires a written description included on or attached to the bill. "BR" procedures require a complete listing of the service, the dates of service, the procedure code, and the payment requested. The report is included in the reimbursement for the procedure.

**Carrier** means any stock company, mutual company, or reciprocal or inter-insurance exchange authorized to write or carry on the business of Workers' Compensation Insurance in this State, or self-insured group, or third-party payer, or self-insured employer, or uninsured employer.

**CMS-1500** means the CMS-1500 form and instructions that are used by noninstitutional providers and suppliers to bill for outpatient services. Use of the most current CMS-1500 form is required. (Implementation of the CMS-1500 (08-05) form that has been revised to accommodate reporting of the National Provider Identifier (NPI) has been postponed by CMS. The previous version, form CMS-1500 (12-90), should be used until replaced with form CMS-1500 (08-05).

**Commission** means the Mississippi Workers' Compensation Commission.

**Case** means a covered injury or illness occurring on a specific date and identified by the worker's name and date of injury or illness.

**Consultation** means a 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. If a consultant, subsequent to the first encounter, assumes responsibility for management of the patient's condition, that physician becomes a treating physician. The first encounter is a consultation and shall be billed and reimbursed as such. A consultant shall provide a written report of his/her findings. *A second opinion is considered a consultation.*

**Controverted claim** is a workers' compensation claim which is pending before the Commission and in which the patient or patient's legal representative has filed a Petition to Controvert.

**Covered injury or illness** means an injury or illness for which treatment is mandated under the Act.

**Critical care** means care rendered in a variety of medical emergencies that requires the constant attention of the practitioner, such as cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, and is usually provided in a critical care unit or an emergency department.

**Day** means a continuous 24-hour period.

**Diagnostic procedure** means a service that helps determine the nature and causes of a disease or injury.

**Durable medical equipment (DME)** means specialized equipment designed to stand repeated use, appropriate for home use, and used solely for medical purposes.

**Expendable medical supply** means a disposable article that is needed in quantity on a daily or monthly basis.

**Follow-up care** means the care which is related to the recovery from a specific procedure and which is considered part of the procedure's maximum reimbursement allowance, but does not include complications.

**Follow-up days** are the days of care following a surgical procedure which are included in the procedure's maximum reimbursement allowance amount, but which do not include complications. The follow-up day period begins on the day of the surgical procedure(s).

**Health care review** means the review of a health care case, bill, or both by the payer or the payer's agent.

**Incident to** means that the services and supplies are commonly furnished as an integral part of the primary service or procedure.

**Incidental surgery** means surgery performed through the same incision, on the same day, by the same doctor, not increasing the difficulty or follow-up of the main procedure, or not related to the diagnosis.

**Incorrect payment** means the provider was not reimbursed according to the rules/guidelines of the Fee Schedule and the payer has failed to provide any reasonable basis for the adjusted payment.

**Independent medical examination (IME)** means a consultation provided by a physician to evaluate a patient at the request of the Commission. This evaluation may include an extensive record review and physical examination of the patient and requires a written report.

**Independent procedure** means a procedure that may be carried out by itself, completely separate and apart from the total service that usually accompanies it.

**Inpatient services** means services rendered to a person who is admitted as an inpatient to a hospital.

**Maximum reimbursement allowance (MRA)** means the lesser of the provider's total billed charge, or the maximum specific fee set forth in this Fee Schedule; or, the usual and customary fee.

**Medical only case** means a case that does not involve more than five (5) days of disability or lost work time and for which only medical treatment is required.

**Medically accepted standard** means a measure set by a competent authority as the rule for evaluating quality or quantity of health care or health care services and which may be defined in relation to any of the following:

- Professional performance
- Professional credentials
- The actual or predicted effects of care
- The range of variation from the norm

**Medically necessary** means any reasonable medical service or supply used to identify or treat a work-related injury/illness which is appropriate to the patient's diagnosis, is based upon accepted standards of the health care specialty involved, represents an appropriate level of care given the location of service, the nature and seriousness of the condition, and the frequency and duration of services, is not experimental or investigational, and is consistent with or comparable to the treatment of like or similar non-work related injuries.

**Medical record** means a record in which the medical service provider records the subjective findings, objective findings, diagnosis, treatment rendered, treatment plan, and return to work status and/or goals and impairment rating as applicable.

**Medical supply** means either a piece of durable medical equipment or an expendable medical supply.

**Observation services** means services rendered to a person who is designated or admitted as observation status.

**Operative report** means the practitioner's written description of the surgery and includes all of the following:

- A preoperative diagnosis;
- A postoperative diagnosis;
- A step-by-step description of the surgery;
- A description of any problems that occurred in surgery; and
- The condition of the patient upon leaving the operating room.

**Optometrist** means an individual licensed to practice optometry.

**Orthotic equipment** means an orthopedic apparatus designed to support, align, prevent, or correct deformities, or improve the function of a moveable body part.

**Orthotist** means a person skilled in the construction and application of orthotic equipment.

**Outpatient service** means services provided to patients at a time when they are not hospitalized as inpatients.

**Payer** means the employer or self-insured employed group, carrier, or third-party administrator (TPA) who pays the provider billings.

**Pharmacy** means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.

**Practitioner** means a person licensed, registered, or certified as an acupuncturist, audiologist, doctor of chiropractic, doctor of dental surgery, doctor of medicine, doctor of osteopathy, doctor of podiatry, doctor of optometry, massage therapist, nurse, nurse anesthetist, nurse practitioner, occupational therapist, orthotist, pharmacist, physical therapist, physician assistant, prosthetist, psychologist, or other person licensed, registered, or certified as a health care professional or provider.

**Primary procedure** means the therapeutic procedure most closely related to the principal diagnosis, and in billing, the CPT code with the highest relative value unit (RVU) that is neither an add-on code nor a code exempt from modifier 51 shall be considered the primary procedure. Reimbursement for the primary procedure is not dependent on the ordering or re-ordering of codes.

**Procedure** means a unit of health service.

**Procedure code** means a five–digit numerical sequence or a sequence containing an alpha character and preceded or followed by four digits, which identifies the service performed and billed.

**Properly submitted bill** means a request by a provider for payment of health care services submitted to a payer on the appropriate forms with appropriate documentation and within the time frame established under the guidelines of the Medical Fee Schedule.

**Prosthesis** means an artificial substitute for a missing body part.

**Prosthetist** means a person skilled in the construction and application of prostheses.

**Provider** means a facility, health care organization, or a practitioner who provides medical care or services.

**Secondary procedure** means a surgical procedure performed during the same operative session as the primary surgery but considered an independent procedure that may not be performed as part of the primary surgery.

**Special report** means a report requested by the payer to explain or substantiate a service or clarify a diagnosis or treatment plan.

**Specialist** means a board-certified practitioner, board-eligible practitioner, or a practitioner otherwise considered an expert in a particular field of health care service by virtue of education, training, and experience generally accepted by practitioners in that particular field of health care service.

**A usual and customary rate/fee** is a reimbursement allowance equal to the amount displayed by the Ingenix MDR Charge Payment System (Mississippi State Version) for the procedure at the 40th percentile. The Ingenix MDR Charge Payment System is a national database of Relative and Actual Charge Data (RACD) which includes charge information for the State of Mississippi.

## V. How to Interpret the Fee Schedule

### CPT Code
The first column lists the American Medical Association's (AMA) CPT code. *CPT 2007* codes are used by arrangement with the AMA.

### Add-on Codes
**+** denotes procedure codes that are considered "add-on" codes as defined in the CPT book.

### Modifier 51 Exempt
⃠ denotes procedure codes that are exempt from the use of modifier 51 and are not designated as add-on procedures/services as defined in the CPT book.

### Conscious Sedation
⊙ denotes procedure codes that include conscious sedation as an inherent part of providing the procedure.

### Description
This Fee Schedule uses actual 2007 CPT full descriptions.

### Relative Value
This column lists the relative value assigned to each procedure. There are, however, procedures too variable to accept a set value—these are "by report" procedures and are noted BR.

### Amount
This column lists the total reimbursable as a monetary amount.

### PC Amount
Where there is an identifiable professional and technical component to a procedure, the portion considered to be the professional component is listed. The professional component gives the total reimbursable as a monetary

amount. The technical component can be identified as the Amount minus the PC Amount.

### FUD

Follow-up days included in a surgical procedure's global charge are listed in this column.

### Assist Surg

The assistant surgeon column identifies procedures that are approved for an assistant to the primary surgeon whether a physician, registered nurse first assistant (RNFA, RA), or other individual qualified for reimbursement as an assistant under the Fee Schedule.

### ASC Amount

Ambulatory Surgery Center (ASC) payment is made for facility services furnished in conjunction with outpatient surgical procedures.

### Facility Fee

The facility fee is paid to the facility for services in conjunction with outpatient pain management, pathology, laboratory, and radiology procedures.

## VI. Authorized Providers

The following health care providers are recognized by the Mississippi Workers' Compensation Commission as acceptable to provide treatment to injured workers under the terms of the Act, and must comply with the rules, guidelines, billing and reimbursement policies and maximum reimbursement allowance (MRA) contained in this Fee Schedule when providing treatment or service under the terms of the Act:

Acupuncturist (L.A.C.)

Audiologist

Certified Registered Nurse Anesthetist (C.R.N.A.)

Doctor of Chiropractic (D.C.)

Doctor of Dental Surgery (D.D.S.)/Doctor of Dental Medicine (D.D.M.)

Doctor of Osteopathy (D.O.)

Licensed Clinical Social Worker (L.C.S.W.)

Licensed Nursing Assistant

Licensed Practical Nurse (L.P.N.)

Massage Therapist

Medical Doctor (M.D.)

Nurse Practitioner (N.P.)

Occupational Therapist (O.T.)

Optometrist (O.D.)

Oral Surgeon (M.D., D.O., D.M.D., D.D.S.)

Pharmacist (R.Ph.)

Physical Therapist (P.T.)

Physician Assistant (P.A.)

Podiatrist (D.P.M.)

Prosthetist or Orthotist

Psychologist (Ph.D.)

Registered Nurse (R.N.)

Registered Nurse First Assistant (R.N.F.A., R.A.)

Speech Therapist

All health care providers, as listed herein, are subject to the rules, limitations, exclusions, and maximum reimbursement allowances of this Fee Schedule. Medical treatment under the terms of the Act may be provided by any other person licensed, registered or certified as a health care professional if approved by the payer or Commission, and in such case, said provider and payer shall be subject to the rules and guidelines, including maximum reimbursement amounts, provided herein.

## VII. Information Program

The Workers' Compensation Commission shall provide ongoing information regarding this Fee Schedule for providers, payers, their representatives and any other interested persons or parties. This information shall be provided primarily through informational sessions and seminar presentations at our Annual Education Conference as well as the distribution of appropriate information materials via the Commission's website, and by other means as needed.

# General Rules

## I. Confirmatory Consultation

As provided in section 71-3-15(1) of the Act, and in M.W.C.C. General Rule 9, a payer/employer may request a second opinion examination or evaluation for the purpose of evaluating temporary or permanent disability or medical treatment being rendered. This examination is considered a confirmatory consultation. The confirmatory consultation is billed using the appropriate level and site specific consultation code appended with modifier 32 to indicate a mandated service and paid in accordance with the Fee Schedule.

## II. Coding Standard

A. The most current version of the American Medical Association's *Current Procedural Terminology* (CPT) book, and, where appropriate, the codes and descriptors of the American Society of Anesthesiologists' *Relative Value Guide*™, in effect at the time service is rendered or provided shall be the authoritative coding guide, unless otherwise specified in this Fee Schedule.

B. The most current version of HCPCS Level II codes developed by CMS in effect at the time service is rendered or provided shall be the authoritative coding guide for durable medical equipment, prosthetics, orthotics, and other medical supplies (DMEPOS), unless otherwise specified in this Fee Schedule.

## III. Deposition/Witness Fees; Medical Records Affidavit

A. Any health care provider who gives a deposition or is otherwise subpoenaed to appear in proceedings pending before the Commission shall be paid a witness fee as provided by M.W.C.C. Procedural Rule 18(h) in the amount of $25.00 per day plus mileage reimbursement at the rate authorized by M.W.C.C. General Rule 14. Procedure code 99075 must be used to bill for a deposition.

B. In addition to the above fee and mileage reimbursement, any health care provider who gives testimony by deposition or who appears in person to testify at a hearing before the Commission shall be paid $500.00 for the first hour and $125.00 per quarter hour thereafter. This fee includes necessary preparation time. In the event a deposition is cancelled through no fault of the provider, the provider shall be entitled to a payment of $250.00 unless notice of said cancellation is given to the provider at least 72 hours in advance. In the event a deposition is cancelled through no fault of the provider within 24 hours of the scheduled time, then, in that event, the provider shall be paid the rate due for the first hour of a deposition. Nothing stated herein shall prohibit a medical provider and a party seeking to take the medical provider's deposition from entereing into a separate contract which provides for reimbursement other than as above provided.

C. Pursuant to Mississippi Workers' Compensation Commission Procedural Rule 9, an examining or treating physician may execute an affidavit in lieu of direct testimony. The Physician's Medical Record Custodian is allowed to sign the affidavit in lieu of the physician's signature. Such charge for execution of the affidavit is limited to a maximum reimbursement of $25.00. Reimbursement for copies of medical records that are attached to affidavits shall be made as outlined elsewhere in the Fee Schedule.

## IV. Impairment Rating

A. In determining the extent of permanent impairment attributable to a compensable injury, the provider shall base this determination on the most current edition of the *Guides to the Evaluation of Permanent Impairment,* as published and copyrighted by the American Medical Association, or on any other credible, accepted source for rating permanent impairment.

B. A provider is entitled to reimbursement for conducting an impairment rating evaluation and determining the extent of permanent impairment, and should bill for such services using CPT codes 99455 or 99456.

## V. Independent Medical Examination (IME)

A. An independent medical examination (IME) may be ordered by the Mississippi Workers' Compensation

Commission or its Administrative Judges. A practitioner other than the treating practitioner must do the medical examination, and the Commission or Judge shall designate the examiner.

B. An independent medical examination (IME) shall include a study of previous history and medical care information, diagnostic studies, diagnostic x-rays, and laboratory studies, as well as an examination and evaluation. An IME can only be ordered by the Workers' Compensation Commission or one of its Administrative Judges. A copy of the report must be sent to the patient, or his attorney if represented, the payer, and the Mississippi Workers' Compensation Commission.

C. The fee for the IME may be set by the Commission or Judge, or negotiated by the payer and provider prior to setting the appointment, and in such cases, reimbursement shall be made according to the order of the Commission or Judge, or according to the mutual agreement of the parties. In the absence of an agreement or order regarding reimbursement for an IME, the provider shall bill for the IME using the appropriate level and site-specific consultation code appended with modifier 32 to indicate a mandated service, and shall be reimbursed according to the Fee Schedule.

## VI. Maximum Medical Improvement

A. When an employee has reached maximum medical improvement (MMI) for the work related injury and/or illness, the physician should promptly, and at least within fourteen (14) days, submit a report to the payer showing the date of maximum medical improvement.

B. Maximum medical improvement is reached at such time as the patient reaches the maximum benefit from medical treatment or is as far restored as the permanent character of his injuries will permit and/or the current limits of medical science will permit. Maximum medical improvement may be found even though the employee will require further treatment or care.

## VII. Out-of-State Medical Treatment

A. Each employer shall furnish all reasonable and necessary drugs, supplies, hospital care and services, and medical and surgical treatment for the work-related injury or illness. All such care, services, and treatment shall be performed at facilities within the state when available.

B. When billing for out-of-state services, supporting documentation is necessary to show that the service being provided cannot be performed within the state, the same quality of care cannot be provided within the state, or more cost-effective care can be provided out-of-state. In determining whether out-of-state treatment is more cost effective, this question must be viewed from both the payer and patient's perspective. As stated in General Rule 9, treatment should be provided in an area reasonably convenient to the place of the injury or the residence of the injured employee, in addition to being reasonably suited to the nature of the injury.

C. Reimbursement for out-of-state services shall be based on one of the following, in order of preference: (1) the workers' compensation fee schedule for the state in which services are rendered; or (2) in cases where there is no applicable fee schedule for the state in which services are rendered, or the fee schedule in said state excludes or otherwise does not provide reimbursement allowances for the services rendered, reimbursement should be paid at the usual and customary rate for the geographical area in which the services are rendered; or (3) reimbursement for out-of-state services may be based on the mutual agreement of the parties.

D. Prior authorization must be obtained from the payer for referral to out-of-state providers. The documentation must include the following:

1. Name and location of the out-of-state provider,
2. Justification for an out-of-state provider, including qualifications of the provider and description of services being requested.

## VIII. Authorization for Treatment

A. **Prior Authorization.** Providers must request authorization from the payer before service is rendered for the services and supplies listed below:

1. Non-emergency elective inpatient hospitalization
2. Non-emergency elective inpatient surgery
3. Non-emergency elective outpatient surgery
4. Physical medicine treatments after 15 visits or 30 days, whichever comes first
5. Rental or purchase of supplies or equipment over the amount of $50.00 per item
6. Rental or purchase of TENS
7. Home health services
8. Pain clinic/therapy programs
9. External spinal stimulators
10. Pain control programs
11. Work hardening programs, back schools, functional capacity testing, ISO kinetic testing

12. Referral for orthotics or prosthetics
13. Referral for acupuncture
14. Referral for biofeedback
15. Referral to psychological testing/counseling
16. Referral to substance abuse program
17. Referral to weight reduction program
18. Referral to any non-emergency medical service outside the State of Mississippi
19. Repeat MRI (more than one per injury)
20. Repeat CT Scan (more than one per injury)

B. **Response Time.** The payer must respond within two (2) business days to a request of prior authorization for non-emergency services.

C. **Federal Facilities.** Treatment provided in federal facilities requires authorization from the payer. However, federal facilities are exempt from the billing requirements and reimbursement policies in this manual.

D. **Pre-certification for Non-emergency Surgery.** Providers must pre-certify all non-emergency surgery. However, certain catastrophic cases require frequent returns to the operating room (O.R.) (e.g., burns may require daily surgical debridement). In such cases, it is appropriate for the provider to obtain certification of the treatment plan to include multiple surgical procedures. The provider's treatment plan must be specific and agreement must be mutual between the provider and the payer regarding the number and frequency of procedures certified.

E. **Retrospective Review.** Failure to obtain pre-certification as required by this Fee Schedule shall not, in and of itself, result in a denial of payment for the services provided. Instead, the payer shall conduct a retrospective review of the services, and if the payer determines that the services provided would have been pre-certified, in whole or in part, if pre-certification had been timely sought by the provider, then the payer shall reimburse the provider for the approved services according to the Fee Schedule, or, if applicable, according to the separate fee agreement between the payer and provider, less a ten percent (10%) penalty for the provider's failure to obtain pre-certification as required by this Fee Schedule. This penalty shall be computed as ten percent (10%) of the total allowed reimbursement. If, upon retrospective review, the payer determines that pre-certification would not have been given, or would not have been given as to part of the requested services, then the payer shall dispute the bill and proceed in accordance with the Billing and Payment Rules as hereafter provided.

F. **Authorization Provided by Employer or Payer.** When authorization for treatment is sought and obtained from the employer, or payer, whether verbally or in writing, and medical treatment is rendered in good faith reliance on this authorization, the provider is entitled to payment from the employer or payer for the initial visit or evaluation, or in emergency cases, for treatment which is medically necessary to stabilize the patient. Reimbursement is not dependent on, and payment is due regardless of, the outcome of medically necessary services which are provided in good faith reliance upon authorization given by the employer or payer.

## IX. Return to Work

If an employee is capable of some form of gainful employment, it may be proper for the physician to release the employee to light work and make a specific report to the payer as to the date of such release and setting out any restrictions on such light work. It can be to the employee's economic advantage to be released to light work, since he/she can receive compensation based on sixty-six and two-thirds percent (66 2/3%) of the difference between the employee's earnings in such light work and the employee's pre-injury average weekly wage. The physician's judgment in such matters is extremely important, particularly as to whether the patient is medically capable of returning to work in some capacity.

## X. Selection of Providers

The selection of appropriate providers for diagnostic testing or analysis, including but not limited to CAT scans, MRI, x-ray, and laboratory, for physical or occupational therapy, including work hardening, functional capacity evaluations, back schools, chronic pain programs, massage therapy, or for orthotics or prosthetics, shall be at the direction of the treating or prescribing physician. In the absence of specific direction from the treating or prescribing physician, the selection shall be made by the payer, in consultation with the treating or prescribing physician.

The selection of providers for the purchase or rental of durable medical equipment shall be at the direction of the payer.

The selection of providers for medical treatment or service, other than as above provided, shall be in accordance with the provisions of MCA section 71-3-15 (Rev. 2000).

# Billing and Reimbursement Rules

## I. General Provisions

A. **Maximum Reimbursement Allowance (MRA).** Unless the payer and provider have a separate fee contract which provides for a different level of reimbursement, the maximum reimbursement allowance for health care services shall be the lesser of (a) the provider's total billed charge, or (b) the maximum specific fee established by the Fee Schedule. Items or services or procedures which do not have a maximum specific fee established by this Fee Schedule shall be reimbursed at the usual and customary fee as defined in this Fee Schedule, and in such cases, the maximum reimbursement allowance shall be the lesser of (1) the provider's total billed charge, or (2) the usual and customary fee as defined by this Fee Schedule.

If this Fee Schedule does not establish a maximum specific fee for a particular service or procedure, and a usual and customary rate cannot be determined because the Ingenix MDR Charge Payment System database does not contain a fee for same, then the maximum reimbursement allowance shall be the provider's total billed charge.

B. **Separate Fee Contract.** An employer/payer may enter into a separate contractual agreement with a medical provider regarding reimbursement for services provided under the provisions of the Mississippi Workers' Compensation Law, and if an employer/payer has such an a contractual agreement with a provider designed to reduce the cost of workers' compensation health care services, the contractual agreement shall control as to the amount of reimbursement and shall not be subject to the maximum reimbursement allowance otherwise established by exempt from the Fee Schedule. However, all other rules, guidelines and policies as provided in this Fee Schedule shall apply and shall be considered to be automatically incorporated into such agreement.

1. **Repricing Agreements.** Payers and providers may voluntarily enter into repricing agreements designed to contain the cost of workers' compensation health care after the medical care or service has been provided, and in such case, the reimbursement voluntarily agreed to by the parties shall control to the exclusion of the Fee Schedule. However, the time spent by the payer and provider attempting to negotiate a post-care repricing agreement does not extend the time elsewhere provided in this Fee Schedule for billing claims, paying claims, requesting correction of an incorrect payment, requesting reconsideration, seeking dispute resolution, or reviewing and responding to requests for correction or reconsideration or dispute resolution. In addition, applicable interest and penalties related to late billing and/or late payment shall continue to accrue as otherwise provided. Efforts to negotiate a post-care repricing agreement do not justify late billing or payment, and either party may seek further relief in accordance with the rules provided herein should billing or payment not be made within the time otherwise due under these rules. No party shall be obligated to negotiate or enter into a repricing agreement of any kind whatsoever.

No party, in attempting to negotiate a repricing or other post treatment price reduction agreement, shall state or imply that consent to such an agreement is mandatory, or that the failure to enter into any such agreement may result in audit, delay of payment, or other adverse consequence. If the Commission determines that any party, or other person in privity therewith, has made such false or misleading statements in an effort to coerce another party's consent to a repricing or other price reduction agreement outside the Fee Schedule, the Commission may refer the matter to the appropriate authorities to consider whether such conduct warrants criminal prosecution under section 71-3-69 of the Law. This statute declares that any false or misleading statement or

representation made for the purpose of wrongfully withholding any benefit or payment otherwise due under the terms of the Workers' Compensation Law shall be considered a felony. In addition, the Commission may levy a civil penalty in an amount not to exceed ten thousand dollars ($10,000.00) if it finds that payment of a just claim has been delayed without reasonable grounds, as provided in section 71-3-59(2) of the Law.

C. **Billing Forms.** Billing for provider services shall be standardized and submitted on the following forms: Providers must bill outpatient professional services on the most recently authorized paper or electronic version of the CMS-1500 (formerly HCFA-1500) form, regardless of the site of service. Health care facilities must bill on the most recently authorized uniform billing form. The electronic version of the UB-04 (CMS-1450) is required beginning May 23, 2007.

D. **Identification Number.** All professional reimbursement submissions by Covered Healthcare Providers as defined under CMS rules for the implementation of the National Provider Identifier (NPI) must include the National Provider Identifier (NPI) field so as to enable the specific identification of individual providers without the need for other unique provider identification numbers. Providers who do not yet have an NPI should continue to use their legacy identifiers until such time as an NPI is obtained. Providers are required to obtain an NPI within the dates specified by CMS in its implementation rules.

E. **Physician Specialty**. The rules and reimbursement allowances in the *Mississippi Workers' Compensation Medical Fee Schedule* do not address physician specialization within a specialty. Payment is not based on the fact that a physician has elected to treat patients with a particular/specific problem. Reimbursement to qualified physicians is the same amount regardless of specialty.

F. **"No Show" Appointments.** When an appointment is made for a physician visit by the employer or payer, and the claimant/patient does not show, the provider is entitled to payment at the rate allowed for a minimal office visit.

G. **"After Hours" and Other Adjunct Service Codes.** When an office service occurs after a provider's normal business hours, procedure code 99050 may be billed. Other adjunct service codes (99051–99060) may be billed as appropriate. Typically, only a single adjunct service code is reported per encounter. However, there may be circumstances in which reporting multiple adjunct codes per patient encounter may be appropriate.

H. **Portable Services.** When procedures are performed using portable equipment, bill the appropriate procedure code. The charge for the procedure includes the cost of the portable equipment.

I. **Injections.**

1. Reimbursement for injections includes charges for the administration of the drug and the cost of the supplies to administer the drug. Medications are charged separately.
2. The description must include the name of the medication, strength, and dose injected.
3. When multiple drugs are administered from the same syringe, reimbursement will be for a single injection.
4. Reimbursement for anesthetic agents such as Xylocaine and Carbocaine, when used for infiltration, is included in the reimbursement for the procedure performed and will not be separately reimbursed.
5. Anesthetic agents for local infiltration must not be billed separately; this is included in the reimbursement for the procedure.
6. Reimbursement for intra-articular and intra-bursal injections (steroids and anesthetic agents) may be separately billed. The description must include the name of the medication, strength, and volume given.

J. **Supplies.** Use CPT code 99070 or specific HCPCS Level II codes to report supplies over and above those usually included with the office visit or service rendered. Do not bill for supplies that are currently included in surgical packages, such as gauze, sponges, and Steri-Strips®. Supplies and materials provided by the physician over and above those usually included with the office visit (drugs, splints, sutures, etc.) may be charged separately and reimbursed at a reasonable rate.

## II. Instructions to Providers

A. All bills for service must be coded with the appropriate CPT, ASA, or HCPCS Level II code.

B. The attending physician must file the appropriate billing form and necessary documentation within thirty (30) days of rendering services on a newly diagnosed work-related injury or illness. Subsequent billings must be submitted at least every thirty (30) days, or within thirty (30) days of each treatment or visit, whichever last occurs, with the appropriate medical records to substantiate the medical necessity for continued services. Late billings will be subject to discounts, not to

exceed one and one-half percent (1.5%) per month of the bill or part thereof which was not timely billed, from the date the billing or part thereof is first due until received by the payer. Any bill or part thereof not submitted to the payer within sixty (60) days after the due date under this rule shall be subject to an additional discount penalty equal to ten percent (10%) of the total bill or part therof.

C. Fees in excess of the maximum reimbursement allowance (MRA) must not be billed to the employee, employer, or payer. The provider cannot collect any non-allowed amount.

D. If it is medically necessary to exceed the Fee Schedule limitations and/or exclusions, substantiating documentation must be submitted by the provider to the payer with the claim form.

F. If a provider believes an incorrect payment was made for services rendered, or disagrees for any reason with the payment and explanation of review tendered by the payer, then the provider may request reconsideration pursuant to the rules set forth in part V below.

G. If, after the resolution of a reconsideration request or a formal dispute resolution request, or otherwise, the provider is determined to owe a refund to the payer, the amount refunded shall bear interest at the rate of one and one-half percent (1.5%) per month from the date the refunded amount was first received by the provider, until refunded to the payer.

## III. Instructions to Payers

A. An employer's/payer's payment shall reflect any adjustments in the bill made through the employer's/payer's bill review program. The employer/payer must provide an explanation of review (EOR) to a health care provider whenever reimbursement differs from the amount billed by the provider. This must be done individually for each bill.

B. In a case where documentation does not indicate the service was performed, the charge for the service may be denied. The explanation of review (EOR) must clearly and specifically indicate the reason for the denial.

C. (1) When a billed service is documented, but the code selected by the provider is not, in the payer's/reviewer's estimation, the most accurate code available to describe the service, the reviewer must not deny payment, but shall reimburse based on the revised code. The explanation of review (EOR) must clearly and specifically detail the reason(s) for recoding the service or otherwise altering the claim. No claim shall be recoded or otherwise revised or altered without the payer having actually reviewed the medical records associated with the claim which document the service(s) provided.

(2) As an alternative to recoding or altering a claim, the payer may treat the matter under rule E(1) and (2) below by paying any undisputed portion of the bill, and notifying the provider by explanation of review (EOR) that the remaining parts of the bill are denied or disputed.

D. Properly submitted bills must be paid within thirty (30) days of receipt by the payer. Properly submitted bills not fully paid within thirty (30) days of receipt by the payer shall automatically include interest on the unpaid balance at the rate of one and one-half percent (1.5%) per month from the due date of any unpaid remaining balance until such time as the claim is fully paid and satisfied. Properly submitted bills not fully paid within sixty (60) days of receipt will be subject to an additional penalty equal to ten percent (10%) of the unpaid remaining balance, including interest as herein provided.

E. (1) When an employer/payer disputes or otherwise adjusts a bill or portion thereof, the employer/payer shall pay the undisputed or unadjusted portion of the bill within thirty (30) days of receipt of the bill. Failure to pay the undisputed portion when due shall subject the payer to interest and penalty as above provided on the undisputed portion of the bill. If the dispute is ultimately resolved in the provider's favor, interest and penalty on the disputed amounts will apply from the original due date of the bill.

(2) When a payer disputes a bill or portion thereof, the payer shall notify the provider within thirty (30) days of the receipt of the bill of the reasons for disputing the bill or portion thereof, and shall notify the provider of its right to provide additional information and to request reconsideration of the payer's action. The payer shall set forth the clear and specific reasons for disputing a bill or portion thereof on the explanation of review (EOR), and shall provide additional documentation if necessary to provide an adequate explanation of the dispute.

F. Reimbursement determinations shall be based on medical necessity of services to either establish a diagnosis or treat an injury/illness. Thus, where service is provided in good faith reliance on authorization given by the employer or payer, reimbursement shall not be dependent on the outcome of medically necessary diagnostic services or treatment.

## IV. Facility Fee Rules

Please refer to the Pain Management section for the State-specific facility reimbursement rules to be used for outpatient pain management procedures.

Please refer to the Surgery section for the State-specific facility reimbursement rules to be used for ambulatory surgery center (ASC) procedures.

A. **Prepayment Review for Facilities.** The payer must perform a prepayment review on inpatient hospital bills and outpatient surgery bills in order to verify the charges submitted.

1. At a minimum, the pre-payment review should:
   a. Validate that prior authorization was approved according to Fee Schedule guidelines;
   b. Validate that the length of stay and the level of service was appropriate for the diagnosis;
   c. Review the bill for possible overcharges or billing errors;
   d. Determine if an on-site audit is appropriate;
   e. Identify over utilization of services;
   f. Identify those bills and case records that shall be subject to professional review by a physician or appropriate peer.
2. The payer must reimburse the hospital within thirty (30) days of receipt of a valid claim form if prepayment review criteria are met. An exception to the thirty (30) day payment time will be made if additional documentation is requested for prepayment review, and in such cases, payment should be made within thirty (30) days following receipt of this additional documentation if prepayment review criteria are met. If a full audit is scheduled, eighty percent (80%) of the total bill must be paid prior to the audit, and in such event, the payer shall not be liable for interest and penalty as above provided on any additional sums which may be due following completion of the audit. Failure to pay eighty percent (80%) of the total bill prior to the audit shall result in interest and penalty as above provided being added to the total amount determined to be due, from the original due date until paid.
3. If the hospital does not forward copies of requested medical records to the payer after two (2) consecutive requests following the initial request, or if it fails to submit necessary or adequate documentation to support the hospital services rendered, the payer should perform a charge audit.

B. **Charge Audit.** All charge audits must be performed on-site unless otherwise agreed to by the provider and payer.

1. The following information must be provided to the hospital by the payer/auditor when scheduling an audit:
   a. Patient name
   b. Account number
   c. Date(s) of service
   d. Diagnosis(es)
   e. Total amount of bill
   f. Insurance company
   g. Name of audit requester
   h. Telephone number and address of requester
2. A hospital must schedule a charge audit within thirty (30) days of a request by a payer/auditor.
3. Hospitals shall be reimbursed an audit fee of $50.00 for associated audit costs.
4. When a charge audit is necessary, the auditor must identify additional charges for medically necessary hospital services that were ordered by the authorized physician and were provided, but were not included, on the initial bill.
5. The auditor must review and verify the audit findings with a hospital representative at the conclusion of the audit. The hospital may waive its right to the exit conference.
6. The auditor must provide written explanation of the final reimbursement determination based on the audit findings, whether or not an exit conference is held with the hospital. This written explanation must be provided within thirty (30) days following the conclusion of the audit.

C. When any hospital bill that has been prescreened and found to be correct, or when corrections have been made to the bill as required, or when a hospital bill has been audited and verified as correct, it must be paid within thirty (30) days thereafter.

D. Any hospital bill not paid when due under these rules shall automatically include interest at the rate of one and one-half percent (1.5%) per month from the due date of such bill until paid. Any such bill not paid within sixty (60) days after it is due under these rules will be subject to an additional penalty equal to ten percent (10%) of the total amount due, including interest as herein provided.

E. **Implantables.** An implantable is an item that is implanted into the body for the purpose of permanent placement, and remains in the body as a fixture. Absorbable items, temporary items, or other items used to help place the implant, are not within the definition of "implantable" and are not reimbursed as such.

Implantables are included in the applicable DRG reimbursement for inpatient treatment, and, therefore, the provider of inpatient services is not required to furnish the payer with an invoice for implantables. For implantables used in the outpatient setting, reimbursement shall be made separately from the facility fee and all other charges; the provider shall furnish a suitable invoice evidencing the cost of the implantable to the payer within sixty (60) days from the date of service. Upon receipt of this invoice, the payer shall pay the amount due within thirty (30) days thereafter. Implantables shall be reimbursed at cost plus ten percent (10%).

## V. Explanation of Review (EOR)

A. Payers must provide an explanation of review (EOR) to health care providers for each bill whenever the payer's reimbursement differs from the amount billed by the provider, or when an original claim is altered or adjusted by the payer. The EOR must be provided within thirty (30) days of receipt of the bill, and must accompany any payment that is being made.

B. A payer may use the listed EOR codes and descriptors or may develop codes of their own to explain why a provider's charge has been reduced or disallowed, or why a claim has been altered or adjusted in some other way. In all cases, the payer must clearly and specifically detail the reasons for adjusting or altering a bill, including references to the applicable provisions of the Fee Schedule or CPT book, or other source(s) used as the basis for the EOR. Should the EOR include an alteration in the codes submitted on the original claim, it must be based on a review of the medical records documenting the service.

C. The EOR must contain appropriate identifying information to enable the provider to relate a specific reimbursement to the applicable claimant, the procedure billed, and the date of service.

D. Acceptable EORs may include manually produced or computerized forms that contain the EOR codes, written explanations, and the appropriate identifying information.

E. The following EOR codes may be used by the payer to explain to the provider why a procedure or service is not reimbursed as billed, provided clear and specific detail is included, along with references to the applicable provisions of the Fee Schedule or CPT book, or other source(s) used as the basis for the EOR:

001 These services are not reimbursable under the Workers' Compensation Law for the following reason(s): [Provide specific reason(s) why services are not reimbursable under the Workers' Compensation Law]

002 Charges exceed maximum reimbursement allowance [Specify]

003 Charge is included in the basic surgical allowance [Specify]

004 Surgical assistant is not routinely allowed for this procedure. Documentation of medical necessity required [Specify]

005 This procedure is included in the basic allowance of another procedure [Specify the other procedure]

006 This procedure is not appropriate to the diagnosis [Specify]

007 This procedure is not within the scope of the license of the billing provider [Specify]

008 Equipment or services are not prescribed by a physician [Specify]

009 This service exceeds reimbursement limitations [Specify]

010 This service is not reimbursable unless billed by a physician [Specify]

011 Incorrect billing form [Specify]

012 Incorrect or incomplete identification number of billing provider [Specify]

013 Medical report required for payment [Specify]

014 Documentation does not justify level of service billed [Specify]

015 Place of service is inconsistent with procedure billed [Specify]

016 Invalid procedure code [Specify]

017 Prior authorization was not obtained [Specify]

## VI. Request for Reconsideration

A. When, after examination of the explanation of review (EOR) and other documentation, a health care provider is dissatisfied with a payer's payment or dispute of a bill for medical services, reconsideration may be requested by the provider. Any other matter in dispute between the provider and payer may be subject to reconsideration as herein provided at the request of either party, including, but not limited to, a request by

the payer for refund of an alleged over-payment. Alleged over-payments should be addressed through the dispute resolution process, if necessary, and not by way of unilateral recoupment initiated by the payer on subsequent billings.

B. A provider or payer must make a written request for reconsideration within thirty (30) days from the receipt of the explanation of review (EOR) or other written documentation evidencing the basis for the dipute. A request for reconsideration must be accompanied by a copy of the bill in question, the payers' explanation of review (EOR), and/or any additional documentation to support the request for reconsideration.

C. The payer or provider, upon receipt of a request for reconsideration, must review and re-evaluate the original bill and accompanying documentation, and, must notify the requesting party within twenty (20) days thereafter of the results of the reconsideration. The response must adequately explain the reason(s) for the decision, and cite the specific basis upon which the final determination was made. If the payer finds the provider's request for reconsideration is meritorious, and that additional payment(s) should be made, or if the provider finds the payer's request for refund or other payment is meritorious, the additional payment should be made within the above twenty (20) day period. Any additional payment(s) made in response to a provider's or payer's request for reconsideration shall include interest from the original due date of the bill or payment, and an additional ten percent (10%) penalty if applicable.

D. If the dispute is not resolved within the above time after a proper request for reconsideration has been served by the provider or payer, then either party may request further review by the Commission pursuant to the Dispute Resolution Rules set forth hereafter.

E. Failure to seek reconsideration within the time above provided shall bar and prohibit any further reconsideration or review of the bill or other issue in question unless, for good cause shown, the Commission or its representative extends the time for seeking reconsideration or review under these rules. In no event shall the time for seeking reconsideration hereunder be extended by more than an additional thirty (30) days, and any such request for additional time in which to seek reconsideration or further review must be made in writing to the Commission within the initial thirty (30) day period set forth in paragraph B. above.

F. Requests by either provider or payer for refunds, or for additional payment, or other requests related to the billing or payment of a claim, must be sought in accordance with the specific rules set forth herein. No retrospective audits or dispute requests shall be allowed beyond the time otherwise provided herein for seeking reconsideration and/or review.

# Medical Records Rules

## I. Medical Records

A. The medical record, which documents the patient's course of treatment, is the responsibility of the provider and is the basis for determining medical necessity and for substantiating the service(s) rendered; therefore, failure to submit necessary or adequate documentation to support the services rendered may result in the services being disallowed.

B. A medical provider may not charge any fee for completing a medical report or form required by the Workers' Compensation Commission which is part of the required supporting documentation which accompanies a request for payment. The supporting documentation that is required to substantiate the medical treatment is included in the fee for service and does not warrant a separate fee as it is incidental to providing medical care. CPT code 99080 is appropriate for billing special reports required by the payer or their representatives.

C. Medical records must be legible and include, as applicable:

1. Initial office visit notes which document a history and physical examination appropriate to the level of service indicated by the presenting injury/illness or treatment of the ongoing injury/illness;
2. Progress notes which reflect patient complaints, objective findings, assessment of the problem, and plan of care or treatment;
3. Copies of lab, x-ray, or other diagnostic tests that reflect current progress of the patient and/or response to therapy or treatment;
4. Physical medicine/occupational therapy progress notes that reflect the patient's response to treatment/therapy;
5. Operative reports, consultation notes with report, and/or dictated report; and
6. Impairment rating (projected and actual) and anticipated MMI date.

D. A plan of care should be included in the medical record and should address, as applicable, the following:

1. The disability;
2. Degree of restoration anticipated;
3. Measurable goals;
4. Specific therapies to be used;
5. Frequency and duration of treatments to be provided;
6. Anticipated return to work date;
7. Projected impairment.

E. Health care providers must submit copies of records and reports to payers upon request. Providers can facilitate the timely processing of claims and payment for services by submitting appropriate documentation to the payer when requested. Only those records for a specific date of injury are considered non-privileged as it relates to a workers' compensation injury. The employer/payer is not privileged to non-work related medical information.

F. Providers must submit documentation for the following:

1. The initial office visit;
2. A progress report if still treating after thirty (30) days;
3. Evaluation for physical medicine treatment (P.T., O.T., C.M.T., O.M.T.);
4. A progress report every thirty (30) days for physical medicine services;
5. An operative report or office note (if done in the office) for a surgical procedure;
6. A consultation;
7. The anesthesia record for anesthesia services;
8. A functional capacity or work hardening evaluation;
9. When billing a by report (BR) service, a description of the service is required;
10. Whenever a modifier is used to describe an unusual circumstance;
11. Whenever the procedure code descriptors include a written report.

G. Hospitals and other inpatient facilities must submit required documentation with the appropriate billing forms as follows:

1. Admission history and physical;
2. Discharge summary;
3. Operative reports;
4. Pathology reports;
5. Consultations and other dictated reports;
6. Emergency room records.

## II. Copies of Records

A. **Outpatient Records.** The payer may request additional records or reports from the provider concerning service or treatment provided to a patient other than on an inpatient basis. These additional records and reports will be reimbursed as follows:

1-5 pages — $15.00

6+ pages — $.50 per page in addition to the above fee

This applies to copies of microfiche and other electronic media or storage systems.

As provided by MCA section 11-1-52(1) (Supp. 2006), as amended, the provider may add ten percent (10%) of the total charge to cover the cost of postage and handling, and may charge an additional fifteen dollars ($15.00) for retrieving records stored off the premises where the provider's facility or office is located.

B. **Inpatient Records.** The payer may request additional records or reports from a facility concerning inpatient service or treatment provided to a patient. Such reports or records requested by the payer will be reimbursed as follows:

1-5 pages — $15.00/per admission

6+ pages — $.50 per page/per admission in addition to the above fee

This applies to copies of microfiche and other electronic media or storage systems.

There is a maximum reimbursement allowance of fifty dollars ($50.00) for a particular inpatient medical record, exclusive of postage, handling and retrieval charges as set forth below. This is per admission.

As provided by MCA section 11-1-52(1) (Supp. 2006), as amended, the provider may add ten percent (10%) of the total charge to cover the cost of postage and handling, and may charge an additional fifteen dollars ($15.00) for retrieving records stored off the premises where the provider's facility or office is located.

C. Copies of records requested by the patient and/or the patient's attorney or legal representative will be reimbursed according to the provisions of this section on additional reports and records.

D. Documentation submitted by the provider which has not been specifically requested will not be subject to reimbursement.

E. Health care providers may charge up to ten dollars ($10.00) per film for copying x-rays. (Copies of film do not have to be returned to the provider.)

F. Payers, their representatives, and other parties requesting records and reports must be specific in their requests so as not to place undue demands on provider time for copying records.

G. Providers should respond promptly (within fourteen (14) working days) to requests for additional records and reports.

H. Records requested by the Mississippi Workers' Compensation Commission will be furnished by the provider without charge to the Commission.

I. Any additional reimbursement, including copy service vendors, other than is specifically set forth above, is not required, and providers or their vendors will not be paid any additional amounts.

# Dispute Resolution Rules

## I. General Provisions

A. Unresolved disputes may be appealed to and resolved by the Mississippi Workers' Compensation Commission.

B. Reconsideration must be sought by the provider or payer prior to a request for resolution of a dispute being sent to the Commission. This provides the payer and provider an opportunity to resolve most concerns in a timely manner.

C. All communication between parties in dispute will be handled by the Mississippi Worker's Compensation Commission, Cost Containment Division. In addition, there will be no communication between the parties in dispute and any Peer Reviewer who might be called upon to assist the Commission in the resolution of a dispute.

## II. Forms and Documentation

A. Valid requests for resolution of a dispute must be submitted on the "Request for Resolution of Dispute" form (in the Forms section) along with the following:

1. Copies of the original and resubmitted bills in dispute that include dates of service, procedure codes, charges for services rendered and any payment received, and an explanation of any unusual services or circumstances;
2. EOR including the specific reimbursement;
3. Supporting documentation and correspondence;
4. Specific information regarding contact with the payer; and
5. Any other information deemed relevant by the applicant for dispute resolution.

B. A request for Resolution of Dispute must be submitted to:

Mississippi Workers' Compensation Commission
Cost Containment Division
1428 Lakeland Drive
P.O. Box 5300
Jackson, MS 39296-5300

## III. Time for Filing

A Request for Resolution of Dispute must be filed with the Commission within twenty (20) days following the payer's or provider's response to a request for reconsideration of any matter in dispute, or, in cases where the payer or provider fails to respond to a request for reconsideration, within twenty (20) days of the expiration of the time in which said response should have been provided. Failure to file a Request for Resolution of Dispute within this time shall bar any further action on the disputed issue(s) unless, for good cause shown, the Commission or its Cost Containment Director extends the time for filing said request. In no event will the time for filing a Request for Resolution of Dispute be extended by more than once or more than an additional twenty (20) days from the time said request was first due to be filed, provided the request for additional time in which to file a Request for Resolution of Dispute is filed within the initial twenty (20) day period provided herein. The decision to extend the time for filing a Request for Resolution of Dispute based on "good cause" shall be entirely at the discretion of the Commission or its Cost Containment Director. Mere neglect will not constitute "good cause."

## IV. Procedure by Cost Containment Division

A. Requests for dispute resolution will be reviewed and decided by the Cost Containment Division of the Commission within thirty (30) days of receipt of the request, unless additional time is required to accommodate a Peer Review. The payer and/or provider may be contacted by telephone for additional information if necessary.

B. Every effort will be made to resolve disputes by telephone or in writing. The payer and provider may be requested to attend an informal hearing conducted by a Commission representative. Failure to appear at an informal hearing may result in dismissal of the request for dispute resolution.

C. Following review of all documentation submitted for dispute resolution and/or following contact with the payer and/or provider for additional information and/or negotiation, the Cost Containment Division shall render

an administrative decision on the request for dispute resolution.

D. Cases involving medical care determination may be referred for Peer Review, but only on request of the Commission. The peer review consultant will render an opinion and submit same to the Commission representative within the time set by the Cost Containment Division. The Commission representative will notify the parties in dispute if a Peer Review has been requested, and of the peer consultant's determination.

## V. Commission Review of a Dispute

A. Any party aggrieved by the decision of the Cost Containment Division shall have twenty (20) days from the date of said decision to request review by the Commission. Failure to file a written request for review with the Commission within this twenty (20) day period shall bar any further review or action with regard to the issue(s) presented. No extension of time within which to file for Commission review of a dispute under these Rules shall be allowed.

B. The request for review by the Commission shall be filed with the Cost Containment Division of the Mississippi Workers' Compensation Commission, and shall be in writing and shall state the grounds on which the requesting party relies. All documentation submitted to and considered by the Cost Containment Division, including the Request for Resolution of Dispute form, along with a copy of the decision of the Cost Containment Division, shall be attached to the request for review which is filed with the Commission.

C. The Commission shall review the issue(s) solely on the basis of the documentation submitted to the Cost Containment Division. No additional documentation not presented to and considered by the Cost Containment Division shall be considered by the Commission on review, unless specifically requested by the Commission, and no hearing or oral argument shall be allowed.

D. The Commission shall consider the request for review and issue a decision thereon within thirty (30) days after said request is filed, unless otherwise provided by the Commission.

E. Following the decision of the Commission, or following the conclusion of the dispute resolution process at any stage without an appeal to the Commission, no further audit, adjustment, refund, review, consideration, reconsideration or appeal with respect to the claim in question may be sought by either party.

F. The costs incurred in seeking Commission review, including reasonable attorney fees, if any, shall be assessed to the party who requested review if that party's position is not sustained by the Commission. Otherwise, each party shall bear their own costs, including attorney's fees.

G. If the Commission determines that a dispute is based on or arises from a billing error, a payment adjustment or error, including but not limited to improper bundling of service codes, unbundling, downcoding, code shifting, or other action by either party to the dispute, or if the Commission determines that a provider or payer has unreasonably refused to comply with the Law, the Rules of the Commission, including this Fee Schedule, or with any decision of the Commission or its representatives, and that this causes proceedings with respect to the billing and/or payment for covered medical services to be instituted or continued or delayed without reasonable grounds, then the Commission may require the responsible party or parties to pay the reasonable expenses, including attorney's fees, if any, to the opposing party; and, in addition, the Commission may levy against the responsible party or parties a civil penalty not to exceed the sum of ten thousand dollars ($10,000.00), payable to the Commission, as provided in section 71-3-59(2) of the Law. The award of costs and penalties as herein provided shall be in addition to interest and penalty charges which may apply under other provisions of this Fee Schedule.

# Utilization Review Rules

The Mississippi Workers' Compensation Commission requires mandatory utilization review of certain medical services and charges associated with the provision of medical treatment covered under the Act and subject to the Fee Schedule. These rules are set forth to encourage consistency in the procedures for interaction between workers' compensation utilization review agents, representatives or organizations, providers, and payers. The provisions herein set forth regarding utilization review are subject to the requirements of MCA section 41-83-1 et seq. (Rev. 2005), as amended, and any regulations adopted pursuant thereto by the State Department of Health or the State Board of Medical Licensure, and in the event of conflict between this Fee Schedule, and the requirements of the above statute, and any implementing regulations, the provisions of this Fee Schedule or other applicable rules of the Mississippi Workers' Compensation Commission shall govern.

## I. Services Requiring Utilization Review

Mandatory utilization review is required for the following:

A. All admissions to inpatient facilities of any type

B. All surgical procedures, inpatient and outpatient

C. Repeat MRI (more than one per injury)

D. Repeat CT Scan (more than one per injury)

E. Work hardening programs, pain management programs, back schools, massage therapy, acupuncture, biofeedback

F. External spinal stimulators

G. FCE and isokinetic testing

H. Physical medicine treatments, after fifteen (15) visits or thirty (30) days, whichever comes first

I. Home health

## II. Definitions

**Case Management.** The clinical and administrative process in which timely, individualized, and cost effective medical rehabilitation services are implemented, coordinated, and evaluated on an ongoing basis for patients who have sustained an injury or illness. Use of case management is optional in Mississippi.

**Certification.** A determination by a utilization review organization or agent that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the requirements of the workers' compensation program.

**Clinical Peer.** A health professional that holds unrestricted license and is qualified to practice in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession (i.e., the same licensure category as the ordering provider).

**Clinical Rationale.** A statement that provides additional clarification of the clinical basis for a non-certification determination. The clinical rationale should relate the non-certification determination to the worker's condition or treatment plan, and should supply a sufficient basis for a decision to pursue an appeal.

**Clinical Review Criteria.** The written screens, decision rules, medical protocols, or guidelines used by the payer's Utilization Management Program as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services.

**Concurrent Review.** Utilization management conducted during a worker's hospital stay or course of treatment, sometimes called continued stay review.

**Discharge Planning.** The process of assessing a patient's need for medically appropriate treatment after hospitalization and affecting an appropriate and timely discharge.

**Expedited Appeal.** An expedited appeal is a request for additional review of a determination not to certify imminent or ongoing services, an admission, an extension of stay, or other medical services of an imminent or ongoing nature. Also sometimes referred to as a reconsideration request.

**First Level Clinical Review.** Review conducted by registered nurses and other appropriate licensed or certified health professionals. First level clinical review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to second level clinical peer reviewers for approval or denial.

**Notification.** Correspondence transmitted by mail, telephone, facsimile, and/or electronic data interchange (EDI).

**Pre-certification.** The review and assessment of medical necessity and appropriateness of services before they occur. The appropriateness of the site or level of care is assessed along with the duration and timing of the proposed services.

**Provider.** A licensed health care facility, program, agency, or health professional that delivers health care services.

**Retrospective Review.** Utilization review conducted after services have been provided to the worker.

**Second Level Clinical Review.** Clinical review conducted by appropriate clinical peers when a request for an admission, procedure, or service does not meet clinical review criteria.

**Standard Appeal.** A request to review a determination not to certify an admission, extension of stay, or other health care service.

**Third Level Clinical Review.** Clinical review conducted by appropriate clinical peers who were not involved in second level review when a decision not to certify a requested admission, procedure, or service has been appealed. The third level peer reviewer must be in the same or like specialty as the requesting provider.

**Utilization Review.** Evaluation of the necessity, appropriateness, and efficiency for the use of health care services. It includes both prospective and concurrent review, and may include retrospective review under certain circumstances.

**Utilization Reviewer.** An entity, organization, or representative thereof, or other person performing utilization review activities or services on behalf of an employer, payer or third-party claims administrator.

**Variance.** A deviation from a specific standard.

## III. STANDARDS

Utilization review organizations or programs are required to meet the following standards:

A. The payer's utilization reviewer must comply with the requirements of MCA section 41-83-1 et seq. (Rev. 2005), as amended, and any regulations adopted pursuant thereto by the State Department of Health or the State Board of Medical Licensure, and shall have utilization review agents or representatives who are properly qualified, trained, supervised, and supported by explicit clinical review criteria and review procedures.

B. The first level review is performed by individuals who are health care professionals, who possess a current and valid professional license, and who have been trained in the principles and procedures of utilization review.

C. The first level reviewers are required to be supported by a doctor of medicine who has an unrestricted license to practice medicine.

D. The second level review is performed by clinical peers who hold a current, unrestricted license and are oriented in the principles and procedures of utilization review. The second level review shall be conducted for all cases where clinical determination to certify cannot be made by first level clinical reviewers. Second level clinical reviewers shall be available within one (1) business day by telephone or other electronic means to discuss the determination with the attending physicians or other ordering providers. In the event more information is required before a determination can be rendered by a second level reviewer, the attending/ordering provider must be notified of the delay and given a specific time frame for determination.

E. The payer's utilization reviewer shall conduct third level reviews by requiring peers who serve in this capacity to hold a current, unrestricted license and be board certified in a specialty board approved by the American Board of Medical Specialties. Board certification requirement is not applicable to reviewers who are not doctors of medicine. Third level clinical reviewers shall be in the same profession or similar specialty as typically manages the medical condition, procedure, or treatment under review.

F. The payer's utilization reviewer shall maintain written policies and procedures for the effective management of its utilization review activities.

G. The payer maintains the responsibility for the oversight of the delegated functions if the payer delegates utilization review responsibility to a vendor. The vendor or organization to which the function is being delegated must be currently certified by the Mississippi Board of Health, Division of Licensure and Certification to perform utilization management in the State of Mississippi. The payer who has another entity perform utilization review functions or activities on its behalf

maintains full responsibility for compliance with the rules.

H. The payer's utilization reviewer shall maintain a telephone review service that provides access to its review staff at a toll free number from at least 9:00 a.m. to 5:00 p.m. CST each normal business day. There should be an established procedure for receiving or redirecting calls after hours or receiving faxed requests. Reviews should be conducted during hospitals' and health professionals' reasonable and normal business hours.

I. The payer's utilization reviewer shall collect only the information necessary to certify the admission procedure or treatment, length of stay, frequency, and duration of services. The utilization reviewer should have a process to share all clinical and demographic information on individual workers among its various clinical and administrative departments to avoid duplicate requests to providers. (Providers may use the Mississippi Workers' Compensation Commission Utilization Review Request Form.)

## IV. Procedures for Review Determinations

The following procedures are required for effective review determination.

A. Review determinations must be made within two (2) business days of receipt of the necessary information on a proposed non-emergency admission or service requiring a review determination. The Mississippi Workers' Compensation Utilization Review Request Form may be used to request pre-certification.

B. When an initial determination is made to certify, notification shall be provided promptly, at least within one (1) business day or before the service is scheduled, whichever first occurs, either by telephone or by written notification to the provider or facility rendering the service. If an initial determination to certify is provided by telephone, a written notification of the determination shall be provided within two (2) business days. The written notification shall include the number of days approved, the new total number of days or services approved, and the date of admission or onset of services.

C. When a determination is made not to certify, notify the attending or ordering provider or facility by telephone within one (1) business day and send a written notification within one (1) business day. The written notification must include the principal reason/clinical rationale for the determination not to certify and instructions for initiating an appeal. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician.

D. The payer's utilization reviewer shall inform the attending physician and/or other ordering provider of their right to initiate an expedited appeal or standard appeal of a determination not to certify, and the procedure to do so.

   1. Expedited appeal—When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review, and the attending physician believes that the determination warrants immediate appeal, the attending physician shall have an opportunity to appeal that determination over the telephone on an expedited basis within one (1) business day.

      a. Each private review agent shall provide for reasonable access to its consulting physician(s) for such appeals.

      b. Both providers of care and private review agents should attempt to share the maximum information by phone, fax, or otherwise to resolve the expedited appeal (sometimes called a reconsideration request) satisfactorily.

      c. Expedited appeals, which do not resolve a difference of opinion, may be resubmitted through the standard appeal process.

   2. Standard appeal—A standard appeal will be considered, and notification of the appeal decision given to the provider, not later than thirty (30) days after receiving the required documentation for the appeal.

      a. An attending physician who has been unsuccessful in an attempt to reverse a determination not to certify should be provided the clinical rationale for the determination upon request.

   3. Retrospective review—For retrospective review, the review determination shall be based on the medical information available to the attending or ordering provider at the time the medical care was provided, and on any other relevant information regardless of whether the information was available to or considered by the provider at the time the care or service was provided.

      a. When there is retrospective determination not to certify an admission, stay, or other service, the attending physician or other ordering provider and hospital or facility shall receive written notification.

b. Notification should include the principal reason for the determination and a statement of method for standard appeal.

4. Emergency admissions or surgical procedures—Emergency admissions or surgical procedures must be reported to the payer by the end of the next business day. Post review activities will be performed following emergency admissions, and a continued stay review will be initiated.

   a. If a licensed physician certifies in writing to the payer or its agent or representative within seventy-two (72) hours of an admission that the injured worker admitted was in need of emergency admission to hospital care, such shall constitute a prima facie case for the medical necessity of the admission. An admission qualifies as an emergency admission if it results from a sudden onset of illness or injury which is manifested by acute symptoms of sufficient severity that the failure to admit to hospital care could reasonably result in (1) serious impairment of bodily function(s), (2) serious or permanent dysfunction of any bodily organ or part or system, (3) permanently placing the person's health in jeopardy, or (4) other serious medical consequence.

   b. To overcome a prima facie case for emergency admission as established above, the utilization reviewer must demonstrate by clear and convincing evidence that the patient was not in need of an emergency admission.

E. Failure of the health care provider to provide necessary information for review may result in denial of certification.

F. When a payer and provider have completed the utilization review appeals process and cannot agree on a resolution to a dispute, either party can appeal to the Cost Containment Division of the Mississippi Workers' Compensation Commission, and should submit this request on the Request for Dispute Resolution Form adopted by the Commission. A request for resolution of a utilization review dispute should be filed with the Commission within twenty (20) days following the conclusion of the underlying appeal process provided by the utilization reviewer. The Commission shall consider and decide a request for resolution of a utilization review dispute in accordance with the Dispute Resolution Rules provided elsewhere in this Fee Schedule.

# Rules for Modifiers and Code Exceptions

Please see the modifier rules in each section of the *Mississippi Workers' Compensation Medical Fee Schedule* for a complete listing of appropriate modifiers for each area.

A. Modifier codes must be used by providers to identify procedures or services that are modified due to specific circumstances.

B. When modifier 22 is used to report an unusual service, a report explaining the medical necessity of the situation must be submitted with the claim to the payer. It is not appropriate to use modifier 22 for routine billing.

C. The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed. Reimbursement for a modified service or procedure is based on documentation of medical necessity and determined on a case-by-case basis.

D. Modifiers allow health care providers to indicate that a service was altered in some way from the stated description without actually changing the definition of the service.

## I. Modifiers for CPT (HCPCS Level I) Codes

This section contains a list of modifiers used with CPT codes. Also consult each practice-area section of the Fee Schedule for additional modifiers.

### *21 Prolonged Evaluation and Management Services*

When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier 21 to the evaluation and management code number. A report may also be appropriate.

### *22 Unusual Procedural Services*

When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

### *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 modifier 23 to the procedure code of the basic service.

### *24 Unrelated Evaluation and Management Services by the Same Physician During a Postoperative Period*

The physician 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 modifier 24 to the appropriate level of E/M service.

### *25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service*

The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). 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 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. See modifier 57.

### *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 modifier 26 to the usual procedure number.

### *TC Technical Component (HCPCS Level II Modifier)*

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

*Mississippi's note: The technical component is calculated by subtracting the professional component amount from the total amount for the reimbursement.*

### *32 Mandated Services*

Services related to mandated consultation and/or related services (e.g., PRO, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

### *47 Anesthesia by Surgeon*

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures 00100-01999.

*Mississippi's note: Reimbursement is made for base units only.*

### *50 Bilateral Procedure*

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five-digit code.

### *51 Multiple Procedures*

When multiple procedures, other than E/M Services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see the applicable CPT book).

*Mississippi's note: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the applicable CPT book.*

### *52 Reduced Services*

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

### *53 Discontinued Procedure*

Under certain circumstances the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

### *54 Surgical Care Only*

When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

### *55 Postoperative Management Only*

When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

### *56 Preoperative Management Only*

When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

### *57 Decision for Surgery*

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

### *58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period*

The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.

### *59 Distinct Procedural Service*

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

### *62 Two Surgeons*

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the cosurgery once using the same procedure code. If an additional procedure(s) (including an add-on procedure(s)) is performed during the same surgical session, a separate code(s) may be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those service(s) may be reported using a separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

### *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 modifier 66 to the basic procedure number used for reporting services.

### *76 Repeat Procedure by Same Physician*

The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

### *77 Repeat Procedure by Another Physician*

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 procedure/service.

### *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 modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

### *79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period*

The physician 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 modifier 79. (For repeat procedures on the same day, see modifier 76.)

### *80 Assistant Surgeon*

Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

*Mississippi's note: Reimbursement is twenty percent (20%) of the maximum reimbursement allowance.*

### *81 Minimum Assistant Surgeon*

Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

*Mississippi's note: Physician reimbursement is ten percent (10%) of the allowable.*

### *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).

### *90 Reference (Outside) Laboratory*

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

### *91 Repeat Clinical Diagnostic Laboratory Test*

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describes a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for a laboratory test(s) performed more than once on the same day on the same patient.

### *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.

### *AA Anesthesiologist Services Performed Personally by an Anesthesiologist*

Report modifier AA when the anesthesia services are personally performed by an anesthesiologist.

### *AD Medical Supervision by a Physician: More Than Four Concurrent Anesthesia Procedures*

Report modifier AD when the anesthesiologist supervises more than four concurrent anesthesia procedures.

### *AS Assistant at Surgery Services Provided by Registered Nurse First Assistant*

Assistant at surgery services provided by a registered nurse first assistant or other qualified individual (excluding assistant at surgery services provided by a physician) are identified by adding modifier AS to the listed applicable surgical procedures. The use of the AS modifier is appropriate for any code that otherwise is reimbursable for a physician assisting a surgeon in the operating room.

*Mississippi's note: AS reimbursement is ten percent (10%) of the allowable. For assistant at surgery services provided by a physician, see modifiers 80, 81, and 82.*

### *NP Nurse Practitioner (Mississippi Modifier)*

This modifier should be added to the appropriate CPT code to indicate that the services being billed were rendered or provided by a nurse practitioner.

### *QK Medical Direction of Two, Three, or Four Concurrent Anesthesia Procedures Involving Qualified Individuals (CRNA) by an Anesthesiologist*

Report modifier QK when the anesthesiologist supervises two, three, or four concurrent anesthesia procedures involving qualified individuals (CRNA or AA).

### *QX CRNA Service: With Medical Direction by an Anesthesiologist*

Regional or general anesthesia provided by the CRNA or AA with medical direction by a physician may be reported by adding modifier QX.

### *QY Medical Direction of One Certified Registered Nurse Anesthetist (CRNA) by an Anesthesiologist*

Report modifier QY when the anesthesiologist supervises one CRNA or AA.

### *QZ CRNA Service: Without Medical Direction by an Anesthesiologist*

Regional or general anesthesia provided by the CRNA or AA without medical direction by a physician may be reported by adding modifier QZ.

## II. Modifiers Approved For Ambulatory Surgery Center (ASC) Hospital Outpatient Use

This section contains a list of modifiers used with ambulatory surgery center and hospital-based outpatient services. Also consult each practice-area section of the Fee Schedule for additional modifiers.

### *25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service*

The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the

other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). 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 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. See modifier 57.

### *27 Multiple Outpatient Hospital E/M Encounters on the Same Date*

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic). **Note:** This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (e.g., hospital emergency department, clinic), see **Evaluation and Management, Emergency Department, or Preventive Medicine Services** codes.

### *50 Bilateral Procedure*

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code.

### *52 Reduced Services*

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

### *58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period*

The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.

### *59 Distinct Procedural Service*

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

### *73 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia*

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

### *74 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia*

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

### *76 Repeat Procedure by Same Physician*

The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

### *77 Repeat Procedure by Another Physician*

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 procedure/service.

### *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 modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

### *79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period*

The physician 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 modifier 79. (For repeat procedures on the same day, see modifier 76.)

### *91 Repeat Clinical Diagnostic Laboratory Test*

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

## III. Modifiers For HCPCS Level II Codes

This section contains a list of commonly used modifiers with HCPCS Level II DME codes. Other HCPCS Level II modifiers, including those which can be used with CPT codes, are acceptable modifiers.

***AU Item furnished in conjunction with a urological, ostomy, or tracheostomy supply***

***AV Item funished in conjunction with a prosthetic device, prosthetic, or orthotic***

***AW Item furnished in conjunction with a surgical dressing***

***KC Replacement of special power wheelchair interface***

***NU Purchased new equipment***

***RR Rental equipment (listed amount is the per-month allowance)***

***UE Purchased used equipment***

## IV. Code Exceptions

A. **Unlisted Procedure Codes.** If a procedure is performed that is not listed in the Medical Fee Schedule, the provider must bill with the appropriate "Unlisted Procedure" code and submit a narrative report to the payer explaining why it was medically necessary to use an unlisted procedure code.

   The CPT book contains codes for unlisted procedures. Use these codes only when there is no procedure code that accurately describes the service rendered. A report is required as these services are reimbursed by report (see below).

B. **By Report (BR) Codes.** By report (BR) codes are used by payers to determine the reimbursement for a service or procedure performed by the provider that does not have an established maximum reimbursement allowance (MRA).

1. Reimbursement for procedure codes listed as "BR" must be determined by the payer based on documentation submitted by the provider in a special report attached to the claim form. The required documentation to substantiate the medical necessity of a procedure does not warrant a separate fee. Information in this report must include, as appropriate:
   a A complete description of the actual procedure or service performed;
   b. The amount of time necessary to complete the procedure or service performed;
   c. Accompanying documentation that describes the expertise and/or equipment required to complete the service or procedure.
2. Reimbursement of "BR" procedures should be based on the usual and customary rate.

C. **Category II Codes.** This Fee Schedule does not include Category II codes as published in *CPT 2007*. Category II codes are supplemental tracking codes that can be used for performance measurements. These codes describe clinical components that are typically included and reimbursed in other services such as evaluation and management (E/M) or laboratory services. These codes do not have an associated relative value or fee.

D. **Category III Codes.** This Fee Schedule does not include Category III codes published in *CPT 2007*. If a provider bills a Category III code, payment may be denied.

E. **Add-On Codes.** Some of the listed procedures are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as add-on codes with a **+** symbol, and are listed in the applicable CPT book. Add-on codes can be readily identified by specific descriptor nomenclature which includes phrases such as "each additional" or "(List separately in addition to code for primary procedure)."

The "add-on" code concept in the CPT book applies only to add-on procedures/services performed by the same physician. Add-on codes describe additional intra-service work associated with the primary procedure (e.g., additional digit(s), lesion(s) neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s)).

Add-on codes are always performed in addition to the primary service/procedure, and must never be reported as a stand-alone code. All add-on codes found in the CPT book are exempt from the multiple procedure concept (see modifier 51 definition in this section). Add-on codes are reimbursed at one hundred percent (100%) of the maximum reimbursement allowance.

Refer to the most current version of the CPT book for a complete list of add-on codes.

F. **Codes Exempt From Modifier 51.** Certain codes are exempt from the use of modifier 51 but have not been designated as CPT add-on procedures/services. Please consult the most current CPT book for the list of codes that are exempt from modifier 51. Codes designated as exempt from modifier 51 are identified with a ⃠ symbol, and are listed in the applicable CPT book.

All codes exempt from modifier 51 found in the CPT book are exempt from the multiple procedure concept (see modifier 51 definition in this section). Codes exempt from modifier 51 are reimbursed at one hundred percent (100%) of the maximum reimbursement allowance or the provider's usual charge whichever is less.

G. **Moderate (Conscious) Sedation.** To report moderate (conscious) sedation provided by the physician also performing the diagnostic or therapeutic service for which conscious sedation is being provided, see codes 99143–99145. It is not appropriate for the physician performing the sedation and the service for which the conscious sedation is being provided to report the sedation separately when the code is listed with the conscious sedation symbol ⊙. The conscious sedation symbol identifies services that include moderate (conscious) sedation. A list of codes for services that include moderate (conscious) sedation is also included in the applicable CPT book.

For procedures listed with ⊙, when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderate (conscious) sedation in the facility setting (e.g., hospital, outpatient hospital/ambulatory surgery center, skilled nursing facility), the second physician reports the associated moderate sedation procedure/service using codes 99148-99150. Moderate (conscious) sedation services are not reported additionally when performed by the second physician in the nonfacility setting (e.g., physician office, freestanding imaging center).

Moderate sedation codes are not used to report minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care.

# Pharmacy Rules

## I. Scope

This section provides specific rules for the dispensing of and payment for medications and other pharmacy services prescribed to treat work-related injury/illness under the terms of the Act.

## II. Definitions

A. **Medications** are defined as drugs prescribed by a licensed health care provider and include name brand and generic drugs as well as patented or over-the-counter drugs.

B. **Average Wholesale Price** means the AWP based on the most current edition of the *Drug Topics Red Book* in effect at the time the medication is dispensed.

## III. Rules

A. Consistent with the Mississippi Pharmacy Practice Act, the following rules apply with regard to the selection of generic equivalent drug products:

1. A pharmacist may select a generic equivalent drug product only when such selection results in a lower cost to the payer, unless product selection is expressly prohibited by the prescriber.
2. A pharmacist shall select a generic equivalent drug product when:
   a. The patient requests the selection of a generic equivalent drug product;
   b. The provider has not expressly prohibited product selections; and
   c. Product selection will result in lower cost to the patient and/or payer.
3. When requested by the patient to dispense the drug product as ordered by the prescriber, a pharmacist shall not select a generic equivalent drug product.

B. A payer may not prohibit or limit any person from selecting a pharmacy or pharmacist of his/her choice, and may not require any person to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy or program.

C. Dietary supplements, including but not limited to minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established.

D. Not more than one dispensing fee shall be paid per drug within a ten (10) day period.

## IV. Reimbursement

A. Reimbursement for pharmaceuticals ordered for the treatment of work-related injury/illness is as follows:

1. Brand/Trade Name Medications: Average Wholesale Price (AWP) plus a five dollar ($5.00) dispensing fee.
2. Generic Medications: Average Wholesale Price (AWP) plus a five dollar ($5.00) dispensing fee.
3. Over-the-counter medications are reimbursed at usual and customary rates.
4. Dispensing fees are payable only if the prescription is filled under the direct supervision of a registered pharmacist. If a physician dispenses medications from his/her office, a dispensing fee is not allowed.

B. Supplies and equipment used in conjunction with medication administration should be billed with the appropriate HCPCS codes and shall be reimbursed according to the Fee Schedule. Supplies and equipment not listed in the Fee Schedule will be reimbursed at the usual and customary rate.

C. Mail-order pharmaceutical services are subject to the rules and reimbursement limitations of this Fee Schedule when supplying medications to Mississippi Workers' Compensation claimants.

# Nurse Practitioner and Physician Assistant Rules

I. Modifier NP should be attached to the appropriate CPT code when billing services rendered by the nurse practitioner. The nurse practitioner must use his/her unique identifier to bill for all services. Nurse practitioners must comply with the requirements for a National Provider Identifier (NPI) as specified in the Billing and Reimbursement Rules of this Fee Schedule.

II. The nurse practitioner is reimbursed at eighty-five percent (85%) of the maximum allowable for the procedure.

III. There is only one fee allowed for each CPT code. It is the decision of the physician or the nurse practitioner as to who will bill for a service when both have shared in the provision of the service. Incorrect billing of the service may cause a delay or improper payment by the payer. The payer will reimburse the bill which is received first.

IV. The physician assistant shall be reimbursed at the same rate as for the nurse practitioner, and the same rules as apply to the nurse practitioners with regard to billing and reimbursement, shall apply to the physician assistant.

V. Modifier PA should be attached to the appropriate CPT code when billing services rendered by the physician assistant.

# Home Health Rules

## I. Scope

This section of the Fee Schedule pertains to home health services provided to patients who have a work-related injury/illness.

A. The determination that the injury/illness or condition is work related must be made by the payer and home health services shall be pre-certified as medically necessary by the payer's Utilization Management Program.

B. All nursing services and personal care services shall have prior authorization by the payer.

C. A description of needed nursing or other attendant care must accompany the request for authorization.

## II. Reimbursement

A. If a payer and provider have a mutually agreed upon contractual arrangement governing the payment for home health services to injured/ill employees, the payer shall reimburse under the contractual agreement and not according to the Fee Schedule.

B. In the absence of a mutually agreed upon contractual arrangement governing payment for home health service, reimbursement shall be made as in other cases (see Billing and Reimbursement Rules) in an amount equal to the maximum reimbursement allowance (MRA).

C. A visit made simultaneously by two or more workers from a home health agency to provide a single covered service for which one supervises or instructs the other shall be counted as one visit.

D. A visit is defined as time up to and including the first two hours.

E. The maximum reimbursement rates listed herein are inclusive of mileage and other incidental travel expenses, unless otherwise agreed to by the payer and provider.

## III. Rates

A. The following rates apply to services provided by or through a home health agency:

| Service | Fee Per Visit |
|---|---|
| Skilled Nursing Care | $120.00 |
| Physical Therapy | $125.00 |
| Speech Therapy | $135.00 |
| Occupational Therapy | $135.00 |
| Medical Social Services | $170.00 |
| Home Health Aid | $60.00 |

For services that exceed two hours, reimbursement for time in excess of the first two hours shall be pro-rated and based on an hourly rate equal to fifty percent (50%) of the above visit fee. For home health services rendered in less than the first hour, reimbursement shall be made for one hour at the hourly rate. For services which exceed one hour, but are provided in less than two hours, reimbursement shall be made for a visit as above provided.

**NOTE:** In addition to the Skilled Nursing Care fees above, an additional sum of $7.16 per visit shall be added to cover the cost of medical supplies, provided the billing form adequately specifies what supplies were utilized.

B. The following **Private Duty Rates** shall apply:

| | |
|---|---|
| Skilled Nursing Care – R.N. | $44.00 per hour |
| Skilled Nursing Care – L.P.N. | $37.00 per hour |
| Certified Nurse Assistant | $20.00 per hour |
| Sitter | $13.00 per hour |

C. Any reimbursement to persons not working under a professional license, such as a spouse or relative, will be at the same rate as allowed for a private duty sitter, excpet that under no circumstances shall a person not working under a professional license be reimbursed under this provision more than the sum of two hundred fifty dollars ($250.00) per day.

D. Professional providers not assigned a maximum allowable rate for home health services and who have not negotiated their rates with the payer prior to provision of home health care, shall be reimbursed at the usual and customary rate, or the total billed charge, whichever is less.

# Skilled Nursing Facility Rules

I. The maximum reimbursement amount for medical care provided within the confines of a freestanding skilled nursing facility, a hospital based skilled nursing facility, or a swing bed facility, shall be three hundred dollars ($300.00) per day. This rate covers and includes all routine and ancillary health care services provided to a claimant during each day of a covered skilled nursing facility stay.

II. The following services are excluded from the daily skilled nursing facility rate, and shall reimbursed separately and in addition to the above daily rate: cardiac catherization; angiography; magnetic resonance imaging (MRI) and computerized axial tomography (CT) scans; radiation therapy and chemotherapy; emergency services, which are defined as an admission or services necessitated by a sudden onset of illness or injury which is manifested by acute symptoms of sufficient severity that the failure to provide services could reasonably result in (a) serious impairment of bodily function(s), (b) serious or permanent dysfunction of any bodily organ or part or system, (c) permanently placing the person's health in jeopardy, or (d) other serious medical consequence; outpatient services when provided in a hospital or other free standing outpatient facility separate from the skilled nursing facility; customized prosthetic services; ambulance transportation related to any of the above service; and services provided independent of the facility by physicians, and other medical practitioners (e.g., NP, PA, CRNA, psychologist).

III. As in other cases, the above provisions shall not apply to any mutual agreement or contract entered into by the payer and provider which sets forth the terms for the provision of skilled nursing facility services and reimbursement therefor.

# Evaluation and Management

This section contains rules and codes used to report evaluation and management services.

**Note:** Rules used by all physicians in reporting their services are presented in the General Rules section.

## I. Definitions and Rules

Definitions and rules pertaining to evaluation and management services are as follows:

A. **Consultations.** The CPT book defines a consultation as "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." (This includes referrals for a second opinion.) Consultations are reimbursable only to physicians with the appropriate specialty for the services provided.

In order to qualify as a consultation the following criteria must be met:

- The verbal or written request for a consult must be documented in the patient's medical record;
- The consultant's opinion and any services ordered or performed must be documented by the consulting physician in the patient's medical record;
- The consulting physician must provide a written report to the requesting physician or other appropirate source.

A payer/employer may request a second opinion examination or evaluation for the purpose of evaluating temporary or permanent disability or medical treatment being rendered, as provided in MCA §71-3-15(1) (Rev. 2000). This examination is considered a confirmatory consultation. The confirmatory consultation is billed using the appropriate level and site specific consultation code, 99241–99245 for office or other outpatient consultations and 99251–99255 for inpatient consultations, appended with modifier 32 to indicate a mandated service.

B. **Referral.** Subject to the definition of "consulation" provided in this Fee Schedule, 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 evaluations and subsequent services are designated as listed in E/M services).

C. **New and Established Patient Service.** Several code subcategories in the Evaluation and Management section are based on the patient's status as new or established. The new versus established patient guidelines also clarify the situation in which a physician is on call or covering for another physician. In this instance, classify the patient encounter the same as if it were for the physician who is unavailable.

- *New Patient.* A new patient is one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.
- *Established Patient.* An established patient is a patient who has been treated for the same injury by any physician, of the same specialty, who belongs to the same group practice.

D. **E/M Service Components.** The first three components of history, examination, and medical decision-making are the keys to selecting the correct level of E/M codes, and all three components must be met or exceeded in the documentation of an initial evaluation. However, in established, subsequent, and follow-up categories, only two of the three must be met or exceeded for a given code.

1. The history component is categorized by four levels:
   a. *Problem Focused.* Chief complaint; brief history of present illness or problem.
   b. *Expanded Problem Focused.* Chief complaint; brief history of present illness; problem-pertinent system review.
   c. *Detailed.* Chief complaint; extended history of present illness; problem-pertinent system review extended to include a review of limited

number of additional systems; pertinent past, family medical and/or social history directly related to the patient's problems.

d. *Comprehensive.* Chief complaint; extended history of present illness; review of systems that are directly related to the problems identified in the history of the present illness, plus a review of all additional body systems; complete past, family, and social history.

2. The physical exam component is similarly divided into four levels of complexity:

   a. *Problem Focused.* An exam limited to the affected body area or organ system.

   b. *Expanded Problem Focused.* A limited examination of the affected body area or organ system and other symptomatic or related organ systems.

   c. *Detailed.* An extended examination of the affected body areas and other symptomatic or related organ systems.

   d. *Comprehensive.* A general multi-system examination or a complete examination of a single organ system.

The CPT book identifies the following body areas:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

The CPT book identifies the following organ systems:

- Constitutional symptoms (fevers, weight loss, etc.)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic
- Allergic/immunologic

3. Medical decision-making is the final piece of the E/M coding process. Medical decision making refers to the complexity of establishing a diagnosis or selecting a management option that can be measured by the following:

   a. The number of diagnoses and/or the number of management options to be considered.

   b. The amount and/or complexity of medical records, diagnostic tests, and other information that must be retrieved, reviewed, and analyzed.

   c. The risk of significant complications, morbidity, mortality, as well as co-morbidities associated with the patient's presenting problems, the diagnostic procedures, and/or the possible management options.

E. **Contributory Components.**

1. Counseling, coordination of care, and the nature of the presenting problem are not major considerations in most encounters, so they generally provide contributory information to the code selection process. The exception arises when counseling or coordination of care dominates the encounter (more than fifty percent (50%) of the time spent). Document the exact amount of time spent to substantiate the selected code and what was clearly discussed during the encounter. Counseling is defined in the CPT book as a discussion with a patient and/or family concerning one or more of the following areas:

   a. Diagnostic results, impressions, and/or recommended diagnostic studies;

   b. Prognosis;

   c. Risks and benefits of management (treatment) options;

   d. Instructions for management (treatment) and/or follow-up;

   e. Importance of compliance with chosen management (treatment) options;

   f. Risk factor reduction;

   g. Patient and family education.

2. E/M codes are designed to report actual work performed, not time spent. But when counseling or coordination of care dominates the encounter, time overrides the other factors and determines the proper code. For office encounters, count only the time spent face-to-face with the patient and/or

family. For hospital or other inpatient encounters, count the time spent rendering services for that patient while on the patient's unit, on the patient's floor, or at the patient's bedside.

F. **Interpretation of Diagnostic Studies in the Emergency Room**

1. Only one fee for the interpretation of an x-ray or EKG procedure will be reimbursed per procedure.
2. The payer is to provide reimbursement to the provider that directly contributed to the diagnosis and treatment of the individual patient.
3. It is necessary to provide a signed report in order to bill the professional component of a diagnostic procedure. The payer may require the report before payment is rendered.
4. If more than one bill is received, physician specialty should not be the deciding factor in determining which physician to reimburse.

   Example: In many EDs, an emergency room (ER) physician orders the x-ray on a particular patient. If the ER physician interprets the x-ray making a notation as to the findings in the chart and then treats the patient according to these radiological findings, the ER physician should be paid for the interpretation and report. There may be a radiologist on staff at the particular facility with quality control responsibilities at that particular facility. However, the fact that the radiolgosit reads all x-rays taken in the ED for quality control purposes is not sufficient to command a separate or additional reimbursement from the payer.

5. There is a provision for payment of a second interpreetation under unusual circumstances such as a questionable finding for which the physician performing the initial interpretation requests the expertise of another physician (i.e., expertise of a radiologist). CPT code 76140 is to be used when a second opinion is required for a radiological procedure. Reimbursement is limited to the professional component listed in the Fee Schedule for that procedure.
6. A review alone of an x-ray or EKG does not meet the conditions for separate payment of a service, as it is already included in the ED visit.

## II. General Guidelines

The E/M code section is divided into subsections by type and place of service. Keep the following in mind when coding each service setting:

- A patient is considered an outpatient at a health care facility until formal inpatient admission occurs.
- All physicians use codes 99281–99285 for reporting emergency department services, regardless of hospital-based or non-hospital-based status.
- Admission to a hospital or nursing facility includes E/M services provided elsewhere on the same day.

## III. Office or Other Outpatient Services (99201–99215)

Use the Office or Other Outpatient Services codes to report the services for most patient encounters. Multiple office or outpatient visits provided on the same calendar date are billable if medically necessary and include documentation to support medical necessity.

## IV. Hospital Observation Services (99217–99220)

CPT codes 99217 through 99220 report E/M services provided to patients designated or admitted as "observation status" in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital to use these codes; however, whenever a patient is placed in a separately designated observation area of the hospital or emergency department, these codes should be used.

The instructional notes for Initial Hospital Observation Care include the following:

A. Use these codes to report the encounters by the supervising physician when the patient is designated as "observation status."

B. These codes include initiation of "observation status," supervision of the health care plan for observation, and performance of periodic reassessments.

C. When a patient is admitted to observation status in the course of an encounter in another site of service (e.g., hospital emergency department, physician's office, nursing facility), all E/M services provided by that physician on the same day are included in the admission for hospital observation. Only one physician can report initial observation services. Do not use these observation codes for post-recovery of a procedure that is considered a global surgical service.

D. Observation services are included in the inpatient admission service when provided on the same date. Use Initial Hospital Care codes for services provided to a patient who, after receiving observation services, is

admitted to the hospital on the same date. The observation service is not reported separately.

E. Admission to a hospital or nursing facility includes evaluation and management services provided elsewhere (office or emergency department) by the admitting physician on the same day.

F. For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission would be reported separately with the appropriate Initial Hospital Care code 99221–99223.

G. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234–99236.

**See Office and Other Outpatient Consultation codes to report observation encounters by other physicians.**

## V. Observation Care Discharge Services (99217)

A. CPT code 99217 is used only if discharge from observation status occurs on a date other than the initial date of observation. The code includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records.

B. If a patient is admitted to and subsequently discharged from observation status on the same date, see codes 99234–99236.

C. Do not report observation discharge 99217 in conjunction with a hospital admission.

## VI. Hospital Inpatient Services (99221–99239)

The codes for hospital inpatient services report admission to a hospital setting, follow-up care provided in a hospital setting, and hospital discharge day management. For inpatient care, the time component includes not only face-to-face time with the patient but also the physician's time spent in the patient's unit or on the patient's floor. This time may include family counseling or discussing the patient's condition with the family; establishing and reviewing the patient's record; documenting within the chart; and communicating with other health care professionals, such as other physicians, nursing staff, respiratory therapists, etc.

A. If the patient is admitted to a facility on the same day as any related outpatient encounter (office, emergency department, nursing facility, etc.), report the total care as one service with the appropriate Initial Hospital Care code.

B. For initial hospital care of a patient admitted on one date and discharged a subsequent day, report 99221–99223 for the initial inpatient care, 99231–99233 for the subsequent hospital care excluding the discharge day.

C. For a patient admitted and discharged for inpatient services or observation status on the same date, report the service with CPT codes 99234–99236.

D. Code 99238 or 99239 reports hospital discharge day management, but excludes discharge of a patient from observation status and inpatients admitted and discharged on the same date. When concurrent care is provided on the day of discharge by a physician other than the attending physician, report these services using Subsequent Hospital Care codes.

## VII. Multiple Hospital Visits

Not more than one hospital visit per day shall be payable except when documentation describes the medical necessity of more than one visit by a particular practitioner. Hospital visit codes shall be combined into the single code that best describes the service rendered.

## VIII. Consultations (99241–99255)

Consultations in *CPT 2007* fall under two subcategories: Office or Other Outpatient Consultations, and Inpatient Consultations. If counseling dominates the encounter, time determines the correct code.

Most requests for a consultation come from the attending physician, the employer, an attorney, or other appropriate source. Include the name of the requesting physician or other source on the claim form or electronic billing. Confirmatory consultations may be requested by the patient and/or family or may result from a second (or third) opinion. When requested by the patient and/or family the service is not reported with consultation codes, but may be reported using the office, home service, or domiciliary/rest home care codes. When required by the attending physician or other appropriate source, report the service with a consultation code for the appropriate site of service, 99241–99245 for office or other outpatient consultation or 99251–99255 for inpatient consultation.

The consultant may initiate diagnostic and/or therapeutic services, such as writing orders or prescriptions and initiating treatment plans.

The opinion rendered and services ordered or performed must be documented in the patient's medical record and a report of this information communicated to the requesting entity.

Report separately any identifiable procedure or service performed on, or subsequent to, the date of the initial consultation.

When the consultant assumes responsibility for the management of any or all of the patient's care subsequent to the consultation encounter, consult codes are no longer appropriate. Depending on the location, identify the correct subsequent or established patient codes.

## IX. Emergency Department Services (99281–99288)

Emergency department (ED) service codes do not differentiate between new and established patients and are used by hospital-based and non-hospital-based physicians. The notes in the CPT book clearly define an emergency department 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." This guideline indicates that care provided in the ED setting for convenience should not be coded as an ED service. Also note that more than one ED service can be reported per calendar day if medically necessary.

Codes 99281–99288 are used to report services provided in a medical emergency. If, however, the physician sees the patient in the emergency room out of convenience for either the patient or physician, the appropriate office visit code should be reported (99201–99215) and reimbursement will be made accordingly.

## X. Critical Care Services (99291–99300)

Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of 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 in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above.

Providing medical care to a critically ill, injured, or postoperative 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.

Critical care services provided to infants 29 days through 24 months of age are reported with pediatric critical care codes 99293 and 99294. Critical care services provided to infants older than one month of age at the time of admission to an intensive care unit are reported with critical care codes 99291 and 99292. Critical care services provided to neonates (28 days of age or less at the time of admission to an intensive care unit) are reported with the neonatal critical care codes 99295, 99296, 99298, 99299, and 99300. The neonatal critical care codes are reported as long as the neonate qualifies for critical care services during the hospital stay. The reporting of pediatric and neonatal critical care services is not based on time, the type of unit (e.g., pediatric or neonatal critical care unit) or the type of provider delivering the care. For additional instructions on reporting these services, see the Inpatient Neonatal and Pediatric Critical Care section of the CPT book and codes 99293–99300.

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

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

The following services are included in reporting critical care when performed during the critical period by the physician(s) providing critical care: the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762), blood gases, and information data stored in computers (e.g., ECGs, blood pressures, Hematologic data (99090)); gastric intubation (43752, 91105); temporary transcutaneous pacing (92953); ventilatory management (94002–94004, 94660, 94662); and vascular access procedures (36000, 36410, 36415, 36540, 36600). Any services performed which are not listed above should be reported separately when performed in conjunction with

critical services reported with code 99291–99292. When reporting inpatient neonatal and pediatric critical care services 99293-99300, consult the CPT book for additional procedures that are bundled into codes 99293–99300.

Codes 99291–99292 should not be reported for the physician's attendance during the transport of critically ill or injured patients to or from a facility or hospital. Physician transport services of the critically ill or injured pediatric patient (24 months of age or less) are separately reportable, see 99289, 99290.

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

## XI. Nursing Facility Services (99304–99318)

Nursing facility E/M services have been grouped into four subcategories: Initial Nursing Facility Care, Subsequent Nursing Facility Care, Nursing Facility Discharge Services, and Other Nursing Facility Services. Included in these codes are E/M services provided to patients in nursing facilities (formerly called skilled nursing facilities (SNFs)), intermediate care facilities (ICFs), long-term care facilities (LTCFs), and psychiatric residential treatment centers. Psychiatric residental treatment centers must provide a "24 hour therapeutically planned and professionally staffed group living and learning environment." Report other services, such as medical psychotherapy, separately when provided in addition to E/M services.

## XII. Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services (99324–99340)

The evaluation and management codes are used to report care given to patients residing in a facility that provides room and board and other personal assistance services. The facility is generally a long-term facility. The facility's services do not include a medical component. Typical times have not been established for this code group.

## XIII. Home Services (99341–99350)

Services and care provided at the patient's home are coded from this subcategory. Typical times have not been established for this code group.

## XIV. Prolonged Services (99354–99359)

A. *Prolonged Physician Service with Direct Patient Contact (99354–99357).* Prolonged physician services are reportable in addition to other physician services, including any level of E/M service. The codes report the total duration of face-to-face time spent by the physician on a given date, even if the time is not continuous.

   Codes 99354 or 99356 report the first hour of prolonged service on a given date, depending on the place of service. Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour. Services lasting less than 15 minutes are not reportable in this category, and the services must extend 15 minutes or more into the next time period to be reportable. For example, services lasting one hour and twelve minutes are reported by code 99354 or code 99356 alone. Services lasting one hour and seventeen minutes are reported using the code for the first hour plus the code for an additional 30 minutes.

   Prolonged physician services should be reported only once per date of service, even if the time spent is not continuous. Please refer to *CPT 2007* for a more complete explanation of prolonged physician care.

B. *Prolonged Physician Service without Direct Patient Contact.* Use code 99358 to report the first hour and 99359 for each additional 30 minutes. All aspects of time reporting are the same as explained above for direct patient contact services.

   Prolonged physician services without direct patient contact may include review of extensive records and tests, and communication (other than telephone calls, 99371–99373) with other professionals and/or the patient and family. These are beyond the usual services and include both inpatient and outpatient settings. Report these services in addition to other services provided, including any level of E/M service.

## XV. Physician Standby Services (99360)

Code 99360 is used to report physician standby service that is requested by another physician and that involves prolonged physician attendance without direct (face-to-face) patient contact. The physician may not be providing care or services to other patients during this period. This code is not used to report time spent proctoring another physician. It is also not used if the period of standby ends with the performance of a procedure subject to a "surgical" package by the physician who was on standby.

Code 99360 is used to report the total duration of time spent by a physician on a given date on standby. Standby service of

less than 30 minutes total duration on a given date is not reported separately.

Second and subsequent periods of standby beyond the first 30 minutes may be reported only if a full 30 minutes of standby was provided for each unit of service reported.

## XVI. Case Management Services (99361–99373)

Physician case management is a process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient.

## XVII. Care Plan Oversight Services (99339–99340, 99374–99380)

Care plan oversight services are reported separately from codes for office/outpatient, hospital, home, nursing facility, or domiciliary services. The complexity and the approximate physician time spent in care plan oversight services provided within a thirty (30) day period determines the code to be billed.

Only one physician may report care plan oversight services during a given period of time, reflecting the physician's sole or predominant supervisory role with the patient. These codes should not be used for supervision of a patient in a nursing facility or under the care of a home health agency unless they require recurrent supervision of therapy. Care plan oversight services are considered part of the patient evaluation and management services when less than fifteen (15) minutes are provided during a thirty (30) day period.

## XVIII. Special Evaluation and Management Services (99450–99456)

This series of codes was introduced in *CPT 1995* to report physician evaluations in order to establish baseline information for insurance certification and/or work-related or medical disability.

## XIX. Other Evaluation and Management Services (99499)

This is an unlisted code to report E/M services not specifically defined in the CPT book.

## XX. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used with E/M procedures are as follows:

### *21 Prolonged Evaluation and Management Services*

When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier 21 to the evaluation and management code number. A report may also be appropriate.

### *24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period*

The physician 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 modifier 24 to the appropriate level of E/M service.

### *25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service*

The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately indentifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See Evaluation and Management Services Guidelines for instructions on determining level of E/M service). 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 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. See modifier 57.

### *32 Mandated Services*

Services related to mandated consultation and/or related services (eg, PRO, third-party payer, governmental,

legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

### *52 Reduced Services*

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

### *57 Decision for Surgery*

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

| Code | Description | Relative Value | Amount |
|---|---|---|---|
| **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; straightforward medical decision making. 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 problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family. | 0.94 | $47.47 |
| **99202** | Office or other outpatient 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; straightforward medical decision making. 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 problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family. | 1.64 | $82.82 |
| **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; medical decision making of low complexity. 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 problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family. | 2.43 | $122.72 |
| **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; medical decision making of moderate complexity. 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 problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family. | 3.69 | $186.35 |
| **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; medical decision making of high complexity. 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 problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family. | 4.63 | $233.82 |
| **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. | 0.53 | $26.77 |
| **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; straightforward medical decision making. 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 problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family. | 0.97 | $48.99 |
| **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; medical decision making of low complexity. Counseling and 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 problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family. | 1.57 | $79.29 |
| **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; medical decision making of moderate complexity. 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 problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family. | 2.38 | $120.19 |
| **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; medical decision making of high complexity. 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 problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family. | 3.22 | $162.61 |
| **99217** | Observation care discharge day management (This code is to be utilized by the physician 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 [including Admission and Discharge Services, 99234-99236 as appropriate.]) | 1.74 | $87.87 |

| Code | Description | Relative Value | Amount |
|---|---|---|---|
| **99218** | Initial observation care, per day, for the evaluation and management of a patient which requires these three key componants: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. 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 problem(s) requiring admission to observation status are of low severity. | 1.64 | $82.82 |
| **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. 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 problem(s) requiring admission to observation status are of moderate severity. | 2.71 | $136.86 |
| **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. 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 problem(s) requiring admission to observation status are of high severity. | 3.82 | $192.91 |
| **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. 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 problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit. | 2.24 | $113.12 |
| **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. 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 problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit. | 3.14 | $158.57 |
| **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. 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 problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit. | 4.58 | $231.29 |
| **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; medical decision making that is straightforward or of low complexity. 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 patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit. | 0.94 | $47.47 |
| **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; medical decision making of moderate complexity. 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 patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit. | 1.68 | $84.84 |
| **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; medical decision making of high complexity. 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 patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit. | 2.40 | $121.20 |
| **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. 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 problem(s) requiring admission are of low severity. | 3.30 | $166.65 |

| Code | Description | Relative Value | Amount |
|---|---|---|---|
| **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. 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 problem(s) requiring admission are of moderate severity. | 4.35 | $219.68 |
| **99236** | Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. 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 problem(s) requiring admission are of high severity. | 5.42 | $273.71 |
| **99238** | Hospital discharge day management; 30 minutes or less | 1.73 | $87.37 |
| **99239** | Hospital discharge day management; more than 30 minutes | 2.50 | $126.25 |
| **99241** | Office 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. 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 problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family. | 1.28 | $64.64 |
| **99242** | Office 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. 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 problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family. | 2.36 | $119.18 |
| **99243** | Office 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. 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 problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family. | 3.23 | $163.12 |
| **99244** | Office 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. 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 problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family. | 4.74 | $239.37 |
| **99245** | Office 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. 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 problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family. | 5.88 | $296.94 |
| **99251** | 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. 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 problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit. | 1.21 | $61.11 |
| **99252** | 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. 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 problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit. | 1.94 | $97.97 |
| **99253** | 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. 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 problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit. | 2.87 | $144.94 |

| | Code | Description | Relative Value | Amount |
|---|---|---|---|---|
| | **99254** | 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. 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 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. | 4.13 | $208.57 |
| | **99255** | 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. 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 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. | 5.15 | $260.08 |
| | **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. 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 problem(s) are self limited or minor. | 0.51 | $25.76 |
| | **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. 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 problem(s) are of low to moderate severity. | 0.98 | $49.49 |
| | **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. 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 problem(s) are of moderate severity. | 1.60 | $80.80 |
| | **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. 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 problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function. | 2.91 | $146.96 |
| | **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. 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 problem(s) are of high severity and pose an immediate significant threat to life or physiologic function. | 4.36 | $220.18 |
| | **99288** | Physician direction of emergency medical systems (EMS) emergency care, advanced life support | 0.00 | BR |
| | **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; first 30-74 minutes of hands on care during transport | 5.92 | $298.96 |
| + | **99290** | 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; each additional 30 minutes (List separately in addition to code for primary service) | 3.04 | $153.52 |
| | **99291** | Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes | 6.76 | $341.38 |
| + | **99292** | Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service) | 3.02 | $152.51 |
| | **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 | 19.97 | $1,008.49 |
| | **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 | 9.88 | $498.94 |
| | **99295** | Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less | 22.90 | $1,156.45 |
| | **99296** | Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less | 9.87 | $498.44 |
| | **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 g) | 3.51 | $177.26 |
| | **99299** | Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 g) | 3.25 | $164.13 |

| Code | Description | Relative Value | Amount |
|---|---|---|---|
| **99300** | Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 g) | 3.13 | $158.07 |
| **99304** | Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. 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 problem(s) requiring admission are of low severity. | 1.61 | $81.31 |
| **99305** | Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. 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 problem(s) requiring admission are of moderate severity. | 2.14 | $108.07 |
| **99306** | Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. 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 problem(s) requiring admission are of high severity. | 2.63 | $132.82 |
| **99307** | Subsequent nursing facility 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; straightforward medical decision making. 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 patient is stable, recovering, or improving. | 0.84 | $42.42 |
| **99308** | Subsequent nursing facility 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; medical decision making of low complexity. 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 patient is responding inadequately to therapy or has developed a minor complication. | 1.39 | $70.20 |
| **99309** | Subsequent nursing facility 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; medical decision making of moderate complexity. 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 patient has developed a significant complication or a significant new problem. | 1.95 | $98.48 |
| **99310** | Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of high complexity. 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. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. | 2.44 | $123.22 |
| **99315** | Nursing facility discharge day management; 30 minutes or less | 1.51 | $76.26 |
| **99316** | Nursing facility discharge day management; more than 30 minutes | 1.98 | $99.99 |
| **99318** | Evaluation and management of a 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 of low to moderate complexity. 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 patient is stable, recovering, or improving. | 1.61 | $81.31 |
| **99324** | Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. 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 problem(s) are of low severity. Physicians typically spend 20 minutes with the patient and/or family or caregiver. | 1.44 | $72.72 |
| **99325** | Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. 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 problem(s) are of moderate severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver. | 2.10 | $106.05 |
| **99326** | Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. 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 problem(s) are of moderate to high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver. | 3.02 | $152.51 |

| Code | Description | Relative Value | Amount |
|---|---|---|---|
| **99327** | Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. 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 problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver. | 3.97 | $200.49 |
| **99328** | Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. 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 patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver. | 4.91 | $247.96 |
| **99334** | Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. 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 problem(s) are self-limited or minor. Physicians typically spend 15 minutes with the patient and/or family or caregiver. | 1.11 | $56.06 |
| **99335** | Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. 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 problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver. | 1.75 | $88.38 |
| **99336** | Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. 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 problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver. | 2.69 | $135.85 |
| **99337** | Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. 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 problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver. | 3.95 | $199.48 |
| **99339** | Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes | 1.76 | $88.88 |
| **99340** | Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more | 2.45 | $123.73 |
| **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 Straightforward medical decision making. 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 problem(s) are of low severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family. | 1.43 | $72.22 |
| **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. 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 problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family. | 2.10 | $106.05 |

| | Code | Description | Relative Value | Amount |
|---|---|---|---|---|
| | **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. 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 problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family. | 3.04 | $153.52 |
| | **99344** | Home visit for the evaluation and management of a new patient, which requires these three components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. 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 problem(s) are of high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family. | 3.98 | $200.99 |
| | **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. 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 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. | 4.91 | $247.96 |
| | **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. 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 problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family. | 1.11 | $56.06 |
| | **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. 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 problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family. | 1.75 | $88.38 |
| | **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. 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 problem(s) are moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family. | 2.70 | $136.35 |
| | **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. 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 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. | 3.98 | $200.99 |
| + | **99354** | Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (eg, prolonged care and treatment of an acute asthmatic patient in an outpatient setting); first hour (List separately in addition to code for office or other outpatient Evaluation and Management service) | 2.41 | $121.71 |
| + | **99355** | Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (eg, prolonged care and treatment of an acute asthmatic patient in an outpatient setting); each additional 30 minutes (List separately in addition to code for prolonged physician service) | 2.39 | $120.70 |
| + | **99356** | Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (eg, maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); first hour (List separately in addition to code for inpatient Evaluation and Management service) | 2.21 | $111.61 |
| + | **99357** | Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (eg, maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); each additional 30 minutes (List separately in addition to code for prolonged physician service) | 2.22 | $112.11 |
| + | **99358** | Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (eg, review of extensive records and tests, communication with other professionals and/or the patient/family); first hour (List separately in addition to code(s) for other physician service(s) and/or inpatient or outpatient Evaluation and Management service) | 2.49 | $125.75 |

| | Code | Description | Relative Value | Amount |
|---|---|---|---|---|
| + | **99359** | Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (eg, review of extensive records and tests, communication with other professionals and/or the patient/family); each additional 30 minutes (List separately in addition to code for prolonged physician service) | 1.20 | $60.60 |
| | **99360** | Physician standby service, requiring prolonged physician attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG) | 1.13 | $57.07 |
| | **99361** | Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes | 1.91 | $96.40 |
| | **99362** | Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 60 minutes | 3.33 | $168.32 |
| | **99363** | Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements) | 2.84 | $143.42 |
| | **99364** | Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of 3 INR measurements) | 0.99 | $50.00 |
| | **99371** | Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (eg, to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy) | 0.30 | $15.30 |
| | **99372** | Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); intermediate (eg, to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care) | 0.76 | $38.28 |
| | **99373** | Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); complex or lengthy (eg, lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan) | 1.52 | $76.51 |
| | **99374** | Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes | 1.70 | $85.85 |
| | **99375** | Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more | 2.98 | $150.49 |
| | **99377** | Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes | 1.70 | $85.85 |
| | **99378** | Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more | 3.27 | $165.14 |

| Code | Description | Relative Value | Amount |
|---|---|---|---|
| **99379** | Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes | 1.69 | $85.35 |
| **99380** | Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more | 2.55 | $128.78 |
| **99381** | Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; infant (age younger than 1 year) | 2.49 | $125.75 |
| **99382** | Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years) | 2.68 | $135.34 |
| **99383** | Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years) | 2.64 | $133.32 |
| **99384** | Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years) | 2.87 | $144.94 |
| **99385** | Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 18-39 years | 2.87 | $144.94 |
| **99386** | Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 40-64 years | 3.35 | $169.18 |
| **99387** | Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 65 years and older | 3.64 | $183.82 |
| **99391** | Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; infant (age younger than 1 year) | 1.94 | $97.97 |
| **99392** | Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years) | 2.16 | $109.08 |
| **99393** | Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years) | 2.14 | $108.07 |
| **99394** | Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years) | 2.35 | $118.68 |
| **99395** | Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 18-39 years | 2.37 | $119.69 |
| **99396** | Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 40-64 years | 2.62 | $132.31 |

| Code | Description | Relative Value | Amount |
|---|---|---|---|
| **99397** | Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 65 years and older | 2.90 | $146.45 |
| **99401** | Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes | 1.00 | $50.50 |
| **99402** | Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes | 1.67 | $84.34 |
| **99403** | Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes | 2.31 | $116.66 |
| **99404** | Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes | 2.97 | $149.99 |
| **99411** | Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes | 0.33 | $16.67 |
| **99412** | Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes | 0.48 | $24.24 |
| **99420** | Administration and interpretation of health risk assessment instrument (eg, health hazard appraisal) | 0.23 | $11.62 |
| **99429** | Unlisted preventive medicine service | 0.00 | BR |
| **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.) | 1.45 | $73.23 |
| **99432** | Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s) | 2.15 | $108.58 |
| **99433** | Subsequent hospital care, for the evaluation and management of a normal newborn, per day | 0.77 | $38.89 |
| **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.) | 1.97 | $99.49 |
| **99436** | Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn | 1.85 | $93.43 |
| **99440** | Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output | 3.63 | $183.32 |
| **99450** | Basic life and/or disability examination that includes: Measurement of height, weight and blood pressure; Completion of a medical history following a life insurance pro forma; Collection of blood sample and/or urinalysis complying with chain of custody protocols; and Completion of necessary documentation/certificates. | 0.00 | BR |
| **99455** | Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report. | 0.00 | BR |
| **99456** | Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report. | 0.00 | BR |
| **99499** | Unlisted evaluation and management service | 0.00 | BR |

# Anesthesia

## I. Introduction

The base units in this section have been determined on an entirely different basis from the relative values in other sections. A conversion factor applicable to this section is not applicable to any other section.

The American Society of Anesthesiologists' (ASA) *Relative Value Guide*™ 2007 is recognized as an appropriate assessment of current relative values for specific anesthesiology procedures. It is the basis for the assigned base units for CPT codes in the Anesthesia section of the Fee Schedule.

The conversion factor for anesthesia services has been designated at $42.00 per unit.

Total anesthesia value is defined in the following formula:

> Base units + time units + modifying units x conversion factor = reimbursement

## II. Base Units

Base units are listed for most procedures. This value is determined by the complexity of the service and includes all usual anesthesia services except the time actively spent in anesthesia care and the modifying factors. The base units include preoperative and postoperative visits, the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring (ECG, temperature, blood pressure, oximetry, and other usual monitoring procedures). The basic anesthesia unit includes the routine follow-up care and observation (including recovery room observation and monitoring). When multiple surgical procedures are performed during the same period of anesthesia, only the highest base unit allowance of the various surgical procedures will be used.

## III. Time Units

Time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area. Time ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision. The anesthesia time units will be calculated in 15-minute intervals, or portions thereof, equaling one (1) time unit. No additional time units are allowed for recovery room time and monitoring.

## IV. Special Circumstances

**A. Physical Status Modifiers**

Physical status modifiers are represented by the initial letter P followed by a single digit from one (1) to six (6) defined below:

| Status | Description | Base Units |
|---|---|---|
| P1 | A normal healthy patient | 0 |
| P2 | A patient with mild systemic disease | 0 |
| P3 | A patient with severe systemic disease | 1 |
| P4 | A patient with severe systemic disease that is a constant threat to life | 2 |
| P5 | A moribund patient who is not expected to survive without the operation | 3 |
| P6 | A patient declared brain-dead whose organs are being removed for donor purposes | 0 |

The above six levels are consistent with the American Society of Anesthesiologists (ASA) ranking of patient physical status. Physical status is included in the CPT book to distinguish between various levels of complexity of the anesthesia service provided.

**B. Qualifying Circumstances**

1. Qualifying circumstances warrant additional value due to unusual events. The following list of CPT codes and the corresponding anesthesia unit values may be listed if appropriate. The unit value listed is added to the existing anesthesia base units.

| CPT | Description | Units |
|---|---|---|
| 99100 | Anesthesia for patient of extreme age, younger than one year and older than seventy (List separately in addition to code for primary anesthesia procedure) | 1 |
| 99116 | Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure) | 5 |
| 99135 | Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure) | 5 |
| 99140 | Anesthesia complicated by emergency conditions (specify conditions) (List separately in addition to code for primary anesthesia procedure) (An emergency is defined as existing when delay in treatment of a patient would lead to a significant increase in the threat to life or body part.) | 2 |

2. Payers must utilize their medical consultants when there is a question regarding modifiers and/or special circumstances for anesthesia charges.

## V. Monitored Anesthesia Care

Monitored anesthesia care occurs when the attending physician requests that an anesthesiologist be present during a procedure. This may be to insure compliance with accepted procedures of the facility. Monitored anesthesia care includes pre-anesthesia exam and evaluation of the patient. The anesthesiologist must participate or provide medical direction for the plan of care. The anesthesiologist, resident, or nurse anesthetist must be in continuous physical presence and provide diagnosis and treatment of emergencies. This will also include noninvasive monitoring of cardiocirculatory and respiratory systems with administration of oxygen and/or intravenous administration of medications. Reimbursement will be the same as if general anesthesia had been administered (time units + base units).

## VI. Reimbursement for Anesthesia Services

A. **Criteria for Reimbursement**

Anesthesia services may be billed for any one of the three following circumstances:

1. An anesthesiologist provides total and individual anesthesia service.
2. An anesthesiologist directs a CRNA or AA.
3. Anesthesia provided by a CRNA or AA working independent of an anesthesiologist's supervision is covered under the following conditions:
   a. The service falls within the CRNA's or AA's scope of practice and scope of license as defined by law.
   b. The service is supervised by a licensed health care provider who has prescriptive authority in accordance with the clinical privileges individually granted by the hospital or other health care organization.

B. **Reimbursement**

1. The maximum reimbursement allowance for anesthesia is calculated by adding the base unit value, the number of time units, any applicable modifier and/or unusual circumstances units, and multiplying the sum by a dollar amount (conversion factor) allowed per unit.
2. Reimbursement includes the usual pre- and postoperative visits, the care by the anesthesiologist during surgery, the administration of fluids and/or blood, and the usual monitoring services. Unusual forms of monitoring, such as central venous, intra-arterial, and Swan-Ganz monitoring, may be reimbursed separately.
3. When an unlisted service or procedure is provided, the value should be substantiated with a report. Unlisted services are identified in this Fee Schedule as by report (BR).
4. When it is necessary to have a second anesthesiologist, the necessity should be substantiated BR. The second anesthesiologist will receive five base units + time units (calculation of total anesthesia value).
5. Payment for covered anesthesia services is as follows:
   a. When the anesthesiologist provides an anesthesia service directly, payment will be made in accordance with the Billing and Reimbursement Rules of this Fee Schedule.
   b. When an anesthesiologist provides medical direction to the CRNA or AA providing the anesthesia service, then the reimbursement will be divided between the two of them at fifty percent (50%).
   c. When the CRNA or AA provides the anesthesia service directly, then payment will be the lesser of the billed charge or eighty percent (80%) of the maximum allowable listed in the Fee Schedule for that procedure.
6. Anesthesiologists, CRNAs, and AAs must bill their services with the appropirate modifiers to indicate which one provided the service. Bills NOT properly

coded may cause a delay or error in reimbursement by the payer. Application of the appropriate modifier to the bill for service is the responsibility of the provider, regardless of the place of service. Modifiers are as follows:

AA Anesthesiologist services performed personally by an anesthesiologist

AD Medical supervision by a physician: more than four concurrent anesthesia procedures

QK Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals (CRNA or AA) by an anesthesiologist

QX CRNA or AA service: with medical direction by an anesthesiologist

QY Medical direction of one certified registered nurse anesthetist (CRNA or AA) by an anesthesiologist

QZ CRNA service: without medical direction by an anesthesiologist

## VII. Anesthesia Modifiers

All anesthesia services are reported by using the anesthesia five-digit procedure codes. The basic value for most procedures may be modified under certain circumstances as listed below. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier (including the hyphen) after the usual anesthesia code. Certain modifiers require a special report for clarification of services provided.

Modifiers commonly used in anesthesia are as follows:

### *22 Unusual Procedural Services*

When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

*Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.*

### *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 modifier 23 to the procedure code of the basic service.

### *32 Mandated Services*

Services related to mandated consultation and/or related services (eg, PRO, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

### *53 Discontinued Procedure*

Under certain circumstances the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

### *59 Distinct Procedural Service*

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

### *AA Anesthesia Services Performed Personally by the Anesthesiologist:*

Report modifier AA when the anesthesia services are personally performed by an anesthesiologist.

### *AD Medical Supervision by a Physician; More Than Four Concurrent Anesthesia Procedures:*

Report modifier AD when the anesthesiologist supervises more than four concurrent anesthesia procedures.

### *QK Medical Direction of Two, Three, or Four Concurrent Anesthesia Procedures Involving Qualified Individuals:*

Report modifier QK when the anesthesiologist supervises two, three, or four concurrent anesthesia procedures.

### *QX CRNA or AA Service with Medical Direction by a Physician:*

Regional or general anesthesia provided by the CRNA or AA with medical direction by a physician may be reported by adding modifier QX.

### *QY Medical Supervision by Physician of One CRNA or AA:*

Report modifier QY when the anesthesiologist supervises one CRNA or AA.

### *QZ CRNA or AA Service without Medical Direction by a Physician:*

Regional or general anesthesia provided by the CRNA or AA without medical direction by a physician may be reported by adding modifier QZ

| Code | Description | Base Unit |
|---|---|---|
| 00100 | Anesthesia for procedures on salivary glands, including biopsy | 5.00 |
| 00102 | Anesthesia for procedures involving plastic repair of cleft lip | 6.00 |
| 00103 | Anesthesia for reconstructive procedures of eyelid (eg, blepharoplasty, ptosis surgery) | 5.00 |
| 00104 | Anesthesia for electroconvulsive therapy | 4.00 |
| 00120 | Anesthesia for procedures on external, middle, and inner ear including biopsy; not otherwise specified | 5.00 |
| 00124 | Anesthesia for procedures on external, middle, and inner ear including biopsy; otoscopy | 4.00 |
| 00126 | Anesthesia for procedures on external, middle, and inner ear including biopsy; tympanotomy | 4.00 |
| 00140 | Anesthesia for procedures on eye; not otherwise specified | 5.00 |
| 00142 | Anesthesia for procedures on eye; lens surgery | 6.00 |
| 00144 | Anesthesia for procedures on eye; corneal transplant | 6.00 |
| 00145 | Anesthesia for procedures on eye; vitreoretinal surgery | 6.00 |
| 00147 | Anesthesia for procedures on eye; iridectomy | 6.00 |
| 00148 | Anesthesia for procedures on eye; ophthalmoscopy | 4.00 |
| 00160 | Anesthesia for procedures on nose and accessory sinuses; not otherwise specified | 5.00 |
| 00162 | Anesthesia for procedures on nose and accessory sinuses; radical surgery | 7.00 |
| 00164 | Anesthesia for procedures on nose and accessory sinuses; biopsy, soft tissue | 4.00 |
| 00170 | Anesthesia for intraoral procedures, including biopsy; not otherwise specified | 5.00 |
| 00172 | Anesthesia for intraoral procedures, including biopsy; repair of cleft palate | 6.00 |
| 00174 | Anesthesia for intraoral procedures, including biopsy; excision of retropharyngeal tumor | 6.00 |
| 00176 | Anesthesia for intraoral procedures, including biopsy; radical surgery | 7.00 |
| 00190 | Anesthesia for procedures on facial bones or skull; not otherwise specified | 5.00 |
| 00192 | Anesthesia for procedures on facial bones or skull; radical surgery (including prognathism) | 7.00 |
| 00210 | Anesthesia for intracranial procedures; not otherwise specified | 11.00 |
| 00212 | Anesthesia for intracranial procedures; subdural taps | 5.00 |
| 00214 | Anesthesia for intracranial procedures; burr holes, including ventriculography | 9.00 |
| 00215 | Anesthesia for intracranial procedures; cranioplasty or elevation of depressed skull fracture, extradural (simple or compound) | 9.00 |
| 00216 | Anesthesia for intracranial procedures; vascular procedures | 15.00 |
| 00218 | Anesthesia for intracranial procedures; procedures in sitting position | 13.00 |
| 00220 | Anesthesia for intracranial procedures; cerebrospinal fluid shunting procedures | 10.00 |
| 00222 | Anesthesia for intracranial procedures; electrocoagulation of intracranial nerve | 6.00 |
| 00300 | Anesthesia for all procedures on the integumentary system, muscles and nerves of head, neck, and posterior trunk, not otherwise specified | 5.00 |
| 00320 | Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; not otherwise specified, age 1 year or older | 6.00 |
| 00322 | Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; needle biopsy of thyroid | 3.00 |
| 00326 | Anesthesia for all procedures on the larynx and trachea in children younger than 1 year of age | 8.00 |
| 00350 | Anesthesia for procedures on major vessels of neck; not otherwise specified | 10.00 |
| 00352 | Anesthesia for procedures on major vessels of neck; simple ligation | 5.00 |
| 00400 | Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified | 3.00 |
| 00402 | Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; reconstructive procedures on breast (eg, reduction or augmentation mammoplasty, muscle flaps) | 5.00 |
| 00404 | Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; radical or modified radical procedures on breast | 5.00 |
| 00406 | Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; radical or modified radical procedures on breast with internal mammary node dissection | 13.00 |
| 00410 | Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; electrical conversion of arrhythmias | 4.00 |
| 00450 | Anesthesia for procedures on clavicle and scapula; not otherwise specified | 5.00 |
| 00452 | Anesthesia for procedures on clavicle and scapula; radical surgery | 6.00 |
| 00454 | Anesthesia for procedures on clavicle and scapula; biopsy of clavicle | 3.00 |

| Code | Description | Base Unit |
|---|---|---|
| 00470 | Anesthesia for partial rib resection; not otherwise specified | 6.00 |
| 00472 | Anesthesia for partial rib resection; thoracoplasty (any type) | 10.00 |
| 00474 | Anesthesia for partial rib resection; radical procedures (eg, pectus excavatum) | 13.00 |
| 00500 | Anesthesia for all procedures on esophagus | 15.00 |
| 00520 | Anesthesia for closed chest procedures; (including bronchoscopy) not otherwise specified | 6.00 |
| 00522 | Anesthesia for closed chest procedures; needle biopsy of pleura | 4.00 |
| 00524 | Anesthesia for closed chest procedures; pneumocentesis | 4.00 |
| 00528 | Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy not utilizing one lung ventilation | 8.00 |
| 00529 | Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy utilizing one lung ventilation | 11.00 |
| 00530 | Anesthesia for permanent transvenous pacemaker insertion | 4.00 |
| 00532 | Anesthesia for access to central venous circulation | 4.00 |
| 00534 | Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator | 7.00 |
| 00537 | Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation | 10.00 |
| 00539 | Anesthesia for tracheobronchial reconstruction | 18.00 |
| 00540 | Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified | 12.00 |
| 00541 | Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing one lung ventilation | 15.00 |
| 00542 | Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); decortication | 15.00 |
| 00546 | Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); pulmonary resection with thoracoplasty | 15.00 |
| 00548 | Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); intrathoracic procedures on the trachea and bronchi | 17.00 |
| 00550 | Anesthesia for sternal debridement | 10.00 |
| 00560 | Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator | 15.00 |
| 00561 | Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, younger than one year of age | 25.00 |
| 00562 | Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator | 20.00 |
| 00563 | Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest | 25.00 |
| 00566 | Anesthesia for direct coronary artery bypass grafting without pump oxygenator | 25.00 |
| 00580 | Anesthesia for heart transplant or heart/lung transplant | 20.00 |
| 00600 | Anesthesia for procedures on cervical spine and cord; not otherwise specified | 10.00 |
| 00604 | Anesthesia for procedures on cervical spine and cord; procedures with patient in the sitting position | 13.00 |
| 00620 | Anesthesia for procedures on thoracic spine and cord; not otherwise specified | 10.00 |
| 00622 | Anesthesia for procedures on thoracic spine and cord; thoracolumbar sympathectomy | 13.00 |
| 00625 | Anesthesia for procedures on the thoracic spine and cord, via an anterior transthoracic approach; not utilizing one lung ventilation | 13.00 |
| 00626 | Anesthesia for procedures on the thoracic spine and cord, via an anterior transthoracic approach; utilizing one lung ventilation | 15.00 |
| 00630 | Anesthesia for procedures in lumbar region; not otherwise specified | 8.00 |
| 00632 | Anesthesia for procedures in lumbar region; lumbar sympathectomy | 7.00 |
| 00634 | Anesthesia for procedures in lumbar region; chemonucleolysis | 10.00 |
| 00635 | Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture | 4.00 |
| 00640 | Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine | 3.00 |
| 00670 | Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures) | 13.00 |
| 00700 | Anesthesia for procedures on upper anterior abdominal wall; not otherwise specified | 4.00 |
| 00702 | Anesthesia for procedures on upper anterior abdominal wall; percutaneous liver biopsy | 4.00 |
| 00730 | Anesthesia for procedures on upper posterior abdominal wall | 5.00 |
| 00740 | Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum | 5.00 |

| Code | Description | Base Unit |
|---|---|---|
| 00750 | Anesthesia for hernia repairs in upper abdomen; not otherwise specified | 4.00 |
| 00752 | Anesthesia for hernia repairs in upper abdomen; lumbar and ventral (incisional) hernias and/or wound dehiscence | 6.00 |
| 00754 | Anesthesia for hernia repairs in upper abdomen; omphalocele | 7.00 |
| 00756 | Anesthesia for hernia repairs in upper abdomen; transabdominal repair of diaphragmatic hernia | 7.00 |
| 00770 | Anesthesia for all procedures on major abdominal blood vessels | 15.00 |
| 00790 | Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified | 7.00 |
| 00792 | Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; partial hepatectomy or management of liver hemorrhage (excluding liver biopsy) | 13.00 |
| 00794 | Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; pancreatectomy, partial or total (eg, Whipple procedure) | 8.00 |
| 00796 | Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient) | 30.00 |
| 00797 | Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity | 11.00 |
| 00800 | Anesthesia for procedures on lower anterior abdominal wall; not otherwise specified | 4.00 |
| 00802 | Anesthesia for procedures on lower anterior abdominal wall; panniculectomy | 5.00 |
| 00810 | Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum | 5.00 |
| 00820 | Anesthesia for procedures on lower posterior abdominal wall | 5.00 |
| 00830 | Anesthesia for hernia repairs in lower abdomen; not otherwise specified | 4.00 |
| 00832 | Anesthesia for hernia repairs in lower abdomen; ventral and incisional hernias | 6.00 |
| 00834 | Anesthesia for hernia repairs in the lower abdomen not otherwise specified, younger than 1 year of age | 5.00 |
| 00836 | Anesthesia for hernia repairs in the lower abdomen not otherwise specified, infants younger than 37 weeks gestational age at birth and younger than 50 weeks gestational age at time of surgery | 6.00 |
| 00840 | Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified | 6.00 |
| 00842 | Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; amniocentesis | 4.00 |
| 00844 | Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; abdominoperineal resection | 7.00 |
| 00846 | Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; radical hysterectomy | 8.00 |
| 00848 | Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; pelvic exenteration | 8.00 |
| 00851 | Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection | 6.00 |
| 00860 | Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified | 6.00 |
| 00862 | Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal procedures, including upper one-third of ureter, or donor nephrectomy | 7.00 |
| 00864 | Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; total cystectomy | 8.00 |
| 00865 | Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; radical prostatectomy (suprapubic, retropubic) | 7.00 |
| 00866 | Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; adrenalectomy | 10.00 |
| 00868 | Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal transplant (recipient) | 10.00 |
| 00870 | Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; cystolithotomy | 5.00 |
| 00872 | Anesthesia for lithotripsy, extracorporeal shock wave; with water bath | 7.00 |
| 00873 | Anesthesia for lithotripsy, extracorporeal shock wave; without water bath | 5.00 |
| 00880 | Anesthesia for procedures on major lower abdominal vessels; not otherwise specified | 15.00 |
| 00882 | Anesthesia for procedures on major lower abdominal vessels; inferior vena cava ligation | 10.00 |
| 00902 | Anesthesia for; anorectal procedure | 5.00 |
| 00904 | Anesthesia for; radical perineal procedure | 7.00 |
| 00906 | Anesthesia for; vulvectomy | 4.00 |
| 00908 | Anesthesia for; perineal prostatectomy | 6.00 |
| 00910 | Anesthesia for transurethral procedures (including urethrocystoscopy); not otherwise specified | 3.00 |

| Code | Description | Base Unit |
|---|---|---|
| 00912 | Anesthesia for transurethral procedures (including urethrocystoscopy); transurethral resection of bladder tumor(s) | 5.00 |
| 00914 | Anesthesia for transurethral procedures (including urethrocystoscopy); transurethral resection of prostate | 5.00 |
| 00916 | Anesthesia for transurethral procedures (including urethrocystoscopy); post-transurethral resection bleeding | 5.00 |
| 00918 | Anesthesia for transurethral procedures (including urethrocystoscopy); with fragmentation, manipulation and/or removal of ureteral calculus | 5.00 |
| 00920 | Anesthesia for procedures on male genitalia (including open urethral procedures); not otherwise specified | 3.00 |
| 00921 | Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral | 3.00 |
| 00922 | Anesthesia for procedures on male genitalia (including open urethral procedures); seminal vesicles | 6.00 |
| 00924 | Anesthesia for procedures on male genitalia (including open urethral procedures); undescended testis, unilateral or bilateral | 4.00 |
| 00926 | Anesthesia for procedures on male genitalia (including open urethral procedures); radical orchiectomy, inguinal | 4.00 |
| 00928 | Anesthesia for procedures on male genitalia (including open urethral procedures); radical orchiectomy, abdominal | 6.00 |
| 00930 | Anesthesia for procedures on male genitalia (including open urethral procedures); orchiopexy, unilateral or bilateral | 4.00 |
| 00932 | Anesthesia for procedures on male genitalia (including open urethral procedures); complete amputation of penis | 4.00 |
| 00934 | Anesthesia for procedures on male genitalia (including open urethral procedures); radical amputation of penis with bilateral inguinal lymphadenectomy | 6.00 |
| 00936 | Anesthesia for procedures on male genitalia (including open urethral procedures); radical amputation of penis with bilateral inguinal and iliac lymphadenectomy | 8.00 |
| 00938 | Anesthesia for procedures on male genitalia (including open urethral procedures); insertion of penile prosthesis (perineal approach) | 4.00 |
| 00940 | Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified | 3.00 |
| 00942 | Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); colpotomy, vaginectomy, colporrhaphy, and open urethral procedures | 4.00 |
| 00944 | Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal hysterectomy | 6.00 |
| 00948 | Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); cervical cerclage | 4.00 |
| 00950 | Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); culdoscopy | 5.00 |
| 00952 | Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography | 4.00 |
| 01112 | Anesthesia for bone marrow aspiration and/or biopsy, anterior or posterior iliac crest | 5.00 |
| 01120 | Anesthesia for procedures on bony pelvis | 6.00 |
| 01130 | Anesthesia for body cast application or revision | 3.00 |
| 01140 | Anesthesia for interpelviabdominal (hindquarter) amputation | 15.00 |
| 01150 | Anesthesia for radical procedures for tumor of pelvis, except hindquarter amputation | 10.00 |
| 01160 | Anesthesia for closed procedures involving symphysis pubis or sacroiliac joint | 4.00 |
| 01170 | Anesthesia for open procedures involving symphysis pubis or sacroiliac joint | 8.00 |
| 01173 | Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum | 12.00 |
| 01180 | Anesthesia for obturator neurectomy; extrapelvic | 3.00 |
| 01190 | Anesthesia for obturator neurectomy; intrapelvic | 4.00 |
| 01200 | Anesthesia for all closed procedures involving hip joint | 4.00 |
| 01202 | Anesthesia for arthroscopic procedures of hip joint | 4.00 |
| 01210 | Anesthesia for open procedures involving hip joint; not otherwise specified | 6.00 |
| 01212 | Anesthesia for open procedures involving hip joint; hip disarticulation | 10.00 |
| 01214 | Anesthesia for open procedures involving hip joint; total hip arthroplasty | 8.00 |
| 01215 | Anesthesia for open procedures involving hip joint; revision of total hip arthroplasty | 10.00 |
| 01220 | Anesthesia for all closed procedures involving upper two-thirds of femur | 4.00 |
| 01230 | Anesthesia for open procedures involving upper two-thirds of femur; not otherwise specified | 6.00 |

| Code | Description | Base Unit |
|---|---|---|
| **01232** | Anesthesia for open procedures involving upper two-thirds of femur; amputation | 5.00 |
| **01234** | Anesthesia for open procedures involving upper two-thirds of femur; radical resection | 8.00 |
| **01250** | Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of upper leg | 4.00 |
| **01260** | Anesthesia for all procedures involving veins of upper leg, including exploration | 3.00 |
| **01270** | Anesthesia for procedures involving arteries of upper leg, including bypass graft; not otherwise specified | 8.00 |
| **01272** | Anesthesia for procedures involving arteries of upper leg, including bypass graft; femoral artery ligation | 4.00 |
| **01274** | Anesthesia for procedures involving arteries of upper leg, including bypass graft; femoral artery embolectomy | 6.00 |
| **01320** | Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of knee and/or popliteal area | 4.00 |
| **01340** | Anesthesia for all closed procedures on lower one-third of femur | 4.00 |
| **01360** | Anesthesia for all open procedures on lower one-third of femur | 5.00 |
| **01380** | Anesthesia for all closed procedures on knee joint | 3.00 |
| **01382** | Anesthesia for diagnostic arthroscopic procedures of knee joint | 3.00 |
| **01390** | Anesthesia for all closed procedures on upper ends of tibia, fibula, and/or patella | 3.00 |
| **01392** | Anesthesia for all open procedures on upper ends of tibia, fibula, and/or patella | 4.00 |
| **01400** | Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified | 4.00 |
| **01402** | Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty | 7.00 |
| **01404** | Anesthesia for open or surgical arthroscopic procedures on knee joint; disarticulation at knee | 5.00 |
| **01420** | Anesthesia for all cast applications, removal, or repair involving knee joint | 3.00 |
| **01430** | Anesthesia for procedures on veins of knee and popliteal area; not otherwise specified | 3.00 |
| **01432** | Anesthesia for procedures on veins of knee and popliteal area; arteriovenous fistula | 6.00 |
| **01440** | Anesthesia for procedures on arteries of knee and popliteal area; not otherwise specified | 8.00 |
| **01442** | Anesthesia for procedures on arteries of knee and popliteal area; popliteal thromboendarterectomy, with or without patch graft | 8.00 |
| **01444** | Anesthesia for procedures on arteries of knee and popliteal area; popliteal excision and graft or repair for occlusion or aneurysm | 8.00 |
| **01462** | Anesthesia for all closed procedures on lower leg, ankle, and foot | 3.00 |
| **01464** | Anesthesia for arthroscopic procedures of ankle and/or foot | 3.00 |
| **01470** | Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; not otherwise specified | 3.00 |
| **01472** | Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; repair of ruptured Achilles tendon, with or without graft | 5.00 |
| **01474** | Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; gastrocnemius recession (eg, Strayer procedure) | 5.00 |
| **01480** | Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified | 3.00 |
| **01482** | Anesthesia for open procedures on bones of lower leg, ankle, and foot; radical resection (including below knee amputation) | 4.00 |
| **01484** | Anesthesia for open procedures on bones of lower leg, ankle, and foot; osteotomy or osteoplasty of tibia and/or fibula | 4.00 |
| **01486** | Anesthesia for open procedures on bones of lower leg, ankle, and foot; total ankle replacement | 7.00 |
| **01490** | Anesthesia for lower leg cast application, removal, or repair | 3.00 |
| **01500** | Anesthesia for procedures on arteries of lower leg, including bypass graft; not otherwise specified | 8.00 |
| **01502** | Anesthesia for procedures on arteries of lower leg, including bypass graft; embolectomy, direct or with catheter | 6.00 |
| **01520** | Anesthesia for procedures on veins of lower leg; not otherwise specified | 3.00 |
| **01522** | Anesthesia for procedures on veins of lower leg; venous thrombectomy, direct or with catheter | 5.00 |
| **01610** | Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla | 5.00 |
| **01620** | Anesthesia for all closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint | 4.00 |
| **01622** | Anesthesia for diagnostic arthroscopic procedures of shoulder joint | 4.00 |
| **01630** | Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified | 5.00 |
| **01632** | Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; radical resection | 6.00 |

| Code | Description | Base Unit |
|---|---|---|
| 01634 | Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; shoulder disarticulation | 9.00 |
| 01636 | Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; interthoracoscapular (forequarter) amputation | 15.00 |
| 01638 | Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement | 10.00 |
| 01650 | Anesthesia for procedures on arteries of shoulder and axilla; not otherwise specified | 6.00 |
| 01652 | Anesthesia for procedures on arteries of shoulder and axilla; axillary-brachial aneurysm | 10.00 |
| 01654 | Anesthesia for procedures on arteries of shoulder and axilla; bypass graft | 8.00 |
| 01656 | Anesthesia for procedures on arteries of shoulder and axilla; axillary-femoral bypass graft | 10.00 |
| 01670 | Anesthesia for all procedures on veins of shoulder and axilla | 4.00 |
| 01680 | Anesthesia for shoulder cast application, removal or repair; not otherwise specified | 3.00 |
| 01682 | Anesthesia for shoulder cast application, removal or repair; shoulder spica | 4.00 |
| 01710 | Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; not otherwise specified | 3.00 |
| 01712 | Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenotomy, elbow to shoulder, open | 5.00 |
| 01714 | Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenoplasty, elbow to shoulder | 5.00 |
| 01716 | Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenodesis, rupture of long tendon of biceps | 5.00 |
| 01730 | Anesthesia for all closed procedures on humerus and elbow | 3.00 |
| 01732 | Anesthesia for diagnostic arthroscopic procedures of elbow joint | 3.00 |
| 01740 | Anesthesia for open or surgical arthroscopic procedures of the elbow; not otherwise specified | 4.00 |
| 01742 | Anesthesia for open or surgical arthroscopic procedures of the elbow; osteotomy of humerus | 5.00 |
| 01744 | Anesthesia for open or surgical arthroscopic procedures of the elbow; repair of nonunion or malunion of humerus | 5.00 |
| 01756 | Anesthesia for open or surgical arthroscopic procedures of the elbow; radical procedures | 6.00 |
| 01758 | Anesthesia for open or surgical arthroscopic procedures of the elbow; excision of cyst or tumor of humerus | 5.00 |
| 01760 | Anesthesia for open or surgical arthroscopic procedures of the elbow; total elbow replacement | 7.00 |
| 01770 | Anesthesia for procedures on arteries of upper arm and elbow; not otherwise specified | 6.00 |
| 01772 | Anesthesia for procedures on arteries of upper arm and elbow; embolectomy | 6.00 |
| 01780 | Anesthesia for procedures on veins of upper arm and elbow; not otherwise specified | 3.00 |
| 01782 | Anesthesia for procedures on veins of upper arm and elbow; phleborrhaphy | 4.00 |
| 01810 | Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand | 3.00 |
| 01820 | Anesthesia for all closed procedures on radius, ulna, wrist, or hand bones | 3.00 |
| 01829 | Anesthesia for diagnostic arthroscopic procedures on the wrist | 3.00 |
| 01830 | Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified | 3.00 |
| 01832 | Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; total wrist replacement | 6.00 |
| 01840 | Anesthesia for procedures on arteries of forearm, wrist, and hand; not otherwise specified | 6.00 |
| 01842 | Anesthesia for procedures on arteries of forearm, wrist, and hand; embolectomy | 6.00 |
| 01844 | Anesthesia for vascular shunt, or shunt revision, any type (eg, dialysis) | 6.00 |
| 01850 | Anesthesia for procedures on veins of forearm, wrist, and hand; not otherwise specified | 3.00 |
| 01852 | Anesthesia for procedures on veins of forearm, wrist, and hand; phleborrhaphy | 4.00 |
| 01860 | Anesthesia for forearm, wrist, or hand cast application, removal, or repair | 3.00 |
| 01905 | Anesthesia for myelography, discography, vertebroplasty | 5.00 |
| 01916 | Anesthesia for diagnostic arteriography/venography | 5.00 |
| 01920 | Anesthesia for cardiac catheterization including coronary angiography and ventriculography (not to include Swan-Ganz catheter) | 7.00 |
| 01922 | Anesthesia for non-invasive imaging or radiation therapy | 7.00 |
| 01924 | Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; not otherwise specified | 6.00 |

| | Code | Description | Base Unit |
|---|---|---|---|
| | **01925** | Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; carotid or coronary | 8.00 |
| | **01926** | Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; intracranial, intracardiac, or aortic | 10.00 |
| | **01930** | Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified | 5.00 |
| | **01931** | Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intrahepatic or portal circulation (eg, transcutaneous porto-caval shunt (TIPS)) | 7.00 |
| | **01932** | Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intrathoracic or jugular | 7.00 |
| | **01933** | Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intracranial | 8.00 |
| | **01951** | Anesthesia for second and third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; less than four percent total body surface area | 3.00 |
| | **01952** | Anesthesia for second and third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; between four and nine percent of total body surface area | 5.00 |
| + | **01953** | Anesthesia for second and third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; each additional nine percent total body surface area or part thereof (List separately in addition to code for primary procedure) | 1.00 |
| | **01958** | Anesthesia for external cephalic version procedure | 5.00 |
| | **01960** | Anesthesia for vaginal delivery only | 5.00 |
| | **01961** | Anesthesia for cesarean delivery only | 7.00 |
| | **01962** | Anesthesia for urgent hysterectomy following delivery | 8.00 |
| | **01963** | Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care | 10.00 |
| | **01965** | Anesthesia for incomplete or missed abortion procedures | 4.00 |
| | **01966** | Anesthesia for induced abortion procedures | 4.00 |
| | **01967** | Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor) | 5.00 |
| + | **01968** | Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed) | 3.00 |
| + | **01969** | Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed) | 5.00 |
| | **01990** | Physiological support for harvesting of organ(s) from brain-dead patient | 7.00 |
| | **01991** | Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than the prone position | 3.00 |
| | **01992** | Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position | 5.00 |
| | **01996** | Daily hospital management of epidural or subarachnoid continuous drug administration | 3.00 |
| | **01999** | Unlisted anesthesia procedure(s) | 0.00 |
| + | **99100** | Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure) | 0.00 |
| + | **99116** | Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure) | 0.00 |
| + | **99135** | Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure) | 0.00 |
| + | **99140** | Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure) | 0.00 |

# Pain Management

In addition to the General Rules, this section provides specific rules for Pain Management services.

## I. Reimbursement for Pain Management Services

A. **Pain Management Base Units for Professional Services**

Base units for professional services in the Pain Management section are state-specific and have been authorized by the Mississippi Workers' Compensation Commission for the professional reimbursement of procedures in Pain Management. Reimbursement is for base units only. Time units will not be considered for reimbursement purposes.

The conversion factor for Pain Management is forty-two dollars ($42.00) per unit. The formula for calculating professional reimbursement is:

Base unit x conversion factor ($42.00) = professional reimbursement

B. **Facility Fees**

Pain management facility fees are state-specific and are based upon the intensity of the procedure and the amount of resources required in completing the procedure. The facility fee is paid for the use of personnel, materials, drugs, equipment and space. The facility reimbursement is all-inclusive and will not be unbundled.

The reimbursement for the use of fluoroscopy (CPT codes 77002 and 77003) is to be one hundred dollars ($100.00), regardless of the number of procedures performed, and may only be billed once per date of service.

CPT code 77002 is to be used for fluoroscopic guidance for needle placement for CPT code 64510 Cervical (stellate ganglion) sympathetic block, or CPT code 64520 Thoracic or lumbar blocks.

CPT code 77003 is to be used for fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (i.e., epidural, transforaminal epidural, paravertebral facet joint or facet joint nerve, or sacroiliac joint), including neurolytic agent destruction.

The facility reimbursement amount for pain management services is listed in the Facility Fee column. This amount is specific to the the pain management section and the facility and not to be used for any other section or physician services. Reimbursement for multiple pain procedures performed in a facility shall be:

- One hundred percent (100%) for the primary procedure
- Fifty percent (50%) for the second and any subsequent procedures

C. **Reimbursement for Injection/Destruction Procedures**

1. The current CPT codes for Pain Management typically have separate codes for injections that may involve additional levels (e.g., 64470 is for injection of cervical facet single or first level, and 64472 is used for additional levels).

2. Facet injections, medial branch blocks and nerve destruction procedures are reimbursed at a maximum of three (3) total anatomic joint levels. Additional level or bilateral modifiers may be used to allow up to a maximum of two (2) additional service levels (but not more) for facet or medial branch blocks in the cervical/thoracic (64472) or lumbar (64476) for a maximum of three (3) procedure levels reimbursed per treatment session or day. Additional injected site levels, beyond the first three (3), will not be reimbursed. These procedures are unilateral by definition. Bilateral modifiers may be used when nerves are treated bilaterally. Reimbursement of the bilateral modifier is fifty percent (50%) of the base amount for the second or contralateral side. Procedures are considered inherently bilateral, and modifiers denoting bilateral injections do not alter reimbursement amounts.

3. Reimbursement for injection/destruction procedure codes is made on the basis of nerves treated (e.g., destruction by neurolytic agent of the L4-L5 facets counts as two (2) levels/nerves and should be billed as 64622 (first level/nerve) and 64623 (each additional level)). There are two nerves supplying each joint and

reimbursement is based upon nerve(s) treated, not the joint levels treated. This applies to CPT codes 64622, 64623 (lumbar), and 64626, 64627 (cervical/thoracic). These procedures are unilateral by definition. Additionally, bilateral modifiers may be used when nerves are treated bilaterally. Reimbursement of the bilateral modifier is fifty percent (50%) of the base amount for the second or contralateral side.

4. Multiple Epidural Injections in a Single Treatment Day/Session. In order to obtain reimbursement for more than one epidural injection in a single treatment day/session (either multiple levels or bilateral injections) there must be appropriate documentation in the medical records of a medical condition for which multiple injections would be appropriate. For bilateral injections, this includes the presence of significant bilateral radiating/radicular pain. For multiple level injections, this includes conditions for which an additional injected level could be anticipated to result in improved clinical outcomes. These conditions would include:

   - Disc pathology (e.g., protrusion) at one level with a dermatomal pain distribution of an adjacent level (e.g., disc affects the traversing nerve root, such as an L4/5 disc herniation affecting the traversing L5 nerve root).
   - Multiple dermatomal nerve root involvement.

   A maximum of two (2) levels of transforaminal epidural steroid injections are reimbursable for a given date of service. This applies to codes 64479, 64480, 64483, and 64484.

   Reimbursement is still limited to two epidural procedures (either two levels, or one level bilaterally) per date of service.

5. A maximum of one (1) interlaminar epidural steroid injection is reimbursable for a given date of service. This applies to codes 62310 and 62311.

6. A maximum of three (3) facet level procedures are reimbursable for a given date of service. This **maximum** applies to facet joint injections and nerve blocks, codes 64470–64476. Nerve destruction procedures, codes 64622–64627, are limited to two (2) facet levels (three (3) nerve branches), unilateral and bilateral, per given date of service.

D. **Multiple Procedure Reimbursement**

Reimbursement for multiple pain procedures shall be:

- One hundred percent (100%) for the primary procedure
- Fifty percent (50%) for the second and any subsequent procedures

For purposes of reimbursement, each injection is considered a separate procedure and will be reimbursed according to the multiple procedure rule. Multiple level injection codes reported with add-on codes (e.g., 64480, 64484, 64486, 64627) shall be reimbursed as additional procedures under applicable multiple injection rules as explained in this section. The reimbursement rate for these add-on procedure codes is fifty percent (50%) of the rate for the primary (base) procedure. Because these are add-on codes, the listed amount for the procedure is fifty percent (50%) of the primary (base) procedure and the add-on code will be reimbursed at the full amount listed in the Fee Schedule.

No more than two (2) types of pain management procedures can be performed on a given day, unless otherwise approved by the payer. "Type" is defined as any procedure code involving an anatomically different structure (e.g., spinal nerve, facet joint, sacroiliac joint, trigger point, etc.). Joints and nerves in different anatomical regions (cervical, thoracic, lumbar, sacral) are considered to be different "types" and are limited to two (2) procedures per given day. Additional level injections in the same area are not considered different "types," and for the purpose of this rule, are considered to be the same "type." However, the multiple level restrictions, as detailed herein, still apply.

Example: A three-level lumbar facet injection would be billed as 64475 for the first level and 64476 for each additional level. Reimbursement is as follows:

| Level | Code | Base Units | Reimbursement |
|---|---|---|---|
| **First** | 64475 | 10 | $420.00 |
| **Second** | 64476 | 5 | $210.00 |
| **Third** | 64476 | 5 | $210.00 |
| **Total Reimbursement** | | | $840.00 |

**Note:** The reimbursement for each of the additional levels is fifty percent (50%) of the reimbursement amount for the first level. However, because these are add-on codes, the reduction in reimbursement is a function of the reduction in the base units. The base units for the second and additional levels already reflect the fifty percent (50%) reduction, so an additional reduction would not be applied when adjudicating the claim. Add-on codes are reimbursed at one hundred percent (100%) of the allowable.

## II. Reimbursement for Refill of Pain Pumps

A. **Code 95990.** This CPT code, which applies to refilling and maintenance of an implantable pump or reservoir for drug delivery spinal (intrathecal, epidural) or brain (intraventricular), is reimbursed at the specified MRA listed in the Medicine section of the Fee Schedule.

B. **Evaluation and Management Services.** Refilling and maintenance of implantable pump or reservoir for pain management drug delivery is a global service. An evaluation and management service is not paid additionally unless significant additional or other cognitive services are provided and documented. To report a significant, separately identifiable evaluation and management service, append modifier 25 to the appropriate evaluation and management code. Documentation is required and payment will be allowed if supported by the documentation.

C. **Drugs.** Those drugs used in the refill of the pain pump shall be reimbursed in accordance with the Pharmacy Rules contained in the Pharmacy Rules section of this Fee Schedule.

D. **Compounding Fee.** If the drugs used in the refill of the pain pump must be compounded, the compounding service shall be reimbursed at $157.44 per individual refill. Report the compounding service with code S9430, Pharmacy compounding and dispensing services.

E. **CPT Code 95990.** This CPT code, which applies to refilling and maintenance of an implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), is reimbursed per the physicians' fee schedule.

## III. "Diagnostic Only" Injections and Procedures

A. Valid "diagnostic only" injections require a reasonably alert patient capable of adequately determining the amount or level of pain relieved or produced by the procedure. This requires judicious use of sedatives in the performance of such procedures. Clearly, analgesic medications such as intravenous narcotics are to be avoided during the procedure and evaluation phase of testing, as these medications can affect the validity of such diagnostic tests. The results of the tests and drugs used during the injection or procedure must be part of the medical records, and available for review by the payer. Failure to document the patient's response to a diagnostic procedure or injection, and the level of alertness following the procedure or injection, could result in denial of reimbursement.

B. Discography requires a reasonably alert patient capable of discriminating the quality and quantity of discomfort during the performance of the procedure in order to provide valid information on concordant or non-concordant pain. The results of the tests and drugs used during the procedure must be part of the medical records, and available for review by the payer. Failure to document the patient's response to the procedure, and level of alertness during discography could result in denial of reimbursement.

C. Medial branch (facet nerve) or *diagnostic* intra-articular facet injections require an alert patient, free from undue influence of intravenous narcotics in order to more reliably determine the analgesic response to the procedure. Failure to document the patient's response to the procedure or injection, and level of alertness after the procedure for diagnostic facet nerve or facet intra-articular injections could result in denial of reimbursement.

D. Diagnostic injections with local anesthetics require documentation of analgesic response through any validated pain measurement test (e.g., numerical pain scale, visual analogue scale). This should be performed after the procedure during the time that there would be an expected analgesic response (every thirty (30) minutes for at least one (1) hour). This must be documented and the documentation must be available to the payer for review. The documentation must also include the drugs used during the procedure, and comments on the patient's level of alertness at each time period when the pain or response is evaluated. If the patient's pre-procedure pain was determined by provocative exam tests or maneuvers, these should be repeated during the evaluation period following the procedure, to differentiate analgesia related to the procedure from positional analgesia, such as, for example, that which may be provided by lying in a recovery bed.

E. Intravenous narcotic pain medications are typically to be avoided for diagnostic analgesic injections, such as facet joint or nerve blocks, as they would be expected to provide an analgesic benefit completely independent of the injection itself. Sedatives such as midazolam or propofol can be used judiciously, if necessary, avoiding excessive post-procedure sedation. Proper documentation must be provided to support a request for reimbursement.

F. Other injections with both therapeutic and potentially diagnostic benefit, such as selective nerve root or peripheral nerve blocks or therapeutic facet injections (see T modifiers), would ideally be performed with minimal sedation and avoidance of intravenous narcotics. However, as these injections also have potential therapeutic benefit, this is NOT a requirement for reimbursement.

## IV. Physical Therapy

In the pain management setting, no more than two (2) modalities and/or procedures may be used on a date of service (e.g., heat/cold, ultrasound, diathermy, iontophoresis, TENS, electrical stimulation, muscle stimulation, etc.). Multiple modalities should be performed sequentially. Only one (1) modality can be reported for concurrently performed procedures.

## V. General Rules

A. Reimbursement for an approved epidural series is limited to two (2) injections. Further injections require a positive analgesic response for approval. For the first injection, the initial analgesic response may be temporary. However, after the second injection, there must be a residual and progressive analgesic benefit in order to perform a third injection. Documentation of a positive patient response will be required to continue epidural treatment. If there is no documented pain relief after two (2) injections, no further injections will be considered medically necessary.

B. Reimbursement will be limited to three (3) epidural pain injections in a twelve (12) month period unless the payer gives prior approval for more than three (3) such injections. Separate billing for the drug injected is not appropriate and will not be reimbursed.

C. Modifiers

### *PM Pain Management*

Modifier PM, which is a Mississippi-specific pain management code modifier, is no longer required, and will not be recognized for reimbursement for dates of service beginning July1, 2007.

### *Modifiers T and D (Mississippi State Modifiers)*

Facet joint/nerve injections can be used for diagnostic or therapeutic indications, or both. These injections should be used with modifier D to indicate a diagnostic intention of the injection, or with modifier T to indicate a therapeutic intention of the injection.

Intra-articular joint injections (cervical, thoracic, lumbar), which can have both diagnostic and therapeutic indications, should always be considered primarily therapeutic and should be billed using modifier T.

The number of facet injections subject to reimbursement is limited to four (4) dates of service with a maximum of two (2) therapeutic and two (2) diagnostic injections for the initial twelve (12) month period of treatment per anatomical region. This allows for a total of four (4) dates of service, regardless of the number of levels treated, which levels are treated, or which side (left or right or bilateral) is treated, in the same anatomical region. For coding purposes, the spine is divided into three (3) anatomical regions, cervical, thoracic, and lumbar/sacral. If treatment for facet related pain continues past twelve (12) months, further injections are limited to a total of three (3) dates of service per twelve (12) month period. This limit applies to both therapeutic and diagnostic injections combined, and reimbursement beyond the initial twelve (12) month period is further limited to no more than two (2) injections of either type, as determined by modifiers T or D, per twelve (12) month period. Failure to designate injections with the appropriate T or D modifier will limit reimbursement to no more than two (2) facet joint/nerve injections per twelve (12) month period. This rule applies to cervical, thoracic and lumbar facet joint and facet joint nerve injections. Facet injections in different anatomical areas are not subject to the above limits, as each different anatomical area would be subject to its own separate limit as described above.

Facet nerve (medial branch **ablation**) for cervical, thoracic or lumbar nerves will only be reimbursed once per nine (9) month period.

D. In order to be eligible for reimbursement under this Fee Schedule, pain management procedures or services which are specifically governed by the rules in this Pain Management section of the Fee Schedule must be performed by a licensed physician holding either an M.D. or D.O. degree. Pain management procedures specifically governed herein which are performed by any other person, such as a Certified Registered Nurse Anesthetist (CRNA), shall not be reimbursed under this Fee Schedule.

E. Trigger point injection is considered one (1) procedure and is reimbursed as such regardless of the number of injection sites. Billing for multiple injections, and multiple regions, falls under the same one-procedure rule. Two codes are available for reporting trigger point injections: use 20552 for injection(s) of single or multiple trigger point(s) in one or two muscles, or 20553 when three or more muscles are involved. When billing for multiple injections, and multiple regions, only code 20552 **OR** 20553 is allowed per date of service.

F. Sacroiliac arthroscopy (CPT code 73542) assumes the use of a fluoroscope and is considered an integral part of the procedures(s). Therefore, an additional fee for the fluoroscopy (CPT code 77002) is not warranted and will not be reimbursed.

G. Epidurography (CPT code 72275), a/k/a "epidural myelogram" or "epidural without dural puncture," is the proper code to use for contrast material injected into the epidural space. The epidurography code involves the

inherent use of a fluoroscope, and, therefore, an additional fluoroscopy fee for procedure code 77003 is not reimbursable.

H. CPT code 62318 includes needle placement, catheter infusion and subsequent injections. Code 62318 should be used for multiple solutions injected by way of the same catheter, or multiple bolus injections during the initial procedure. The epidural needle or catheter placement is inherent to the procedure, and, therefore, no additional charge for needle or catheter placement is allowed.

I. Investigational Procedures. The following procedures are considered investigational, and, therefore, do not presently qualify for reimbursement under the *Mississippi Workers' Compensation Medical Fee Schedule:*

1. Intradiscal electrothermal therapy (IDET) (22526, 22527) and intradiscal annuloplasty by other method (0062T, 0063T);
2. Intraventricular administration of Morphine;
3. Pulse radiofrequency, regardless of procedure involved or indication (e.g., medial branch radiofrequency, dorsal root radiofrequency, etc.). If pulsed radiofrequency is used, but not specifically recorded as such in the medical records, the payer may retroactively deny payment for the service and request for reimbursement from the provider;
4. Intradiscal therapies used in discography, such as percutaneous disc decompression (Dekompressor), fluoroscopic, laser, radiofrequency, and thermal disc therapies;
5. Percutaneous disc nucleoplasty;
6. Epidural adhesiolysis, also known as Racz procedure or lysis of epidural adhesions.

J. The following procedures must be performed fluoroscopically in order to qualify for reimbursement:

1. Facet injections (64470, 64472, 64475, 64476)
2. Sacroiliac (SI) injections (27096)
3. Transforaminal epidural steroid injections (64479, 64480, 64483, 64484)
4. Cervical translaminar/interlaminar epidural injections (62310)

K. Any analgesia/sedation used in the performance of the procedures in this section is considered integral to the procedure, and will not be separately reimbursed. This rule applies whether or not the person administering the analgesia/sedation is the physician who is performing the pain management injection. Administration of analgesia/sedation by a different person from the physician performing the injection, including an RN, PA, CRNA, or MD/DO, DOES NOT allow for separate billing of analgesia/sedation.

L. Anatomical descriptions of the procedures performed must accompany the bill for service in order for reimbursement to be made. These descriptions must include landmarks used in determining needle positioning, needles used, and the type and quantity of drugs injected. Tolerance to the procedure, and side effects or lack thereof should be included in this documentation.

M. Discography. Discography is a diagnostic test to identify (or rule out) painful intervertebral discs. Discography is appropriate only in patients for whom no other treatment options remain except for possible surgical stabilization (spinal fusion). A discography is then used on these patients to determine which discs, if any, are painful and abnormal, so that a surgical correction (fusion) can be performed. If a patient is not considered to be a candidate for surgery (fusion), then a discogram is not considered medically necessary. Investigational intradiscal therapies such as percutaneous disc decompression (Dekompressor), fluoroscopic, laser, radiofrequency, and thermal disc therapies are not an indication for a discography.

Reimbursement of discography:

62290 — 10 units; additional levels denoted with modifier 51 or 59 are reimbursed at five (5) units per level

62291 — 12 units; additional levels denoted with modifier 51 or 59 are reimbursed at six (6) units per level

72285, 72295 — 8 units

The radiographic interpretation codes 72285 and 72295 can only be used ONCE per treatment session and additional level modifiers are not allowed.

When reporting the radiological supervision and interpretation professional components for discography (72285, 72295), the anatomical localization for needle placement is inclusive with the procedure and code 77003 should NOT be additionally reported.

Radiographic interpretation codes 72285 and 72295 must include a thorough description of radiographic findings available in a separate report with hard copy radiographs or other media, such as digital, that will allow review of images (AP and lateral at a minimum).

N. BOTOX. BOTOX is not indicated for the relief of musculoskeletal pain, and its use as such is not covered by the Fee Schedule. An exception is made when BOTOX treatment is indicated for spasticity or other indications and requires prior approval.

O. Use of Opioids or Other Controlled Substances for Management of Chronic (Non-Terminal) Pain. It is recognized that optimal or effective treatment for chronic pain may require the use of opioids or other controlled substances. The proper and effective use of opioids or other controlled substances has been specifically addressed by the Mississippi Board of Medical Licensure. Unless otherwise directed by the Commission, reimbursement for prescriptions for opioids or other controlled substances used for the management or treatment of chronic, non-terminal pain shall not be provided under this Fee Schedule unless treatment is sufficiently documented and complies with the following Rules and Regulations, as promulgated by the Mississippi State Board of Medical Licensure, and supplemented by the Commission accordingly:

1. DEFINITIONS: For the purpose of this provision, the following terms have the meanings indicated:

   a. **"Chronic Pain"** is a pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending physician and one or more physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain. Further, if a patient is receiving controlled substances for the treatment of pain for a prolonged period of time (more than six (6) months), then they will be considered for the purposes of this regulation to have "de facto" chronic pain and subject to the same requirements of this regulation. "Terminal Disease Pain" should not be confused with "Chronic Pain." For the purpose of this section, "Terminal Disease Pain" is pain arising from a medical condition for which there is no possible cure and the patient is expected to live no more than six (6) months.

   b. **"Acute Pain"** is the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time limited and is responsive to therapies, including controlled substances as defined by the U.S. Drug Enforcement Administration. Title 21 CFR Part 1301 Food and Drugs.

   c. **"Addiction"** is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

   d. **"Physical Dependence"** is a physiological state of neuroadaptation to a substance which is characterized by the emergence of a withdrawal syndrome if the use of the substance is stopped or decreased abruptly, or if an antagonist is administered. Withdrawal may be relieved by re-administration of the substance. Physical dependence is a normal physiological consequence of extended opioid therapy for pain and should not be considered addiction.

   e. **"Substance Abuse"** is the use of any substance(s) for non-therapeutic purposes; or use of medication for purposes other than those for which it is prescribed.

   f. **"Tolerance"** is a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect or a reduced effect is observed with a constant dose. Tolerance occurs to different degrees for various drug effects, including sedation, analgesia and constipation. Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Such tolerance may or may not be evident during treatment and does not equate with addiction.

2. Notwithstanding any other provisions of these rules and regulations, a physician may prescribe, administer, or dispense controlled substances in Schedules II, IIN, III, IIIN, IV and V, or other drugs having addiction-forming and addiction-sustaining liability to a person in the usual course of treatment of that person for a diagnosed condition causing chronic pain.

3. Notwithstanding any other provisions of these rules and regulations, as to the prescribing, administration, or dispensation of controlled substances in Schedules II, IIN, III, IIIN, IV and V, or other drugs having addiction-forming and addiction-sustaining liability, use of said medications in the treatment of chronic pain should be done with caution. A physician may administer, dispense or prescribe said medications for the

purpose of relieving chronic pain, provided that the following conditions are met:

a. Before initiating treatment utilizing a Schedules II, IIN, III, IIIN, IV or V controlled substance, or any other drug having addiction-forming and addiction-sustaining liability, the physician shall conduct an appropriate risk/benefit analysis by reviewing his own records of prior treatment, or review the records of prior treatment which another treating physician has provided to the physician, that there is an indicated need for long term controlled substance therapy. Such a determination shall take into account the specifics of each patient's diagnosis, past treatments and suitability for long term controlled substance use either alone or in combination with other indicated modalities for the treatment of chronic pain. This shall be clearly entered into the patient medical record, and shall include consultation/referral reports to determine the underlying pathology or cause of the chronic pain.

b. Documentation in the patient record shall include a complete medical history and physical examination that indicates the presence of one or more recognized medical indications for the use of controlled substances.

c. Documentation of a written treatment plan which shall contain stated objectives as a measure of successful treatment and planned diagnostic evaluations, e.g., psychiatric evaluation or other treatments. The plan should also contain an informed consent agreement for treatment that details relative risks and benefits of the treatment course. This should also include specific requirements of the patient, such as using one physician and pharmacy if possible, and urine/serum medication level monitoring when requested, but no less than once every twelve (12) months.

d. Periodic review and documentation of the treatment course is conducted at reasonable intervals (no less than every six months) with modification of therapy dependent on the physician's evaluation of progress toward the stated treatment objectives. This should include referrals and consultations as necessary to achieve those objectives.

4. No physician shall administer, dispense or prescribe a controlled substance or other drug having addiction-forming and addiction-sustaining liability that is non-therapeutic in nature or non-therapeutic in the manner the controlled substance or other drug is administered, dispensed or prescribed.

5. No physician shall administer, dispense or prescribe a controlled substance for treatment of chronic pain to any patient who has consumed or disposed of any controlled substance or other drug having addiction-forming and addiction-sustaining liability other than in strict compliance with the treating physician's directions. These circumstances include those patients obtaining controlled substances or other abusable drugs from more than one physician and those patients who have obtained or attempted to obtain new prescriptions for controlled substances or other abusable drugs before a prior prescription should have been consumed according to the treating physician's directions. This requirement will not be enforced in cases where a patient has legitimately temporarily escalated a dose of their pain medication due to an acute exacerbation of their condition but have maintained a therapeutic dose level, however, it will be required of the treating physician to document in the patient record that such increase in dose level was due to a recognized indication and was within appropriate therapeutic dose ranges. Repetitive or continuing escalations should be a reason for concern and a re-evaluation of the present treatment plan shall be undertaken by the physician.

6. No physician shall prescribe any controlled substance or other drug having addiction-forming or addiction-sustaining liability to a patient who is a drug addict for the purpose of "detoxification treatment," or "maintenance treatment," and no physician shall administer or dispense any narcotic controlled substance for the purpose of "detoxification treatment" or "maintenance treatment" unless they are properly registered in accordance with MCA section 303(g) 21 U.S.C. 823(g). Nothing in this paragraph shall prohibit a physician from administering narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment. Not more than one (1) day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three (3) days. Nothing in this paragraph shall prohibit a physician

from administering or dispensing narcotic controlled substances in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction.

7. In addition to the specific Rules and Regulations promulgated by the Mississippi State Board of Medical Licensure as set forth above and incorporated herein, the payer may, as in other cases, obtain a second opinion from an appropriate and qualified physician to determine the appropriateness of the treatment being rendered, including but not limited to the appropriateness of the continuing use of opioids or other controlled substances for treatment of the patient's chronic pain. However, any such second opinion shall not be used as the basis for abrupt withdrawal of medication or payment therefor. Nothing in this paragraph shall prohibit a physician from administering narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral or discontinuance of treatment, and the payer shall provide reimbursement in accordance with this Fee Schedule, as follows: not more than one (1) day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three (3) days. Discontinuance of treatment or reimbursement of prescriptions based on a second opinion obtained hereunder shall be subject to review by the Commission pursuant to the Dispute Resolution Rules set forth in the Dispute Resolution Rules section in this Fee Schedule.

P. Radiographic Codes in Pain Management. Beginning January 1, 2007, code 76003 is replaced by code 77002, and code 76005 (fluoroscopy for injection) is replaced by code 77003. Description of service and reimbursement will remain the same.

Codes 72000–72220 which apply to radiographic examination of the spine are not reimbursed concurrent with the pain management procedures in this section or with fluoroscopy services.

Code 73542 is not separately reimbursed with facet or sacroiliac joint injections.

Q. Soft Tissue Injections. "Myofascial, myoneural, and trigger point injections" are synonymous and are to be reimbursed with the 20552 and/or 20553 codes. Modifiers for additional injections are not allowed with these codes. Reimbursement for codes 20552 and 20553 will be identical, and not additive.

Codes 20550 and 20551 are used for the injections of tendon origins and are NOT to be used for "myofascial, myoneural or trigger point" injections. Failure to observe this rule could result in denial of service on retrospective review and/or request for reimbursement.

Code 20612 is to be used for the aspirations/injection of a ganglion cyst and NOT for "myofascial, myoneural, or trigger point" injections. Failure to observe this rule could result in denial of service on retrospective review and/or request for reimbursement.

R. Implantation of spinal cord stimulators. The following conditions must be met for consideration of spinal cord stimulators.

- Patient must have a medical condition for which spinal cord stimulation (SCS) is a recognized and accepted form of treatment.
- There must be a trial stimulation that includes a minimum seven (7) day home trial with the temporary stimulating electrode.
- During the trial stimulation, the patient must report at least fifty percent (50%) pain reduction during the last four (4) days of the stimulation trial.
- Psychological screening must be used to determine if the patient is free from:
  - Substance abuse issues
  - Untreated psychiatric conditions
  - Major psychiatric illness that could impair the patient's ability to respond appropriately to the trial stimulation

| Code | Description | Base Units | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|
| **20526** | Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel | See Page 111 | 000 | N | $140.00 |
| **20550** | Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar fascia) | 3.00 | 000 | N | $140.00 |
| **20551** | Injection(s); single tendon origin/insertion | 3.00 | 000 | N | $140.00 |
| **20552** | Injection(s); single or multiple trigger point(s), one or two muscle(s) | 3.00 | 000 | N | $140.00 |
| **20553** | Injection(s); single or multiple trigger point(s), three or more muscle(s) | 3.00 | 000 | N | $140.00 |
| **20600** | Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes) | 3.00 | 000 | N | $140.00 |
| **20605** | Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) | See Page 111 | 000 | N | $140.00 |
| **20610** | Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa) | See Page 111 | 000 | N | $140.00 |
| **27096** | Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid | 7.00 | 000 | N | $400.00 |
| **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 | 20.00 | 010 | N | $350.00 |
| **62264** | 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; 1 day | 14.00 | 010 | N | $350.00 |
| **62270** | Spinal puncture, lumbar, diagnostic | 5.00 | 000 | N | $85.00 |
| **62272** | Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter) | 8.00 | 000 | N | $85.00 |
| **62273** | Injection, epidural, of blood or clot patch | 8.00 | 000 | N | $450.00 |
| **62280** | Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid | 8.00 | 010 | N | $450.00 |
| **62281** | Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic | 17.00 | 010 | N | $475.00 |
| **62282** | Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal) | 16.00 | 010 | N | $525.00 |
| **62290** | Injection procedure for discography, each level; lumbar | 10.00 | 000 | N | $480.00 |
| **62291** | Injection procedure for discography, each level; cervical or thoracic | 13.00 | 000 | N | $480.00 |
| **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, steroid, other solution), epidural or subarachnoid; cervical or thoracic | 9.00 | 000 | N | $450.00 |
| **62311** | 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, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal) | 8.00 | 000 | N | $425.00 |
| **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, steroid, other solution), epidural or subarachnoid; cervical or thoracic | 10.00 | 000 | N | $450.00 |
| **62319** | 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, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal) | 9.00 | 000 | N | $425.00 |
| **64400** | Injection, anesthetic agent; trigeminal nerve, any division or branch | 10.00 | 000 | N | $125.00 |
| **64402** | Injection, anesthetic agent; facial nerve | 7.00 | 000 | N | $125.00 |
| **64405** | Injection, anesthetic agent; greater occipital nerve | 5.00 | 000 | N | $125.00 |
| **64408** | Injection, anesthetic agent; vagus nerve | 7.00 | 000 | N | $125.00 |
| **64410** | Injection, anesthetic agent; phrenic nerve | 8.00 | 000 | N | $480.00 |
| **64412** | Injection, anesthetic agent; spinal accessory nerve | 7.00 | 000 | N | $480.00 |

| | Code | Description | Base Units | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|
| | 64413 | Injection, anesthetic agent; cervical plexus | 8.00 | 000 | N | $140.00 |
| | 64415 | Injection, anesthetic agent; brachial plexus, single | 8.00 | 000 | N | $250.00 |
| | 64416 | Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration | 13.00 | 010 | N | $250.00 |
| | 64417 | Injection, anesthetic agent; axillary nerve | 8.00 | 000 | N | $250.00 |
| | 64418 | Injection, anesthetic agent; suprascapular nerve | 5.00 | 000 | N | $120.00 |
| | 64420 | Injection, anesthetic agent; intercostal nerve, single | 5.00 | 000 | N | $250.00 |
| | 64421 | Injection, anesthetic agent; intercostal nerves, multiple, regional block | 8.00 | 000 | N | $250.00 |
| | 64425 | Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves | 5.00 | 000 | N | $140.00 |
| | 64430 | Injection, anesthetic agent; pudendal nerve | 5.00 | 000 | N | $140.00 |
| | 64435 | Injection, anesthetic agent; paracervical (uterine) nerve | 5.00 | 000 | N | $140.00 |
| | 64445 | Injection, anesthetic agent; sciatic nerve, single | 7.00 | 000 | N | $140.00 |
| | 64446 | Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter, (including catheter placement) including daily management for anesthetic agent administration | 12.00 | 010 | N | $485.00 |
| | 64447 | Injection, anesthetic agent; femoral nerve, single | 7.00 | 000 | N | $150.00 |
| | 64448 | Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration | 12.00 | 010 | N | $150.00 |
| | 64449 | Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration | 12.00 | 010 | N | $150.00 |
| | 64450 | Injection, anesthetic agent; other peripheral nerve or branch | 5.00 | 000 | N | $125.00 |
| | 64470 | Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level | 10.00 | 000 | N | $465.00 |
| + | 64472 | Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure) | 5.00 | 000 | N | $395.00 |
| | 64475 | Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level | 8.00 | 000 | N | $465.00 |
| + | 64476 | Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure) | 4.00 | 000 | N | $395.00 |
| | 64479 | Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, single level | 10.00 | 000 | N | $465.00 |
| + | 64480 | Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, each additional level (List separately in addition to code for primary procedure) | 6.00 | 000 | N | $425.00 |
| | 64483 | Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level | 8.00 | 000 | N | $465.00 |
| + | 64484 | Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level (List separately in addition to code for primary procedure) | 5.00 | 000 | N | $425.00 |
| | 64505 | Injection, anesthetic agent; sphenopalatine ganglion | 8.00 | 000 | N | $140.00 |
| | 64508 | Injection, anesthetic agent; carotid sinus (separate procedure) | 7.00 | 000 | Y | $140.00 |
| | 64510 | Injection, anesthetic agent; stellate ganglion (cervical sympathetic) | 7.00 | 000 | N | $450.00 |
| | 64517 | Injection, anesthetic agent; superior hypogastric plexus | 10.00 | | N | $450.00 |
| | 64520 | Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic) | 8.00 | 000 | N | $450.00 |
| | 64530 | Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring | 12.00 | 000 | N | $475.00 |
| | 64600 | Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch | 10.00 | 010 | N | $670.00 |
| | 64605 | Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale | 20.00 | 010 | N | $670.00 |
| | 64610 | Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring | 20.00 | 010 | N | $670.00 |
| | 64620 | Destruction by neurolytic agent, intercostal nerve | 10.00 | 010 | N | $670.00 |

| | Code | Description | Base Units | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|
| | **64622** | Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level | 12.00 | 010 | N | $750.00 |
| + | **64623** | Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure) | 6.00 | 000 | N | $395.00 |
| | **64626** | Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level | 12.00 | 010 | N | $750.00 |
| + | **64627** | Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure) | 6.00 | 000 | N | $395.00 |
| | **64630** | Destruction by neurolytic agent; pudendal nerve | 10.00 | 010 | N | $365.00 |
| | **64640** | Destruction by neurolytic agent; other peripheral nerve or branch | 9.00 | 010 | N | $365.00 |
| | **64680** | Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus | 20.00 | 010 | N | $450.00 |
| | **64681** | Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus | 16.00 | 010 | N | $650.00 |
| | **72275** | Epidurography, radiological supervision and interpretation | 3.00 | 000 | N | BR |
| | **72285** | Discography, cervical or thoracic, radiological supervision and interpretation | 8.00 | | N | BR |
| | **72295** | Discography, lumbar, radiological supervision and interpretation | 12.00 | | N | BR |
| | **73542** | Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation | 3.00 | 000 | N | BR |
| | **95991** | Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician | 3.00 | 000 | N | BR |

# Surgery

## I. General Guidelines

A. **Global Reimbursement**
The reimbursement allowances for surgical procedures are based on a global reimbursement concept that covers performing the basic service and the normal range of care required after surgery.

Global reimbursement includes:

1. The operation per se
2. Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
3. Subsequent to the decision and/or authorization for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure (including history and physical), but does not include the initial consultation
4. Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
5. Writing orders
6. Evaluating the patient in the postanesthesia recovery area
7. Normal, uncomplicated follow-up (FU) care for the time periods indicated in the follow- up days (FUD) column to the right of each procedure code. The number in that column establishes the days during which no additional reimbursement is allowed for the usual care provided following surgery, absent complications or unusual circumstances.
8. The maximum reimbursement allowances cover all normal postoperative care, including the removal of sutures by the surgeon or associate. Follow-up days are specified by procedure. Follow-up days listed are for 0, 10, or 90 days and are listed in the Fee Schedule as 000, 010, or 090. Follow-up days may also be listed as MMM indicating that services are for uncomplicated maternity care, XXX indicating that the global surgery concept does not apply, YYY indicating that the follow-up period is to be set by the payer (used primarily with BR procedures), or ZZZ indicating that the code is related to another service and is treated in the global period of the other procedure billed in conjunction with the ZZZ procedure (used primarily with add-on and exempt from modifier 51 codes). The day of surgery is day one when counting follow-up days. Hospital discharge day management is considered to be normal, uncomplicated follow-up care.

B. **Follow-up Care for Diagnostic Procedures**
Follow-up care for diagnostic procedures (e.g., endoscopy, injection procedures for radiography) includes only the care related to recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be charged for in accordance with the services rendered.

C. **Follow-up Care for Therapeutic Surgical Procedures**
Follow-up care for therapeutic surgical procedures includes only care that is usually part of the surgical procedure. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services concurrent with the procedure(s) or during the listed period of normal follow-up care may warrant additional charges.

D. **Separate Procedures**
Separate procedures are commonly carried out as an integral part of another procedure. They should not be billed in conjunction with the related procedure. These procedures may be billed when performed independently by adding modifier 59 to the specific "separate procedure" code.

E. **Additional Surgical Procedure(s)**
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.

F. **Microsurgery, Operating Microscope, and Use of Code 69990**
The surgical microscope is employed when the surgical services are performed using the technique of microsurgery. Code 69990 should be reported (without

modifier 51 appended) in addition to the code for the primary procedure performed. Do not use 69990 for reporting visualization with magnifying loupes or corrected vision. Do not report code 69990 in addition to procedures where the use of the operating microscope is considered an inclusive component. The operating microscope is considered inclusive in the following codes only: 15756–15758; 15842; 19364; 19368; 20955–20962; 20969–20973; 26551–26554; 26556; 31526; 31531; 31536; 31541; 31545; 31546; 31561; 31571; 43116; 43496; 49906; 61548; 63075-63078; 64727; 64820–64823; 65091–68850. For purposes of clarification, if microsurgery technique is employed and the primary procedure code is not contained in the aforementioned list, it is appropriate to report 69990 with the primary procedure performed and reimbursement is required for said services. (For example, code 63030 is not included in the aforementioned list and, as such, it is appropriate for providers to report 69990 along with 63030 to describe microsurgical technique. Reimbursement for 69990 is required provided operative documentation affirms microsurgical technique and not just visualization with magnifying loupes or corrected vision.

G. **Unique Techniques**
A surgeon is not entitled to an extra fee for a unique technique. It is inappropriate to use modifier 22 unless the procedure is significantly more difficult than indicated by the description of the code.

H. **Surgical Destruction**
Surgical destruction is part of a surgical procedure, and different methods of destruction (e.g., laser surgery) are not ordinarily listed separately unless the technique substantially alters the standard management of a problem or condition. Exceptions under special circumstances are provided for by separate code numbers.

I. **Incidental Procedure(s)**
An additional charge for an incidental procedure (e.g., incidental appendectomy, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernia, etc.) is not customary and does not warrant additional reimbursement.

J. **Endoscopic Procedures**
When multiple endoscopic procedures are performed by the same practitioner at a single encounter, the major procedure is reimbursed at one hundred percent (100%). If a secondary procedure is performed through the same opening/orifice, fifty percent (50%) is allowable as a multiple procedure. However, diagnostic procedures during the same session and entry site are incidental to the major procedure.

K. **Biopsy Procedures**
A biopsy of the skin and another surgical procedure performed on the same lesion on the same day must be billed as one procedure.

L. **Repair of Nerves, Blood Vessels, and Tendons with Wound Repairs**
The repair of nerves, blood vessels, and tendons is usually reported under the appropriate system. The repair of associated wounds is included in the primary procedure unless it qualifies as a complex wound, in which case modifier 51 may be applied. Simple exploration of nerves, blood vessels, and tendons exposed in an open wound is also considered part of the essential treatment of the wound closure and is not a separate procedure unless appreciable dissection is required.

M. **Suture Removal**
Billing for suture removal by the operating surgeon is not appropriate as this is considered part of the global fee.

N. **Joint Manipulation Under Anesthesia**
There is no charge for manipulation of a joint under anesthesia when it is preceded or followed by a surgical procedure on that same day by that surgeon. However, when manipulation of a joint is the scheduled procedure and it indicates additional procedures are necessary and appropriate, fifty percent (50%) of the manipulation may be allowed.

O. **Supplies and Materials**
Supplies and materials provided by the physician (e.g., sterile trays/drugs) over and above those usually included with the office visit may be listed separately using CPT code 99070 or specific HCPCS Level II codes.

P. **Plastic and Metallic Implants**
Plastic and metallic implants or non-autogenous graft materials supplied by the physician are to be reimbursed at cost.

Q. **Aspirations and Injections**
Puncture of a cavity or joint for aspiration followed by injection of a therapeutic agent is one procedure and should be billed as such.

R. **Surgical Assistant**
1. Physician surgical assistant — For the purpose of reimbursement, a physician who assists at surgery is reimbursed as a surgical assistant. Assistant

surgeons should use modifier 80 and are allowed twenty percent (20%) of the maximum reimbursement allowance (MRA) for the procedure(s).

2. Registered Nurse Surgical Assistant

   a. Registered nurses who have completed an approved first assistant training course may be allowed a fee when assisting a surgeon in the operating room (O.R.).

   b. The maximum reimbursement allowance for the registered nurse first assistant (RNFA) is ten percent (10%) of the surgeon's fee for the procedure(s) performed.

   c. Under no circumstances will a fee be allowed for an assistant surgeon and a RNFA at the same surgical encounter.

   d. Registered nurses on staff in the O.R. of a hospital, clinic, or outpatient surgery center do not qualify for reimbursement as a RNFA

   e. CPT codes with modifier AS should be used to bill for RNFA services on a CMS-1500 form and should be submitted with the charge for the surgeon's services.

S. **Operative Reports**
An operative report must be submitted to the payer before reimbursement can be made for the surgeon's or assistant surgeon's services.

T. **Needle Procedures**
Needle procedures (lumbar puncture, thoracentesis, jugular or femoral taps, etc.) should be billed in addition to the medical care on the same day.

U. **Therapeutic Procedures**
Therapeutic procedures (injecting into cavities, nerve blocks, etc.) (CPT codes 20526–20610, 64400, 64450) may be billed in addition to the medical care for a new patient. (Use appropriate level of service plus injection.)

In follow-up cases for additional therapeutic injections and/or aspirations, an office visit is only indicated if it is necessary to re-evaluate the patient. In this case, a minimal visit may be listed in addition to the injection. Documentation supporting the office visit charge must be submitted with the bill to the payer. Reimbursement for therapeutic injections will be made according to the multiple procedure rules.

Trigger point injection is considered one procedure and reimbursed as such regardless of the number of injection sites. Two codes are available for reporting trigger point injections. Use 20552 for injection(s) of single or multiple trigger point(s) in one or two muscles or 20553 when three or more muscles are involved.

V. **Anesthesia by Surgeon**
In certain circumstances it may be appropriate for the attending surgeon to provide regional or general anesthesia. Anesthesia by the surgeon is considered to be more than local or digital anesthesia. Identify this service by adding modifier 47 to the surgical code. Only base anesthesia units are allowed. See the Anesthesia section.

W. **Therapeutic/Diagnostic Injections**
Injections are considered incidental to the procedure when performed with a related invasive procedure.

X. **Intervertebral Biomechanical Device(s) and Use of Code 22851**
Code 22851 describes the application of an intervertebral biomechanical device to a vertebral defect or interspace. Code 22851 should be listed in conjunction with a primary procedure without the use of modifier 51. The use of 22851 is limited to one instance per single interspace or single vertebral defect regardless of the number of devices applied and infers additional qualifying training, experience, sizing, and/or use of special surgical appliances to insert the biomechanical device. Qualifying devices include manufactured pre-machined synthetic or allograft biomechanical devices, or methyl methacrylate constructs, and are not dependant on a specific manufacturer, shape, or material of which it is constructed. (For example, the use of code 22851 would be appropriate during a cervical arthrodesis (22554) when applying a synthetic alloy cage, a threaded bone dowel, or a pre-machined hexahedron tricortical allograft biomechanical device. Surgeons utilizing generic non-machined bony allografts or autografts are referred to code sets 20930–20931, 20936–20938 respectively.)

## II. Ambulatory Surgery Centers

A. **Definition**
For purposes of this section of the Fee Schedule, "ambulatory surgery center" means an establishment with an organized medical staff of physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; with continuous physicians and registered nurses on site or on call; which provides services and accommodations for patients to recover for a period not to exceed twenty-three (23) hours after surgery. An ambulatory surgery center may be a freestanding facility

or may be attached to a hospital facility. For purposes of Workers' Compensation reimbursement to ASCs, the facility must be an approved Medicare ASC.

B. **Coding and Billing Rules**

1. Facility fees for ambulatory surgery must be billed on the UB-04 form.
2. The CPT/HCPCS code(s) of the procedure(s) performed determines the reimbursement for the facility fee. Report all procedures performed.
3. If more than one surgical procedure is furnished in a single operative encounter, the multiple procedure rule applies. The primary procedure is reimbursed at one hundred percent (100%) of the maximum reimbursable allowance (MRA), the second and subsequent procedures are reimbursed at fifty percent (50%) of the MRA.
4. If the billed total for an outpatient surgical encounter is less than the ASC MRA, the lesser of the charges is paid to the facility.
5. The payment rate for an ASC surgical procedure includes all facility services directly related to the procedure performed on the day of surgery. Facility services include:
   - Nursing and technician services
   - Use of the facility
   - Drugs, biologicals, surgical dressings, splints, casts and equipment directly related to the provision of the surgical procedure
   - Materials for anesthesia
   - Administration, record keeping and housekeeping items and services
6. Separate payment is not made for the following services that are directly related to the surgery:
   - Pharmacy
   - Medical/surgical supplies
   - Sterile supplies
   - Operating room services
   - Anesthesia
   - Ambulatory surgical care
   - Recovery room
   - Treatment or Observation room
7. Facility fees do not include physician services, x-rays, diagnostic procedures, laboratory procedures, CRNA or anesthesia physician services, prosthetic devices, ambulance services, braces, artificial limbs or DME for use in the patient's home. These items will be reimbursed according to Fee Schedule MRA or HCPCS MRA, whichever is appropriate.

C. **Facility Fee Reimbursement for ASCs**

1. The Mississippi Worker's Compensation Commission has adopted the Medicare ASC Payment Groups for classifying payment of facility fees for ambulatory surgery.
2. The ASC payment rate has been added to the CPT code listing of fees in the Surgery section of the Fee Schedule. The column lists the total approved facility fee for that particular CPT code.
3. The facility fees will be paid for medically necessary services only. All ambulatory elective procedures must be precertified according to the rules and guidelines of the Fee Schedule.
4. Procedures not assigned an ASC facility fee will be reimbursed according to the lesser of total billed charges or usual and customary rates.

## III. Multiple Procedures

A. **Multiple Procedure Reimbursement Rule**

Multiple procedures performed during the same operative session at the same operative site are reimbursed as follows:

- One hundred percent (100%) of the allowable fee for the primary procedure
- Fifty percent (50%) of the allowable fee for the second through fifth procedure
- Sixth and subsequent procedures are reimbursed by report

B. **Bilateral Procedure Reimbursement Rule**

Physicians and staff are sometimes confused by the definition of bilateral. Bilateral procedures are identical procedures (i.e., use the same CPT code) performed on the same anatomic site but on opposite sides of the body. Furthermore, each procedure should be performed through its own separate incision to qualify as bilateral. For example, open reductions of bilateral fractures of the mandible treated through a common incision would not qualify under the definition of bilateral and would be reimbursed according to the multiple procedure rule. Medicare's accepted method of billing bilateral services is to list the procedure once and add modifier 50. Mississippi is adopting this same policy. Refer to the example below:

69300-50 Otoplasty, protruding ear

Place a "2" in the UNITS column of the CMS-1500 claim form so that payers are aware that two procedures were performed. List the charge as one hundred fifty percent (150%) of your normal charge. Reimbursement shall be at one hundred fifty percent (150%) of the amount allowed for a unilateral procedure(s). For example, if the allowable for a unilateral surgery is one hundred dollars ($100.00) and it is performed bilaterally, reimbursement shall be one hundred fifty dollars ($150.00). However, if the procedure description states "bilateral," reimbursement shall be as listed in the Fee Schedule since the fee was calculated for provision of the procedure bilaterally.

C. **Multiple Procedures—Different Areas Rule**
When multiple surgical procedures are performed in different areas of the body during the same operative sessions and the procedures are unrelated (e.g., abdominal hernia repair and a knee arthroscopy), the multiple procedure reimbursement rule will apply independently to each area. Modifier 51 must be added.

D. **Multiple Procedure Billing Rules**
1. The primary procedure, which is defined as the procedure with the highest RVU, must be billed with the applicable CPT code.
2. The second or lesser or additional procedure(s) must be billed by adding modifier 51 to the codes, unless the procedure(s) is exempt from modifier 51 or qualifies as an add-on code.

## IV. Repair of Wounds

A. **Definitions**
Wound repairs are classified as simple, intermediate, or complex.

1. **Simple repair.** Simple repair is repair of superficial wounds involving primarily epidermis and dermis or subcutaneous tissues without significant involvement of deeper structures and simple one layer closure/suturing. This includes local anesthesia and chemical or electrocauterization of wounds not closed.
2. **Intermediate repair.** Intermediate repair is repair of wounds that requires layered closure of one or more of the subcutaneous tissues and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. Single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter also constitutes intermediate repair.
3. **Complex repair.** Complex repair is repair of wounds requiring more than layered closure, scar revision, debridement (e.g., traumatic lacerations or avulsions), extensive undermining, stents or retention sutures. It may include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations or avulsions.

B. **Reporting**
The following instructions are for reporting services at the time of the 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 anatomical grouping and report as a single item. When more than one classification of wound is repaired, list the more complicated as the primary procedure and the less complicated as the secondary procedure using modifier 51.
3. 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 (extensive debridement of soft tissue and/or bone).
4. Report involvement of nerves, blood vessels, and tendons under the appropriate system (nervous, musculoskeletal, etc.) for repair. The repair of these wounds is included in the fee for the primary procedure unless it qualifies as a complex wound, in which case modifier 51 applies.
5. Simple ligation of vessels in an open wound is considered part of any wound closure, as is simple exploration of nerves, blood vessels, or tendons.
6. Adjacent tissue transfers, flaps and grafts include such procedures as Z-plasty, W- plasty, V-4-plasty or rotation flaps. Reimbursement is based on the size of the defect. Closing the donor site with a skin graft is considered an additional procedure and will be reimbursed in addition to the primary procedure. Excision of a lesion prior to repair by adjacent tissue transfer is considered "bundled" into the tissue transfer procedure and is not reimbursed separately.
7. Wound exploration codes should not be billed with codes that specifically describe a repair to major structure or major vessel. The specific repair code supersedes the use of a wound exploration code.

# V. MUSCULOSKELETAL SYSTEM

A. **Casting and Strapping**
This applies to severe muscle sprains or strains that require casting or strapping.

1. Initial (new patient) treatment for soft tissue injuries must be billed under the appropriate office visit code.
2. When a cast or strapping is applied during an initial visit, supplies and materials (e.g., stockinet, plaster, fiberglass, ace bandages) may be itemized and billed separately using the appropriate HCPCS Level II code.
3. When initial casting and/or strapping is applied for the first time during an established patient visit, reimbursement may be made for the itemized supplies and materials in addition to the appropriate established patient visit.
4. Replacement casts or strapping provided during a follow-up visit (established patient) include reimbursement for the replacement service as well as the removal of casts, splints, or strapping. Follow-up visit charges may be reimbursed in addition to replacement casting and strapping only when additional significantly identifiable medical services are provided. Office notes should substantiate medical necessity of the visit. Cast supplies may be billed using the appropriate HCPCS Level II code and reimbursed separately.

B. **Fracture Care**
1. Fracture care is a global service. It includes the examination, restoration or stabilization of the fracture, application of the first cast, and cast removal. Casting material is not considered part of the global package and may be reimbursed separately. It is inappropriate to bill an office visit since the reason for the encounter is for fracture care. However, if the patient requires surgical intervention, additional reimbursement can be made for the appropriate E/M code to properly evaluate the patient for surgery. Use modifier 57 with the E/M code.
2. Reimbursement for fracture care includes the application and removal of the first cast or traction device only. Replacement casting during the period of follow-up care is reimbursed separately.
3. The phrase "with manipulation" describes reduction of a fracture.
4. Re-reduction of a fracture performed by the primary physician may be identified by the addition of modifier 76 to the usual procedure code to indicate "repeat procedure" by the same physician.
5. The term "complicated" appears in some musculoskeletal code descriptions. It implies an infection occurred or the surgery took longer than usual. Be sure the medical record documentation supports the "complicated" descriptor to justify reimbursement.

C. **Bone, Cartilage, and Fascia Grafts**
1. Reimbursement for obtaining autogenous bone, cartilage or fascia grafts, or other tissue through separate incisions is made only when the graft is not described as part of the basic procedure.
2. Tissue obtained from a cadaver for grafting must be billed using code 99070 and accompanied by a report in order to ensure an equitable reimbursement by the payer.

D. **Arthroscopy**
**Note:** Surgical arthroscopy always includes a diagnostic arthroscopy. Only in the most unusual case is an increased fee justified because of increased complexity of the intra-articular surgery performed.

1. Diagnostic arthroscopy should be billed at fifty percent (50%) when followed by open surgery.
2. Diagnostic arthroscopy is not billed when followed by arthroscopic surgery.
3. If there are only minor findings that do not confirm a significant preoperative diagnosis, the procedure should be billed as a diagnostic arthroscopy.

E. **Arthrodesis Procedures**
Many revisions have occurred in CPT coding for arthrodesis procedures. References to bone grafting and fixation are now procedures which are listed and reimbursed separately from the arthrodesis codes.

To help alleviate any misunderstanding about when to code a discectomy in addition to an arthrodesis, the statement "including minimal discectomy" to prepare interspace has been added to the anterior interbody technique. If the disk is removed for decompression of the spinal cord, the decompression should be coded and reimbursed separately.

F. **External Spinal Stimulators Post Fusion**

1. The following criteria is established for the medically accepted standard of care when determining applicability for the use of an external spinal stimulator. However, the medical necessity should be determined on a case-by-case basis.
    a. Patient has had a previously failed spinal fusion, and/or
    b. Patient is scheduled for revision or repair of pseudoarthrosis, and/or
    c. The patient smokes greater than a pack of cigarettes per day and is scheduled for spinal fusion
2. The external spinal stimulator is not approved by the Mississippi Workers' Compensation Commission for use in primary spinal fusions.
3. The external spinal stimulator will be reimbursed by report (BR).
4. Precertification is required for use of the external spinal stimulator.

G. **Carpal Tunnel Release**

The following intraoperative services are included in the global service package for carpal tunnel release and should not be reported separately and do not warrant additional reimbursement:

- Surgical approach
- Isolation of neurovascular structures
- Video imaging
- Stimulation of nerves for identification
- Application of dressing, splint, or cast
- Tenolysis of flexor tendons
- Flexor tenosynovectomy
- Excision of lipoma of carpal canal
- Exploration of incidental release of ulnar nerve
- Division of transverse carpal ligament
- Use of endoscopic equipment
- Placement and removal of surgical drains or suction device
- Closure of wound

## VI. Burns, Local Treatment

A. **Degree of Burns**

1. Code 16000 must be used when billing for treatment of first degree burns when no more than local treatment of burned surfaces is required.
2. Codes 16020–16030 must be used when billing for treatment of partial-thickness burns only.
3. The claim form must be accompanied by a report substantiating the services performed.
4. Major debridement of foreign bodies, grease, epidermis, or necrotic tissue may be billed separately under codes 11000–11001. Modifier 51 does not apply.

B. **Percentage of Total Body Surface Area**

The following definitions apply to codes 16020–16030:

1. "Small" means less than five percent (5%) of the total body surface area
2. "Medium" means whole face or whole extremity or five to ten percent (5%–10%) of the total body surface area
3. "Large" means more than one extremity or greater than ten percent (10%) of the total body surface area

C. **Reimbursement**

1. To identify accurately the proper procedure code and substantiate the descriptor for billing, the exact percentage of the body surface involved and the degree of the burn must be specified on the claim form submitted or by attaching a special report. Claims submitted without this specification will be returned to the physician for this additional information.
2. Hospital visits, emergency room visits, or critical care visits provided by the same physician on the same day as the application of burn dressings will be reimbursed as a single procedure at the highest level of service.

## VII. Nerve Blocks

A. **Diagnostic or Therapeutic**

1. Please refer to the Pain Management section for guidelines and reimbursement of nerve blocks.
2. Medications such as steroids, pain medication, etc., may be separately billed using the appropriate HCPCS Level II code.

a. The name of the medication(s), dosage, and volume must be identified.

b. Medication will be reimbursed according to fees listed in the HCPCS section. If not listed in HCPCS, reimbursement will be according to the Pharmacy section in the General Guidelines.

B. **Anesthetic**
When a nerve block for anesthesia is provided by the operating room surgeon, the procedure codes listed in the Anesthesia section must be followed.

## VIII. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code. The modifier may be reported by a two-digit number placed after the usual procedure number and separated by a hyphen. If more than one modifier is used, place the multiple modifiers code 99 immediately after the procedure code. This indicates that one or more additional modifier codes follow. Modifiers commonly used in surgery are as follows:

### *22 Unusual Procedural Services*

When the services provided are greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

*Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.*

### *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 modifier 26 to the usual procedure number.

### *32 Mandated Services*

Services related to mandated consultation and/or related services (e.g., PRO, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

### *47 Anesthesia by Surgeon*

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures 00100–01999.

*Mississippi's note: Reimbursement is made for base units only.*

### *50 Bilateral Procedure*

Unless otherwise identified in the listings, bilateral procedures that are performed during the same operative session should be identified by adding modifier 50 to the appropriate five-digit code.

### *51 Multiple Procedures*

When multiple procedures, other than evaluation and management services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see the applicable CPT book).

*Mississippi's note: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the applicable CPT book.*

### *52 Reduced Services*

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

### *53 Discontinued Procedure*

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

### 54 Surgical Care Only

When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

### 55 Postoperative Management Only

When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

### 56 Preoperative Management Only

When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

### 57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

### 58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** This modifier is not used to report the treatment of a problem that requires a return to the operation room. See modifier 78.

### 59 Distinct Procedural Service

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 by used.

### 62 Two Surgeons

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If an additional procedure(s) (including an add-on procedure(s)) is performed during the same surgical session, a separate code(s) may be reported with modifier 62 added. **Note:** If a co- surgeon acts as an assistant in the performance of an additional procedure(s) during the same surgical session, the service(s) may be reported using a separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

### 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 and 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 modifier 66 to the basic procedure number used for reporting services.

### 76 Repeat Procedure by Same Physician

The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

### 77 Repeat Procedure by Another Physician

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 procedure/service.

### 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 modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

### 79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

The physician 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 modifier 79. (For repeat procedures on the same day, see modifier 76.)

### 80 Assistant Surgeon

Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

*Mississippi's note: Reimbursement is twenty percent (20%) of the maximum reimbursement allowance.*

### 81 Minimum Assistant Surgeon

Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

*Mississippi's note: Physician reimbursement is ten percent (10%) of the allowable.*

### 82 Assistant Surgeon (when qualified resident surgeon not available)

The unavailability of a qualified resident surgeon is prerequisite for use of modifier 82 appended to the unusual procedure code number(s).

### 90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

### 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 Assistant At Surgery Services Provided By Registered Nurse First Assistant

Assistant at surgery services provided by a Registered Nurse First Assistant (RNFA), Nurse Practitioner or Clinical Nurse Specialist are identified by adding modifier AS to the listed applicable surgical procedures. The use of the AS moidifier is appropriate for any code that otherwise is reimbursable for a physician assisting a surgeon in the operating room.

*Mississippi's note: Modifier AS reimbursement is ten percent (10%) of the allowable.*

## IX. Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use

### 25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately indentifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). 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 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. See modifier 57.

### 27 Multiple Outpatient Hospital E/M Encounters on the Same Date

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency departement E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and managment services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic). **Note:** This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (e.g., hospital emergency department, clinic), see Evaluation and Management, Emergency Department, or Preventive Medicine Services codes.

### 50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code.

### *52 Reduced Services*

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

### *58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period*

The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.

### *59 Distinct Procedural Service*

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

### *73 Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia*

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patientís surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

### 74 Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

### *76 Repeat Procedure by Same Physician*

The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

### *77 Repeat Procedure by Another Physician*

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 procedure/service.

### *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 modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

### *79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period*

The physician 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 modifier 79. (For repeat procedures on the same day, see modifier 76.)

### *91 Repeat Clinical Diagnostic Laboratory Test*

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problesm with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **10021** | Fine needle aspiration; without imaging guidance | 3.38 | $282.23 | | 000 | N | |
| | **10022** | Fine needle aspiration; with imaging guidance | 3.63 | $303.11 | | 000 | N | |
| | **10040** | Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules) | 2.21 | $184.54 | | 010 | N | |
| | **10060** | Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single | 2.48 | $207.08 | | 010 | N | |
| | **10061** | Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple | 4.33 | $361.56 | | 010 | N | |
| | **10080** | Incision and drainage of pilonidal cyst; simple | 4.17 | $348.20 | | 010 | N | |
| | **10081** | Incision and drainage of pilonidal cyst; complicated | 6.38 | $532.73 | | 010 | N | |
| | **10120** | Incision and removal of foreign body, subcutaneous tissues; simple | 3.35 | $279.73 | | 010 | N | |
| | **10121** | Incision and removal of foreign body, subcutaneous tissues; complicated | 6.28 | $524.38 | | 010 | N | $669.00 |
| | **10140** | Incision and drainage of hematoma, seroma or fluid collection | 3.47 | $289.75 | | 010 | N | |
| | **10160** | Puncture aspiration of abscess, hematoma, bulla, or cyst | 2.90 | $242.15 | | 010 | N | |
| | **10180** | Incision and drainage, complex, postoperative wound infection | 5.45 | $455.08 | | 010 | N | $669.00 |
| | **11000** | Debridement of extensive eczematous or infected skin; up to 10% of body surface | 1.23 | $102.71 | | 000 | N | |
| + | **11001** | Debridement of extensive eczematous or infected skin; each additional 10% of the body surface (List separately in addition to code for primary procedure) | 0.54 | $45.09 | | 000 | N | |
| | **11004** | Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum | 14.11 | $1,178.19 | | 000 | N | |
| | **11005** | Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure | 19.00 | $1,586.50 | | 000 | N | |
| | **11006** | Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure | 17.65 | $1,473.78 | | 000 | N | |
| + | **11008** | Removal of prosthetic material or mesh, abdominal wall for necrotizing soft tissue infection (List separately in addition to code for primary procedure) | 6.97 | $582.00 | | 000 | N | |
| | **11010** | Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin and subcutaneous tissues | 11.26 | $940.21 | | 010 | N | $377.28 |
| | **11011** | Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, and muscle | 13.06 | $1,090.51 | | 000 | N | $377.28 |
| | **11012** | Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, muscle, and bone | 18.66 | $1,558.11 | | 000 | N | $377.28 |
| | **11040** | Debridement; skin, partial thickness | 1.07 | $89.35 | | 000 | N | |
| | **11041** | Debridement; skin, full thickness | 1.32 | $110.22 | | 000 | N | |
| | **11042** | Debridement; skin, and subcutaneous tissue | 1.82 | $151.97 | | 000 | N | $246.63 |
| | **11043** | Debridement; skin, subcutaneous tissue, and muscle | 6.50 | $542.75 | | 010 | N | $246.63 |
| | **11044** | Debridement; skin, subcutaneous tissue, muscle, and bone | 8.71 | $727.29 | | 010 | N | $634.65 |
| | **11055** | Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion | 1.07 | $89.35 | | 000 | N | |
| | **11056** | Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); two to four lesions | 1.32 | $110.22 | | 000 | N | |
| | **11057** | Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than four lesions | 1.62 | $135.27 | | 000 | N | |
| | **11100** | Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion | 2.17 | $181.20 | | 000 | N | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| + | **11101** | Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure) | 0.74 | $61.79 | | 000 | N | |
| | **11200** | Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions | 1.84 | $153.64 | | 010 | N | |
| + | **11201** | Removal of skin tags, multiple fibrocutaneous tags, any area; each additional ten lesions (List separately in addition to code for primary procedure) | 0.44 | $36.74 | | 000 | N | |
| | **11300** | Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less | 1.53 | $127.76 | | 000 | N | |
| | **11301** | Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm | 2.01 | $167.84 | | 000 | N | |
| | **11302** | Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm | 2.41 | $201.24 | | 000 | N | |
| | **11303** | Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm | 2.88 | $240.48 | | 000 | N | |
| | **11305** | Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less | 1.58 | $131.93 | | 000 | N | |
| | **11306** | Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm | 2.14 | $178.69 | | 000 | N | |
| | **11307** | Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm | 2.50 | $208.75 | | 000 | N | |
| | **11308** | Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm | 2.93 | $244.66 | | 000 | N | |
| | **11310** | Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less | 1.88 | $156.98 | | 000 | N | |
| | **11311** | Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm | 2.33 | $194.56 | | 000 | N | |
| | **11312** | Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm | 2.69 | $224.62 | | 000 | N | |
| | **11313** | Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm | 3.46 | $288.91 | | 000 | N | |
| | **11400** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less | 2.80 | $233.80 | | 010 | N | |
| | **11401** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm | 3.30 | $275.55 | | 010 | N | |
| | **11402** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm | 3.67 | $306.45 | | 010 | N | |
| | **11403** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm | 4.23 | $353.21 | | 010 | N | |
| | **11404** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm | 4.82 | $402.47 | | 010 | N | $499.50 |
| | **11406** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm | 6.61 | $551.94 | | 010 | N | $669.00 |
| | **11420** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less | 2.77 | $231.30 | | 010 | N | |
| | **11421** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm | 3.53 | $294.76 | | 010 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **11422** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm | 3.93 | $328.16 | | 010 | N | |
| **11423** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm | 4.63 | $386.61 | | 010 | N | |
| **11424** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm | 5.29 | $441.72 | | 010 | N | $669.00 |
| **11426** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm | 7.58 | $632.93 | | 010 | N | $669.00 |
| **11440** | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less | 3.15 | $263.03 | | 010 | N | |
| **11441** | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm | 3.83 | $319.81 | | 010 | N | |
| **11442** | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm | 4.28 | $357.38 | | 010 | N | |
| **11443** | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm | 5.20 | $434.20 | | 010 | N | |
| **11444** | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm | 6.56 | $547.76 | | 010 | N | $499.50 |
| **11446** | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm | 8.75 | $730.63 | | 010 | N | $669.00 |
| **11450** | Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair | 8.22 | $686.37 | | 090 | N | $669.00 |
| **11451** | Excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair | 10.92 | $911.82 | | 090 | Y | $669.00 |
| **11462** | Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with simple or intermediate repair | 8.11 | $677.19 | | 090 | N | $669.00 |
| **11463** | Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with complex repair | 11.22 | $936.87 | | 090 | Y | $669.00 |
| **11470** | Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with simple or intermediate repair | 8.88 | $741.48 | | 090 | N | $669.00 |
| **11471** | Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with complex repair | 11.55 | $964.43 | | 090 | Y | $669.00 |
| **11600** | Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.5 cm or less | 4.18 | $349.03 | | 010 | N | |
| **11601** | Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm | 4.83 | $403.31 | | 010 | N | |
| **11602** | Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm | 5.20 | $434.20 | | 010 | N | |
| **11603** | Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm | 5.97 | $498.50 | | 010 | N | |
| **11604** | Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm | 6.63 | $553.61 | | 010 | N | $627.74 |
| **11606** | Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm | 9.25 | $772.38 | | 010 | N | $669.00 |
| **11620** | Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less | 4.18 | $349.03 | | 010 | N | |
| **11621** | Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm | 4.85 | $404.98 | | 010 | N | |
| **11622** | Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm | 5.46 | $455.91 | | 010 | N | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **11623** | Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm | 6.48 | $541.08 | | 010 | N | |
| | **11624** | Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm | 7.40 | $617.90 | | 010 | N | $669.00 |
| | **11626** | Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm | 9.26 | $773.21 | | 010 | N | $669.00 |
| | **11640** | Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less | 4.32 | $360.72 | | 010 | N | |
| | **11641** | Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm | 5.25 | $438.38 | | 010 | N | |
| | **11642** | Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm | 6.06 | $506.01 | | 010 | N | |
| | **11643** | Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm | 7.21 | $602.04 | | 010 | N | |
| | **11644** | Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm | 9.01 | $752.34 | | 010 | N | $669.00 |
| | **11646** | Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm | 11.98 | $1,000.33 | | 010 | N | $669.00 |
| | **11719** | Trimming of nondystrophic nails, any number | 0.45 | $37.58 | | 000 | N | |
| | **11720** | Debridement of nail(s) by any method(s); one to five | 0.70 | $58.45 | | 000 | N | |
| | **11721** | Debridement of nail(s) by any method(s); six or more | 1.03 | $86.01 | | 000 | N | |
| | **11730** | Avulsion of nail plate, partial or complete, simple; single | 2.24 | $187.04 | | 000 | N | |
| + | **11732** | Avulsion of nail plate, partial or complete, simple; each additional nail plate (List separately in addition to code for primary procedure) | 1.05 | $87.68 | | 000 | N | |
| | **11740** | Evacuation of subungual hematoma | 0.98 | $81.83 | | 000 | N | |
| | **11750** | Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal; | 4.75 | $396.63 | | 010 | N | |
| | **11752** | Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal; with amputation of tuft of distal phalanx | 6.76 | $564.46 | | 010 | N | |
| | **11755** | Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure) | 3.01 | $251.34 | | 000 | N | |
| | **11760** | Repair of nail bed | 4.48 | $374.08 | | 010 | N | |
| | **11762** | Reconstruction of nail bed with graft | 6.08 | $507.68 | | 010 | N | |
| | **11765** | Wedge excision of skin of nail fold (eg, for ingrown toenail) | 2.73 | $227.96 | | 010 | N | |
| | **11770** | Excision of pilonidal cyst or sinus; simple | 6.18 | $516.03 | | 010 | N | $765.00 |
| | **11771** | Excision of pilonidal cyst or sinus; extensive | 12.02 | $1,003.67 | | 090 | N | $765.00 |
| | **11772** | Excision of pilonidal cyst or sinus; complicated | 15.01 | $1,253.34 | | 090 | N | $765.00 |
| | **11900** | Injection, intralesional; up to and including seven lesions | 1.21 | $101.04 | | 000 | N | |
| | **11901** | Injection, intralesional; more than seven lesions | 1.50 | $125.25 | | 000 | N | |
| | **11920** | Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less | 5.07 | $423.35 | | 000 | N | |
| | **11921** | Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm | 5.68 | $474.28 | | 000 | N | |
| + | **11922** | Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm (List separately in addition to code for primary procedure) | 1.60 | $133.60 | | 000 | N | |
| | **11950** | Subcutaneous injection of filling material (eg, collagen); 1 cc or less | 1.89 | $157.82 | | 000 | N | |
| | **11951** | Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc | 2.60 | $217.10 | | 000 | N | |
| | **11952** | Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc | 3.51 | $293.09 | | 000 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **11954** | Subcutaneous injection of filling material (eg, collagen); over 10.0 cc | 4.18 | $349.03 | | 000 | N | |
| **11960** | Insertion of tissue expander(s) for other than breast, including subsequent expansion | 21.69 | $1,811.12 | | 090 | N | $669.00 |
| **11970** | Replacement of tissue expander with permanent prosthesis | 14.31 | $1,194.89 | | 090 | N | $765.00 |
| **11971** | Removal of tissue expander(s) without insertion of prosthesis | 11.91 | $994.49 | | 090 | N | $499.50 |
| **11975** | Insertion, implantable contraceptive capsules | 2.95 | $246.33 | | 000 | N | |
| **11976** | Removal, implantable contraceptive capsules | 3.53 | $294.76 | | 000 | N | |
| **11977** | Removal with reinsertion, implantable contraceptive capsules | 5.54 | $462.59 | | 000 | N | |
| **11980** | Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin) | 2.56 | $213.76 | | 000 | N | |
| **11981** | Insertion, non-biodegradable drug delivery implant | 3.21 | $268.04 | | 000 | Y | |
| **11982** | Removal, non-biodegradable drug delivery implant | 3.74 | $312.29 | | 000 | Y | |
| **11983** | Removal with reinsertion, non-biodegradable drug delivery implant | 5.58 | $465.93 | | 000 | Y | |
| **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 | 3.62 | $302.27 | | 010 | N | |
| **12002** | Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm | 3.84 | $320.64 | | 010 | N | |
| **12004** | Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm | 4.50 | $375.75 | | 010 | N | |
| **12005** | Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm | 5.61 | $468.44 | | 010 | N | $136.86 |
| **12006** | Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm | 6.96 | $581.16 | | 010 | N | $136.86 |
| **12007** | Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm | 7.87 | $657.15 | | 010 | N | $136.86 |
| **12011** | Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less | 3.83 | $319.81 | | 010 | N | |
| **12013** | Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm | 4.21 | $351.54 | | 010 | N | |
| **12014** | Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm | 4.96 | $414.16 | | 010 | N | |
| **12015** | Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm | 6.22 | $519.37 | | 010 | N | |
| **12016** | Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm | 7.36 | $614.56 | | 010 | N | $136.86 |
| **12017** | Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm | 6.51 | $543.59 | | 010 | Y | $136.86 |
| **12018** | Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm | 7.81 | $652.14 | | 010 | Y | $136.86 |
| **12020** | Treatment of superficial wound dehiscence; simple closure | 6.47 | $540.25 | | 010 | N | $136.86 |
| **12021** | Treatment of superficial wound dehiscence; with packing | 3.74 | $312.29 | | 010 | N | $136.86 |
| **12031** | Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less | 4.81 | $401.64 | | 010 | N | |
| **12032** | Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm | 6.59 | $550.27 | | 010 | N | |
| **12034** | Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm | 6.43 | $536.91 | | 010 | N | $136.86 |
| **12035** | Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm | 8.69 | $725.62 | | 010 | N | $136.86 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **12036** | Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm | 9.71 | $810.79 | | 010 | N | $136.86 |
| | **12037** | Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); over 30.0 cm | 10.92 | $911.82 | | 010 | Y | $484.92 |
| | **12041** | Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less | 5.21 | $435.04 | | 010 | N | |
| | **12042** | Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm | 6.22 | $519.37 | | 010 | N | |
| | **12044** | Layer closure of wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm | 6.85 | $571.98 | | 010 | N | $136.86 |
| | **12045** | Layer closure of wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm | 8.90 | $743.15 | | 010 | N | $136.86 |
| | **12046** | Layer closure of wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm | 10.65 | $889.28 | | 010 | Y | $136.86 |
| | **12047** | Layer closure of wounds of neck, hands, feet and/or external genitalia; over 30.0 cm | 11.07 | $924.35 | | 010 | Y | $484.92 |
| | **12051** | Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less | 5.92 | $494.32 | | 010 | N | |
| | **12052** | Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm | 6.34 | $529.39 | | 010 | N | |
| | **12053** | Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm | 6.82 | $569.47 | | 010 | N | |
| | **12054** | Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm | 7.44 | $621.24 | | 010 | N | $136.86 |
| | **12055** | Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm | 9.31 | $777.39 | | 010 | N | $136.86 |
| | **12056** | Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm | 11.93 | $996.16 | | 010 | Y | $136.86 |
| | **12057** | Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm | 12.40 | $1,035.40 | | 010 | Y | $484.92 |
| | **13100** | Repair, complex, trunk; 1.1 cm to 2.5 cm | 7.23 | $603.71 | | 010 | N | $484.92 |
| | **13101** | Repair, complex, trunk; 2.6 cm to 7.5 cm | 8.78 | $733.13 | | 010 | N | $484.92 |
| + | **13102** | Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure) | 2.47 | $206.25 | | 000 | N | $136.86 |
| | **13120** | Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm | 7.51 | $627.09 | | 010 | N | $136.86 |
| | **13121** | Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm | 9.49 | $792.42 | | 010 | N | $136.86 |
| + | **13122** | Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure) | 2.93 | $244.66 | | 000 | N | $136.86 |
| | **13131** | Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm | 8.21 | $685.54 | | 010 | N | $136.86 |
| | **13132** | Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm | 12.57 | $1,049.60 | | 010 | N | $136.86 |
| + | **13133** | Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure) | 3.87 | $323.15 | | 000 | N | $136.86 |
| | **13150** | Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less | 8.61 | $718.94 | | 010 | N | $484.92 |
| | **13151** | Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm | 9.31 | $777.39 | | 010 | N | $484.92 |
| | **13152** | Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm | 12.52 | $1,045.42 | | 010 | N | $484.92 |
| + | **13153** | Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure) | 4.34 | $362.39 | | 000 | N | $136.86 |
| | **13160** | Secondary closure of surgical wound or dehiscence, extensive or complicated | 19.34 | $1,614.89 | | 090 | N | $669.00 |
| | **14000** | Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less | 14.87 | $1,241.65 | | 090 | N | $669.00 |
| | **14001** | Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm | 19.31 | $1,612.39 | | 090 | N | $765.00 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **14020** | Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less | 16.51 | $1,378.59 | | 090 | N | $765.00 |
| | **14021** | Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm | 21.50 | $1,795.25 | | 090 | N | $765.00 |
| | **14040** | Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less | 17.38 | $1,451.23 | | 090 | N | $669.00 |
| | **14041** | Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm | 23.50 | $1,962.25 | | 090 | N | $765.00 |
| | **14060** | Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less | 17.86 | $1,491.31 | | 090 | N | $765.00 |
| | **14061** | Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm | 25.50 | $2,129.25 | | 090 | N | $765.00 |
| | **14300** | Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area | 24.86 | $2,075.81 | | 090 | Y | $945.00 |
| | **14350** | Filleted finger or toe flap, including preparation of recipient site | 18.19 | $1,518.87 | | 090 | Y | $765.00 |
| | **15002** | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children | 7.89 | $658.82 | | 000 | N | $484.92 |
| + | **15003** | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure) | 1.75 | $146.13 | | 000 | N | $484.92 |
| | **15004** | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children | 9.51 | $794.09 | | 000 | N | $484.92 |
| + | **15005** | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure) | 2.94 | $245.49 | | 000 | N | $484.92 |
| | **15040** | Harvest of skin for tissue cultured skin autograft, 100 sq cm or less | 6.43 | $536.91 | | 000 | N | $136.86 |
| | **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 | 12.51 | $1,044.59 | | 090 | N | $484.92 |
| | **15100** | Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) | 21.95 | $1,832.83 | | 090 | N | $669.00 |
| + | **15101** | Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 5.22 | $435.87 | | 000 | N | $765.00 |
| | **15110** | Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children | 21.36 | $1,783.56 | | 090 | N | $669.00 |
| + | **15111** | Epidermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 3.11 | $259.69 | | 000 | N | $499.50 |
| | **15115** | Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children | 20.45 | $1,707.58 | | 090 | N | $669.00 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| + | 15116 | Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 4.08 | $340.68 | | 000 | N | $499.50 |
| | 15120 | Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) | 21.89 | $1,827.82 | | 090 | N | $669.00 |
| + | 15121 | Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 7.00 | $584.50 | | 000 | N | $765.00 |
| | 15130 | Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children | 17.05 | $1,423.68 | | 090 | N | $669.00 |
| + | 15131 | Dermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 2.54 | $212.09 | | 000 | N | $499.50 |
| | 15135 | Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children | 20.83 | $1,739.31 | | 090 | N | $669.00 |
| + | 15136 | Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 2.39 | $199.57 | | 000 | N | $499.50 |
| | 15150 | Tissue cultured epidermal autograft, trunk, arms, legs; first 25 sq cm or less | 17.67 | $1,475.45 | | 090 | N | $669.00 |
| + | 15151 | Tissue cultured epidermal autograft, trunk, arms, legs; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure) | 3.29 | $274.72 | | 000 | N | $499.50 |
| + | 15152 | Tissue cultured epidermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 4.04 | $337.34 | | 000 | N | $499.50 |
| | 15155 | Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 25 sq cm or less | 17.89 | $1,493.82 | | 090 | N | $669.00 |
| + | 15156 | Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure) | 4.30 | $359.05 | | 000 | N | $499.50 |
| + | 15157 | Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 4.77 | $398.30 | | 000 | N | $499.50 |
| | 15170 | Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children | 9.73 | $812.46 | | 090 | N | |
| + | 15171 | Acellular dermal replacement, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 2.26 | $188.71 | | 000 | N | |
| | 15175 | Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children | 13.41 | $1,119.74 | | 090 | N | |
| + | 15176 | Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 3.59 | $299.77 | | 000 | N | |
| | 15200 | Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less | 18.59 | $1,552.27 | | 090 | N | $765.00 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| + | **15201** | Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm (List separately in addition to code for primary procedure) | 3.83 | $319.81 | | 000 | Y | $484.92 |
| | **15220** | Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less | 17.49 | $1,460.42 | | 090 | N | $669.00 |
| + | **15221** | Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm (List separately in addition to code for primary procedure) | 3.48 | $290.58 | | 000 | N | $484.92 |
| | **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 | 20.71 | $1,729.29 | | 090 | N | $765.00 |
| + | **15241** | Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; each additional 20 sq cm (List separately in addition to code for primary procedure) | 4.37 | $364.90 | | 000 | N | $484.92 |
| | **15260** | Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less | 21.86 | $1,825.31 | | 090 | N | $669.00 |
| + | **15261** | Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; each additional 20 sq cm (List separately in addition to code for primary procedure) | 4.98 | $415.83 | | 000 | N | $484.92 |
| | **15300** | Allograft skin for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children | 7.92 | $661.32 | | 090 | N | $484.92 |
| + | **15301** | Allograft skin for temporary wound closure, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 1.51 | $126.09 | | 000 | N | $484.92 |
| | **15320** | Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children | 9.06 | $756.51 | | 090 | N | $484.92 |
| + | **15321** | Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 2.25 | $187.88 | | 000 | N | $484.92 |
| | **15330** | Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children | 7.26 | $606.21 | | 090 | N | $484.92 |
| + | **15331** | Acellular dermal allograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 1.50 | $125.25 | | 000 | N | $484.92 |
| | **15335** | Acellular dermal allograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children | 8.06 | $673.01 | | 090 | N | $484.92 |
| + | **15336** | Acellular dermal allograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 2.19 | $182.87 | | 000 | N | $484.92 |
| | **15340** | Tissue cultured allogeneic skin substitute; first 25 sq cm or less | 7.74 | $646.29 | | 010 | N | |
| + | **15341** | Tissue cultured allogeneic skin substitute; each additional 25 sq cm | 1.15 | $96.03 | | 000 | N | |
| | **15360** | Tissue cultured allogeneic dermal substitute, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children | 8.43 | $703.91 | | 090 | N | |
| + | **15361** | Tissue cultured allogeneic dermal substitute, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 1.75 | $146.13 | | 000 | N | |
| | **15365** | Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children | 8.75 | $730.63 | | 090 | N | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| + | 15366 | Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 2.17 | $181.20 | | 000 | N | |
| | 15400 | Xenograft, skin (dermal), for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children | 8.66 | $723.11 | | 090 | N | $484.92 |
| + | 15401 | Xenograft, skin (dermal), for temporary wound closure, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 2.71 | $226.29 | | 000 | N | $484.92 |
| | 15420 | Xenograft skin (dermal), for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children | 9.78 | $816.63 | | 090 | N | $484.92 |
| + | 15421 | Xenograft skin (dermal), for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 2.85 | $237.98 | | 000 | N | $484.92 |
| | 15430 | Acellular xenograft implant; first 100 sq cm or less, or 1% of body area of infants and children | 12.94 | $1,080.49 | | 090 | N | $484.92 |
| + | 15431 | Acellular xenograft implant; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | 5.05 | $421.42 | | 000 | N | $484.92 |
| | 15570 | Formation of direct or tubed pedicle, with or without transfer; trunk | 21.42 | $1,788.57 | | 090 | N | $765.00 |
| | 15572 | Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs | 19.73 | $1,647.46 | | 090 | N | $765.00 |
| | 15574 | Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet | 21.30 | $1,778.55 | | 090 | N | $765.00 |
| | 15576 | Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral | 18.92 | $1,579.82 | | 090 | N | $765.00 |
| | 15600 | Delay of flap or sectioning of flap (division and inset); at trunk | 9.05 | $755.68 | | 090 | Y | $765.00 |
| | 15610 | Delay of flap or sectioning of flap (division and inset); at scalp, arms, or legs | 7.48 | $624.58 | | 090 | Y | $765.00 |
| | 15620 | Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet | 11.05 | $922.68 | | 090 | N | $945.00 |
| | 15630 | Delay of flap or sectioning of flap (division and inset); at eyelids, nose, ears, or lips | 10.93 | $912.66 | | 090 | N | $765.00 |
| | 15650 | Transfer, intermediate, of any pedicle flap (eg, abdomen to wrist, Walking tube), any location | 11.73 | $979.46 | | 090 | Y | $1,075.50 |
| | 15731 | Forehead flap with preservation of vascular pedicle (eg, axial pattern flap, paramedian forehead flap) | 26.11 | $2,180.19 | | 090 | N | $765.00 |
| | 15732 | Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae) | 36.99 | $3,088.67 | | 090 | Y | $765.00 |
| | 15734 | Muscle, myocutaneous, or fasciocutaneous flap; trunk | 37.85 | $3,160.48 | | 090 | Y | $765.00 |
| | 15736 | Muscle, myocutaneous, or fasciocutaneous flap; upper extremity | 34.85 | $2,909.98 | | 090 | N | $765.00 |
| | 15738 | Muscle, myocutaneous, or fasciocutaneous flap; lower extremity | 36.72 | $3,066.12 | | 090 | Y | $765.00 |
| | 15740 | Flap; island pedicle | 22.05 | $1,841.18 | | 090 | N | $669.00 |
| | 15750 | Flap; neurovascular pedicle | 21.91 | $1,829.49 | | 090 | Y | $669.00 |
| | 15756 | Free muscle or myocutaneous flap with microvascular anastomosis | 57.81 | $4,827.14 | | 090 | Y | |
| | 15757 | Free skin flap with microvascular anastomosis | 57.59 | $4,808.77 | | 090 | Y | |
| | 15758 | Free fascial flap with microvascular anastomosis | 57.66 | $4,814.61 | | 090 | Y | |
| | 15760 | Graft; composite (eg, full thickness of external ear or nasal ala), including primary closure, donor area | 19.66 | $1,641.61 | | 090 | N | $669.00 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **15770** | Graft; derma-fat-fascia | 15.58 | $1,300.93 | | 090 | Y | $765.00 |
| | **15775** | Punch graft for hair transplant; 1 to 15 punch grafts | 8.12 | $678.02 | | 000 | N | $484.92 |
| | **15776** | Punch graft for hair transplant; more than 15 punch grafts | 10.68 | $891.78 | | 000 | N | $484.92 |
| | **15780** | Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis) | 19.91 | $1,662.49 | | 090 | N | |
| | **15781** | Dermabrasion; segmental, face | 12.11 | $1,011.19 | | 090 | N | |
| | **15782** | Dermabrasion; regional, other than face | 14.06 | $1,174.01 | | 090 | N | |
| | **15783** | Dermabrasion; superficial, any site, (eg, tattoo removal) | 11.36 | $948.56 | | 090 | N | |
| | **15786** | Abrasion; single lesion (eg, keratosis, scar) | 5.42 | $452.57 | | 010 | N | |
| + | **15787** | Abrasion; each additional four lesions or less (List separately in addition to code for primary procedure) | 1.37 | $114.40 | | 000 | N | |
| | **15788** | Chemical peel, facial; epidermal | 9.16 | $764.86 | | 090 | N | |
| | **15789** | Chemical peel, facial; dermal | 13.00 | $1,085.50 | | 090 | N | |
| | **15792** | Chemical peel, nonfacial; epidermal | 8.83 | $737.31 | | 090 | N | |
| | **15793** | Chemical peel, nonfacial; dermal | 9.73 | $812.46 | | 090 | N | |
| | **15819** | Cervicoplasty | 17.46 | $1,457.91 | | 090 | Y | |
| | **15820** | Blepharoplasty, lower eyelid; | 12.74 | $1,063.79 | | 090 | N | $765.00 |
| | **15821** | Blepharoplasty, lower eyelid; with extensive herniated fat pad | 13.65 | $1,139.78 | | 090 | N | $765.00 |
| | **15822** | Blepharoplasty, upper eyelid; | 10.15 | $847.53 | | 090 | N | $765.00 |
| | **15823** | Blepharoplasty, upper eyelid; with excessive skin weighting down lid | 15.60 | $1,302.60 | | 090 | N | $1,075.50 |
| | **15824** | Rhytidectomy; forehead | 22.43 | $1,873.07 | | 000 | Y | $765.00 |
| | **15825** | Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap) | 25.24 | $2,107.21 | | 000 | Y | $765.00 |
| | **15826** | Rhytidectomy; glabellar frown lines | 18.23 | $1,521.87 | | 000 | Y | $765.00 |
| | **15828** | Rhytidectomy; cheek, chin, and neck | 47.67 | $3,980.28 | | 000 | Y | $765.00 |
| | **15829** | Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap | 53.28 | $4,448.55 | | 000 | Y | $1,075.50 |
| | **15830** | Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy | 28.28 | $2,361.38 | | 090 | Y | $765.00 |
| | **15832** | Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh | 21.40 | $1,786.90 | | 090 | Y | $765.00 |
| | **15833** | Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg | 19.96 | $1,666.66 | | 090 | Y | $765.00 |
| | **15834** | Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip | 20.11 | $1,679.19 | | 090 | Y | $765.00 |
| | **15835** | Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock | 20.74 | $1,731.79 | | 090 | Y | $484.92 |
| | **15836** | Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm | 17.57 | $1,467.10 | | 090 | Y | $765.00 |
| | **15837** | Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand | 18.22 | $1,521.37 | | 090 | N | |
| | **15838** | Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad | 13.63 | $1,138.11 | | 090 | Y | |
| | **15839** | Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area | 19.47 | $1,625.75 | | 090 | N | $765.00 |
| | **15840** | Graft for facial nerve paralysis; free fascia graft (including obtaining fascia) | 24.27 | $2,026.55 | | 090 | Y | $945.00 |
| | **15841** | Graft for facial nerve paralysis; free muscle graft (including obtaining graft) | 40.24 | $3,360.04 | | 090 | Y | $945.00 |
| | **15842** | Graft for facial nerve paralysis; free muscle flap by microsurgical technique | 64.12 | $5,354.02 | | 090 | Y | |
| | **15845** | Graft for facial nerve paralysis; regional muscle transfer | 22.64 | $1,890.44 | | 090 | Y | $945.00 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| + | 15847 | Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure) | 9.81 | $819.47 | | 000 | Y | $765.00 |
| | 15850 | Removal of sutures under anesthesia (other than local), same surgeon | 2.22 | $185.37 | | 000 | N | |
| | 15851 | Removal of sutures under anesthesia (other than local), other surgeon | 2.42 | $202.07 | | 000 | N | |
| | 15852 | Dressing change (for other than burns) under anesthesia (other than local) | 1.17 | $97.70 | | 000 | N | |
| | 15860 | Intravenous injection of agent (eg, fluorescein) to test vascular flow in flap or graft | 2.78 | $232.13 | | 000 | N | |
| | 15876 | Suction assisted lipectomy; head and neck | 0.00 | BR | | 000 | N | $765.00 |
| | 15877 | Suction assisted lipectomy; trunk | 0.00 | BR | | 000 | N | $765.00 |
| | 15878 | Suction assisted lipectomy; upper extremity | 0.00 | BR | | 000 | N | $765.00 |
| | 15879 | Suction assisted lipectomy; lower extremity | 0.00 | BR | | 000 | N | $765.00 |
| | 15920 | Excision, coccygeal pressure ulcer, with coccygectomy; with primary suture | 14.00 | $1,169.00 | | 090 | N | $377.28 |
| | 15922 | Excision, coccygeal pressure ulcer, with coccygectomy; with flap closure | 17.81 | $1,487.14 | | 090 | Y | $945.00 |
| | 15931 | Excision, sacral pressure ulcer, with primary suture; | 15.86 | $1,324.31 | | 090 | N | $765.00 |
| | 15933 | Excision, sacral pressure ulcer, with primary suture; with ostectomy | 19.69 | $1,644.12 | | 090 | Y | $765.00 |
| | 15934 | Excision, sacral pressure ulcer, with skin flap closure; | 21.93 | $1,831.16 | | 090 | N | $765.00 |
| | 15935 | Excision, sacral pressure ulcer, with skin flap closure; with ostectomy | 26.44 | $2,207.74 | | 090 | Y | $945.00 |
| | 15936 | Excision, sacral pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure; | 21.57 | $1,801.10 | | 090 | N | $945.00 |
| | 15937 | Excision, sacral pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure; with ostectomy | 25.21 | $2,105.04 | | 090 | Y | $945.00 |
| | 15940 | Excision, ischial pressure ulcer, with primary suture; | 16.51 | $1,378.59 | | 090 | N | $765.00 |
| | 15941 | Excision, ischial pressure ulcer, with primary suture; with ostectomy (ischiectomy) | 21.92 | $1,830.32 | | 090 | Y | $765.00 |
| | 15944 | Excision, ischial pressure ulcer, with skin flap closure; | 21.25 | $1,774.38 | | 090 | Y | $765.00 |
| | 15945 | Excision, ischial pressure ulcer, with skin flap closure; with ostectomy | 23.62 | $1,972.27 | | 090 | Y | $945.00 |
| | 15946 | Excision, ischial pressure ulcer, with ostectomy, in preparation for muscle or myocutaneous flap or skin graft closure | 38.92 | $3,249.82 | | 090 | Y | $945.00 |
| | 15950 | Excision, trochanteric pressure ulcer, with primary suture; | 13.57 | $1,133.10 | | 090 | N | $765.00 |
| | 15951 | Excision, trochanteric pressure ulcer, with primary suture; with ostectomy | 19.67 | $1,642.45 | | 090 | Y | $945.00 |
| | 15952 | Excision, trochanteric pressure ulcer, with skin flap closure; | 20.31 | $1,695.89 | | 090 | Y | $765.00 |
| | 15953 | Excision, trochanteric pressure ulcer, with skin flap closure; with ostectomy | 22.90 | $1,912.15 | | 090 | N | $945.00 |
| | 15956 | Excision, trochanteric pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure; | 27.67 | $2,310.45 | | 090 | Y | $765.00 |
| | 15958 | Excision, trochanteric pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure; with ostectomy | 28.05 | $2,342.18 | | 090 | Y | $945.00 |
| | 15999 | Unlisted procedure, excision pressure ulcer | 0.00 | BR | | 000 | N | |
| | 16000 | Initial treatment, first degree burn, when no more than local treatment is required | 1.71 | $142.79 | | 000 | N | |
| | 16020 | Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area) | 2.05 | $171.18 | | 000 | N | |
| | 16025 | Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area) | 3.57 | $298.10 | | 000 | N | $100.67 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **16030** | Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (eg, more than one extremity, or greater than 10% total body surface area) | 4.23 | $353.21 | | 000 | N | $149.75 |
| | **16035** | Escharotomy; initial incision | 5.33 | $445.06 | | 090 | N | |
| + | **16036** | Escharotomy; each additional incision (List separately in addition to code for primary procedure) | 2.12 | $177.02 | | 000 | N | |
| | **17000** | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion | 1.67 | $139.45 | | 010 | N | |
| + | **17003** | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion) | 0.18 | $15.03 | | 000 | N | |
| ⊘ | **17004** | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions | 4.08 | $340.68 | | 010 | N | |
| | **17106** | Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm | 9.14 | $763.19 | | 090 | N | |
| | **17107** | Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm | 16.14 | $1,347.69 | | 090 | N | |
| | **17108** | Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm | 21.77 | $1,817.80 | | 090 | Y | |
| | **17110** | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions; up to 14 lesions | 2.31 | $192.89 | | 010 | N | |
| | **17111** | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions; 15 or more lesions | 2.73 | $227.96 | | 010 | N | |
| | **17250** | Chemical cauterization of granulation tissue (proud flesh, sinus or fistula) | 1.76 | $146.96 | | 000 | N | |
| | **17260** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5 cm or less | 2.20 | $183.70 | | 010 | N | |
| | **17261** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm | 2.96 | $247.16 | | 010 | N | |
| | **17262** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm | 3.63 | $303.11 | | 010 | N | |
| | **17263** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 2.1 to 3.0 cm | 4.01 | $334.84 | | 010 | N | |
| | **17264** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 3.1 to 4.0 cm | 4.33 | $361.56 | | 010 | N | |
| | **17266** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter over 4.0 cm | 4.98 | $415.83 | | 010 | N | |
| | **17270** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less | 3.15 | $263.03 | | 010 | N | |
| | **17271** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm | 3.42 | $285.57 | | 010 | N | |
| | **17272** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm | 3.92 | $327.32 | | 010 | N | |
| | **17273** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 2.1 to 3.0 cm | 4.40 | $367.40 | | 010 | N | |

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|---|---|---|---|---|---|---|---|---|
| | **17274** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 3.1 to 4.0 cm | 5.29 | $441.72 | | 010 | N | |
| | **17276** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter over 4.0 cm | 6.25 | $521.88 | | 010 | N | |
| | **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 | 2.92 | $243.82 | | 010 | N | |
| | **17281** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm | 3.75 | $313.13 | | 010 | N | |
| | **17282** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm | 4.34 | $362.39 | | 010 | N | |
| | **17283** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 2.1 to 3.0 cm | 5.31 | $443.39 | | 010 | N | |
| | **17284** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 3.1 to 4.0 cm | 6.24 | $521.04 | | 010 | N | |
| | **17286** | Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 4.0 cm | 8.10 | $676.35 | | 010 | N | |
| | **17311** | Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks | 16.61 | $1,386.94 | | 000 | N | |
| + | **17312** | Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure) | 10.02 | $836.67 | | 000 | N | |
| | **17313** | Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks | 15.17 | $1,266.70 | | 000 | N | |
| + | **17314** | Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure) | 9.28 | $774.88 | | 000 | N | |

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|---|---|---|---|---|---|---|---|---|
| + | **17315** | Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure) | 1.96 | $163.66 | | 000 | N | |
| | **17340** | Cryotherapy ($CO_2$ slush, liquid $N_2$) for acne | 1.09 | $91.02 | | 010 | N | |
| | **17360** | Chemical exfoliation for acne (eg, acne paste, acid) | 2.90 | $242.15 | | 010 | N | |
| | **17380** | Electrolysis epilation, each 30 minutes | 1.19 | $99.53 | | 000 | N | |
| | **17999** | Unlisted procedure, skin, mucous membrane and subcutaneous tissue | 0.00 | BR | | 000 | N | |
| | **19000** | Puncture aspiration of cyst of breast; | 2.78 | $232.13 | | 000 | N | |
| + | **19001** | Puncture aspiration of cyst of breast; each additional cyst (List separately in addition to code for primary procedure) | 0.67 | $55.95 | | 000 | N | |
| | **19020** | Mastotomy with exploration or drainage of abscess, deep | 10.20 | $851.70 | | 090 | N | $669.00 |
| | **19030** | Injection procedure only for mammary ductogram or galactogram | 4.23 | $353.21 | | 000 | N | |
| | **19100** | Biopsy of breast; percutaneous, needle core, not using imaging guidance | 3.37 | $281.40 | | 000 | N | $360.00 |
| | **19101** | Biopsy of breast; open, incisional | 7.72 | $644.62 | | 010 | N | $669.00 |
| | **19102** | Biopsy of breast; percutaneous, needle core, using imaging guidance | 5.62 | $469.27 | | 000 | N | $360.00 |
| | **19103** | Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance | 14.63 | $1,221.61 | | 000 | N | $593.66 |
| | **19105** | Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma | 49.55 | $4,137.43 | | 000 | N | |
| | **19110** | Nipple exploration, with or without excision of a solitary lactiferous duct or a papilloma lactiferous duct | 10.41 | $869.24 | | 090 | N | $669.00 |
| | **19112** | Excision of lactiferous duct fistula | 9.93 | $829.16 | | 090 | N | $765.00 |
| | **19120** | Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, one or more lesions | 10.65 | $889.28 | | 090 | N | $765.00 |
| | **19125** | Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion | 11.70 | $976.95 | | 090 | N | $765.00 |
| + | **19126** | Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker (List separately in addition to code for primary procedure) | 3.96 | $330.66 | | 000 | N | $765.00 |
| | **19260** | Excision of chest wall tumor including ribs | 28.90 | $2,413.15 | | 090 | Y | |
| | **19271** | Excision of chest wall tumor involving ribs, with plastic reconstruction; without mediastinal lymphadenectomy | 39.72 | $3,316.62 | | 090 | Y | |
| | **19272** | Excision of chest wall tumor involving ribs, with plastic reconstruction; with mediastinal lymphadenectomy | 43.77 | $3,654.80 | | 090 | Y | |
| | **19290** | Preoperative placement of needle localization wire, breast; | 4.02 | $335.67 | | 000 | N | $499.50 |
| + | **19291** | Preoperative placement of needle localization wire, breast; each additional lesion (List separately in addition to code for primary procedure) | 1.78 | $148.63 | | 000 | N | $499.50 |
| + | **19295** | Image guided placement, metallic localization clip, percutaneous, during breast biopsy (List separately in addition to code for primary procedure) | 2.58 | $215.43 | | 000 | Y | $160.14 |
| | **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 | 118.54 | $9,898.09 | | 000 | N | $2,008.50 |

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|---|---|---|---|---|---|---|---|---|
| + | 19297 | Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure) | 2.32 | $193.72 | | 000 | N | $2,008.50 |
| ⊙ | 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 | 43.22 | $3,608.87 | | 000 | N | $2,008.50 |
| | 19300 | Mastectomy for gynecomastia | 12.71 | $1,061.29 | | 090 | N | $945.00 |
| | 19301 | Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); | 9.68 | $808.28 | | 090 | Y | $765.00 |
| | 19302 | Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy | 20.57 | $1,717.60 | | 090 | Y | $1,492.50 |
| | 19303 | Mastectomy, simple, complete | 20.79 | $1,735.97 | | 090 | Y | $945.00 |
| | 19304 | Mastectomy, subcutaneous | 12.86 | $1,073.81 | | 090 | Y | $945.00 |
| | 19305 | Mastectomy, radical, including pectoral muscles, axillary lymph nodes | 25.44 | $2,124.24 | | 090 | Y | |
| | 19306 | Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation) | 26.46 | $2,209.41 | | 090 | Y | |
| | 19307 | Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle | 26.61 | $2,221.94 | | 090 | Y | |
| | 19316 | Mastopexy | 18.97 | $1,584.00 | | 090 | Y | $945.00 |
| | 19318 | Reduction mammaplasty | 28.18 | $2,353.03 | | 090 | Y | $945.00 |
| | 19324 | Mammaplasty, augmentation; without prosthetic implant | 11.66 | $973.61 | | 090 | N | $945.00 |
| | 19325 | Mammaplasty, augmentation; with prosthetic implant | 15.54 | $1,297.59 | | 090 | N | $2,008.50 |
| | 19328 | Removal of intact mammary implant | 11.67 | $974.45 | | 090 | N | $499.50 |
| | 19330 | Removal of mammary implant material | 14.92 | $1,245.82 | | 090 | N | $499.50 |
| | 19340 | Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction | 9.81 | $819.14 | | 000 | N | $669.00 |
| | 19342 | Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction | 21.99 | $1,836.17 | | 090 | Y | $765.00 |
| | 19350 | Nipple/areola reconstruction | 22.40 | $1,870.40 | | 090 | N | $945.00 |
| | 19355 | Correction of inverted nipples | 18.10 | $1,511.35 | | 090 | N | $945.00 |
| | 19357 | Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion | 37.13 | $3,100.36 | | 090 | Y | $1,075.50 |
| | 19361 | Breast reconstruction with latissimus dorsi flap, without prosthetic implant | 37.42 | $3,124.57 | | 090 | Y | |
| | 19364 | Breast reconstruction with free flap | 67.92 | $5,671.32 | | 090 | Y | |
| | 19366 | Breast reconstruction with other technique | 34.03 | $2,841.51 | | 090 | Y | $1,075.50 |
| | 19367 | Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; | 44.42 | $3,709.07 | | 090 | Y | |
| | 19368 | Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging) | 54.66 | $4,564.11 | | 090 | Y | |
| | 19369 | Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site | 50.31 | $4,200.89 | | 090 | Y | |
| | 19370 | Open periprosthetic capsulotomy, breast | 16.31 | $1,361.89 | | 090 | N | $945.00 |
| | 19371 | Periprosthetic capsulectomy, breast | 18.84 | $1,573.14 | | 090 | N | $945.00 |
| | 19380 | Revision of reconstructed breast | 18.36 | $1,533.06 | | 090 | N | $1,075.50 |
| | 19396 | Preparation of moulage for custom breast implant | 4.20 | $350.70 | | 000 | N | |
| | 19499 | Unlisted procedure, breast | 0.00 | BR | | 000 | N | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **20000** | Incision of soft tissue abscess (eg, secondary to osteomyelitis); superficial | 4.88 | $407.48 | | 010 | N | |
| | **20005** | Incision of soft tissue abscess (eg, secondary to osteomyelitis); deep or complicated | 7.19 | $600.37 | | 010 | N | $669.00 |
| | **20100** | Exploration of penetrating wound (separate procedure); neck | 14.76 | $1,232.46 | | 010 | Y | |
| | **20101** | Exploration of penetrating wound (separate procedure); chest | 9.37 | $782.40 | | 010 | N | |
| | **20102** | Exploration of penetrating wound (separate procedure); abdomen/flank/back | 11.36 | $948.56 | | 010 | Y | |
| | **20103** | Exploration of penetrating wound (separate procedure); extremity | 13.89 | $1,159.82 | | 010 | Y | |
| | **20150** | Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision | 22.40 | $1,870.40 | | 090 | Y | |
| | **20200** | Biopsy, muscle; superficial | 4.60 | $384.10 | | 000 | N | $669.00 |
| | **20205** | Biopsy, muscle; deep | 6.31 | $526.89 | | 000 | N | $765.00 |
| | **20206** | Biopsy, muscle, percutaneous needle | 7.08 | $591.18 | | 000 | N | $360.00 |
| | **20220** | Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs) | 5.29 | $441.72 | | 000 | N | $377.28 |
| | **20225** | Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur) | 23.39 | $1,953.07 | | 000 | N | $627.74 |
| | **20240** | Biopsy, bone, open; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur) | 5.80 | $484.30 | | 010 | N | $669.00 |
| | **20245** | Biopsy, bone, open; deep (eg, humerus, ischium, femur) | 15.58 | $1,300.93 | | 010 | N | $765.00 |
| | **20250** | Biopsy, vertebral body, open; thoracic | 9.22 | $769.87 | | 010 | Y | $765.00 |
| | **20251** | Biopsy, vertebral body, open; lumbar or cervical | 10.37 | $865.90 | | 010 | Y | $765.00 |
| | **20500** | Injection of sinus tract; therapeutic (separate procedure) | 3.25 | $271.38 | | 010 | N | |
| | **20501** | Injection of sinus tract; diagnostic (sinogram) | 3.46 | $288.91 | | 000 | N | |
| | **20520** | Removal of foreign body in muscle or tendon sheath; simple | 4.72 | $394.12 | | 010 | N | |
| | **20525** | Removal of foreign body in muscle or tendon sheath; deep or complicated | 12.29 | $1,026.22 | | 010 | N | $765.00 |
| | **20526** | Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel | 1.91 | $181.45 | | 000 | N | |
| | **20550** | Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar fascia) | 1.45 | $121.08 | | 000 | N | |
| | **20551** | Injection(s); single tendon origin/insertion | 1.42 | $118.57 | | 000 | N | |
| | **20552** | Injection(s); single or multiple trigger point(s), one or two muscle(s) | 1.33 | $111.06 | | 000 | N | |
| | **20553** | Injection(s); single or multiple trigger point(s), three or more muscle(s) | 1.49 | $124.42 | | 000 | N | |
| | **20600** | Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes) | 1.33 | $111.06 | | 000 | N | |
| | **20605** | Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) | 1.45 | $137.75 | | 000 | N | |
| | **20610** | Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa) | 1.80 | $171.00 | | 000 | N | |
| | **20612** | Aspiration and/or injection of ganglion cyst(s) any location | 1.44 | $120.24 | | 000 | N | |
| | **20615** | Aspiration and injection for treatment of bone cyst | 5.58 | $465.93 | | 010 | N | |
| | **20650** | Insertion of wire or pin with application of skeletal traction, including removal (separate procedure) | 4.73 | $394.96 | | 010 | N | $765.00 |
| ⊘ | **20660** | Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure) | 5.99 | $500.17 | | 000 | N | |
| | **20661** | Application of halo, including removal; cranial | 10.95 | $914.33 | | 090 | N | |
| | **20662** | Application of halo, including removal; pelvic | 11.55 | $964.43 | | 090 | Y | |
| | **20663** | Application of halo, including removal; femoral | 10.91 | $910.99 | | 090 | Y | |

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|---|---|---|---|---|---|---|---|---|
| | **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 | 17.95 | $1,498.83 | | 090 | N | |
| | **20665** | Removal of tongs or halo applied by another physician | 3.37 | $281.40 | | 010 | N | |
| | **20670** | Removal of implant; superficial, (eg, buried wire, pin or rod) (separate procedure) | 12.18 | $1,017.03 | | 010 | N | $499.50 |
| | **20680** | Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate) | 14.50 | $1,210.75 | | 090 | Y | $765.00 |
| ⊘ | **20690** | Application of a uniplane (pins or wires in one plane), unilateral, external fixation system | 6.35 | $530.23 | | 090 | N | $669.00 |
| ⊘ | **20692** | Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type) | 10.46 | $873.41 | | 090 | Y | $765.00 |
| | **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)) | 11.57 | $966.10 | | 090 | N | $765.00 |
| | **20694** | Removal, under anesthesia, of external fixation system | 11.18 | $933.53 | | 090 | N | $499.50 |
| | **20802** | Replantation, arm (includes surgical neck of humerus through elbow joint), complete amputation | 63.77 | $5,324.80 | | 090 | Y | |
| | **20805** | Replantation, forearm (includes radius and ulna to radial carpal joint), complete amputation | 83.11 | $6,939.69 | | 090 | Y | |
| | **20808** | Replantation, hand (includes hand through metacarpophalangeal joints), complete amputation | 104.94 | $8,762.49 | | 090 | Y | |
| | **20816** | Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon), complete amputation | 67.58 | $5,642.93 | | 090 | Y | |
| | **20822** | Replantation, digit, excluding thumb (includes distal tip to sublimis tendon insertion), complete amputation | 59.53 | $4,970.76 | | 090 | Y | |
| | **20824** | Replantation, thumb (includes carpometacarpal joint to MP joint), complete amputation | 67.06 | $5,599.51 | | 090 | Y | |
| | **20827** | Replantation, thumb (includes distal tip to MP joint), complete amputation | 61.55 | $5,139.43 | | 090 | Y | |
| | **20838** | Replantation, foot, complete amputation | 59.49 | $4,967.42 | | 090 | Y | |
| ⊘ | **20900** | Bone graft, any donor area; minor or small (eg, dowel or button) | 14.78 | $1,234.13 | | 090 | Y | $765.00 |
| ⊘ | **20902** | Bone graft, any donor area; major or large | 15.11 | $1,261.69 | | 090 | Y | $945.00 |
| ⊘ | **20910** | Cartilage graft; costochondral | 10.64 | $888.44 | | 090 | Y | $765.00 |
| ⊘ | **20912** | Cartilage graft; nasal septum | 11.99 | $1,001.17 | | 090 | N | $765.00 |
| ⊘ | **20920** | Fascia lata graft; by stripper | 9.80 | $818.30 | | 090 | N | $945.00 |
| ⊘ | **20922** | Fascia lata graft; by incision and area exposure, complex or sheet | 14.40 | $1,202.40 | | 090 | Y | $765.00 |
| ⊘ | **20924** | Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris) | 12.64 | $1,055.44 | | 090 | Y | $945.00 |
| ⊘ | **20926** | Tissue grafts, other (eg, paratenon, fat, dermis) | 10.67 | $890.95 | | 090 | N | $945.00 |
| ⊘ | **20930** | Allograft for spine surgery only; morselized | 3.23 | $269.29 | | 000 | N | |
| ⊘ | **20931** | Allograft for spine surgery only; structural | 2.93 | $278.35 | | 000 | N | |
| ⊘ | **20936** | Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision | 4.91 | $409.73 | | 000 | Y | |
| ⊘ | **20937** | Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) | 4.42 | $369.07 | | 000 | Y | |
| ⊘ | **20938** | Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) | 4.83 | $403.31 | | 000 | Y | |
| | **20950** | Monitoring of interstitial fluid pressure (includes insertion of device, eg, wick catheter technique, needle manometer technique) in detection of muscle compartment syndrome | 7.50 | $626.25 | | 000 | N | |
| | **20955** | Bone graft with microvascular anastomosis; fibula | 63.72 | $5,320.62 | | 090 | Y | |
| | **20956** | Bone graft with microvascular anastomosis; iliac crest | 67.63 | $5,647.11 | | 090 | Y | |

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|---|---|---|---|---|---|---|---|---|
| | **20957** | Bone graft with microvascular anastomosis; metatarsal | 64.26 | $5,365.71 | | 090 | Y | |
| | **20962** | Bone graft with microvascular anastomosis; other than fibula, iliac crest, or metatarsal | 67.10 | $5,602.85 | | 090 | Y | |
| | **20969** | Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, metatarsal, or great toe | 70.54 | $5,890.09 | | 090 | Y | |
| | **20970** | Free osteocutaneous flap with microvascular anastomosis; iliac crest | 70.60 | $5,895.10 | | 090 | Y | |
| | **20972** | Free osteocutaneous flap with microvascular anastomosis; metatarsal | 64.95 | $5,423.33 | | 090 | Y | |
| | **20973** | Free osteocutaneous flap with microvascular anastomosis; great toe with web space | 70.46 | $5,883.41 | | 090 | Y | |
| ⊘ | **20974** | Electrical stimulation to aid bone healing; noninvasive (nonoperative) | 1.44 | $120.24 | | 000 | N | |
| ⊘ | **20975** | Electrical stimulation to aid bone healing; invasive (operative) | 4.51 | $376.59 | | 000 | Y | $56.27 |
| | **20979** | Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative) | 1.40 | $116.90 | | 000 | N | |
| ⊙ | **20982** | Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance | 108.99 | $9,100.67 | | 000 | Y | |
| | **20999** | Unlisted procedure, musculoskeletal system, general | 0.00 | BR | | 000 | N | |
| | **21010** | Arthrotomy, temporomandibular joint | 17.72 | $1,479.62 | | 090 | Y | $669.00 |
| | **21015** | Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp | 10.58 | $883.43 | | 090 | Y | $765.00 |
| | **21025** | Excision of bone (eg, for osteomyelitis or bone abscess); mandible | 23.60 | $1,970.60 | | 090 | N | $669.00 |
| | **21026** | Excision of bone (eg, for osteomyelitis or bone abscess); facial bone(s) | 13.66 | $1,140.61 | | 090 | N | $669.00 |
| | **21029** | Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia) | 17.73 | $1,480.46 | | 090 | Y | $669.00 |
| | **21030** | Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage | 11.41 | $952.74 | | 090 | N | |
| | **21031** | Excision of torus mandibularis | 8.78 | $733.13 | | 090 | N | |
| | **21032** | Excision of maxillary torus palatinus | 8.94 | $746.49 | | 090 | N | |
| | **21034** | Excision of malignant tumor of maxilla or zygoma | 32.43 | $2,707.91 | | 090 | Y | $765.00 |
| | **21040** | Excision of benign tumor or cyst of mandible, by enucleation and/or curettage | 11.47 | $957.75 | | 090 | N | $669.00 |
| | **21044** | Excision of malignant tumor of mandible; | 21.39 | $1,786.07 | | 090 | Y | $669.00 |
| | **21045** | Excision of malignant tumor of mandible; radical resection | 29.64 | $2,474.94 | | 090 | Y | |
| | **21046** | Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s)) | 26.28 | $2,194.38 | | 090 | N | $669.00 |
| | **21047** | Excision of benign tumor or cyst of mandible; requiring extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion(s)) | 32.53 | $2,716.26 | | 090 | Y | $669.00 |
| | **21048** | Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s)) | 26.75 | $2,233.63 | | 090 | N | |
| | **21049** | Excision of benign tumor or cyst of maxilla; requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion(s)) | 30.83 | $2,574.31 | | 090 | Y | |
| | **21050** | Condylectomy, temporomandibular joint (separate procedure) | 21.00 | $1,753.50 | | 090 | Y | $765.00 |
| | **21060** | Meniscectomy, partial or complete, temporomandibular joint (separate procedure) | 19.55 | $1,632.43 | | 090 | Y | $669.00 |
| | **21070** | Coronoidectomy (separate procedure) | 15.79 | $1,318.47 | | 090 | Y | $765.00 |
| | **21076** | Impression and custom preparation; surgical obturator prosthesis | 25.31 | $2,113.39 | | 010 | Y | |
| | **21077** | Impression and custom preparation; orbital prosthesis | 63.06 | $5,265.51 | | 090 | Y | |
| | **21079** | Impression and custom preparation; interim obturator prosthesis | 42.83 | $3,576.31 | | 090 | N | |

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|---|---|---|---|---|---|---|---|
| **21080** | Impression and custom preparation; definitive obturator prosthesis | 48.68 | $4,064.78 | | 090 | N | |
| **21081** | Impression and custom preparation; mandibular resection prosthesis | 44.20 | $3,690.70 | | 090 | N | |
| **21082** | Impression and custom preparation; palatal augmentation prosthesis | 40.12 | $3,350.02 | | 090 | Y | |
| **21083** | Impression and custom preparation; palatal lift prosthesis | 38.01 | $3,173.84 | | 090 | Y | |
| **21084** | Impression and custom preparation; speech aid prosthesis | 43.33 | $3,618.06 | | 090 | N | |
| **21085** | Impression and custom preparation; oral surgical splint | 17.30 | $1,444.55 | | 010 | N | |
| **21086** | Impression and custom preparation; auricular prosthesis | 47.14 | $3,936.19 | | 090 | Y | |
| **21087** | Impression and custom preparation; nasal prosthesis | 46.58 | $3,889.43 | | 090 | N | |
| **21088** | Impression and custom preparation; facial prosthesis | 0.00 | BR | | 090 | Y | |
| **21089** | Unlisted maxillofacial prosthetic procedure | 0.00 | BR | | 000 | N | |
| **21100** | Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure) | 16.53 | $1,380.26 | | 090 | Y | $669.00 |
| **21110** | Application of interdental fixation device for conditions other than fracture or dislocation, includes removal | 16.43 | $1,371.91 | | 090 | N | |
| **21116** | Injection procedure for temporomandibular joint arthrography | 4.63 | $386.61 | | 000 | N | |
| **21120** | Genioplasty; augmentation (autograft, allograft, prosthetic material) | 15.55 | $1,298.43 | | 090 | N | $1,492.50 |
| **21121** | Genioplasty; sliding osteotomy, single piece | 17.79 | $1,485.47 | | 090 | Y | $1,492.50 |
| **21122** | Genioplasty; sliding osteotomies, two or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin) | 17.20 | $1,436.20 | | 090 | Y | $1,492.50 |
| **21123** | Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts) | 22.13 | $1,847.86 | | 090 | Y | $1,492.50 |
| **21125** | Augmentation, mandibular body or angle; prosthetic material | 68.95 | $5,757.33 | | 090 | Y | $1,492.50 |
| **21127** | Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft) | 66.44 | $5,547.74 | | 090 | Y | $2,008.50 |
| **21137** | Reduction forehead; contouring only | 17.83 | $1,488.81 | | 090 | Y | |
| **21138** | Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft) | 22.56 | $1,883.76 | | 090 | Y | |
| **21139** | Reduction forehead; contouring and setback of anterior frontal sinus wall | 25.00 | $2,087.50 | | 090 | Y | |
| **21141** | Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft | 32.85 | $2,742.98 | | 090 | Y | |
| **21142** | Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft | 32.64 | $2,725.44 | | 090 | Y | |
| **21143** | Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, without bone graft | 33.25 | $2,776.38 | | 090 | Y | |
| **21145** | Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts) | 37.72 | $3,149.62 | | 090 | Y | |
| **21146** | Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft) | 38.96 | $3,253.16 | | 090 | Y | |
| **21147** | Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies) | 40.09 | $3,347.52 | | 090 | Y | |
| **21150** | Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome) | 41.58 | $3,471.93 | | 090 | Y | |
| **21151** | Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts) | 48.36 | $4,038.06 | | 090 | Y | |
| **21154** | Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I | 53.21 | $4,443.04 | | 090 | Y | |

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|---|---|---|---|---|---|---|---|
| **21155** | Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I | 59.36 | $4,956.56 | | 090 | Y | |
| **21159** | Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I | 72.37 | $6,042.90 | | 090 | Y | |
| **21160** | Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I | 73.01 | $6,096.34 | | 090 | Y | |
| **21172** | Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts) | 42.59 | $3,556.27 | | 090 | Y | |
| **21175** | Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts) | 51.55 | $4,304.43 | | 090 | Y | |
| **21179** | Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material) | 36.46 | $3,044.41 | | 090 | Y | |
| **21180** | Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts) | 41.12 | $3,433.52 | | 090 | Y | |
| **21181** | Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial | 17.85 | $1,490.48 | | 090 | Y | $1,492.50 |
| **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 | 49.93 | $4,169.16 | | 090 | Y | |
| **21183** | 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 greater than 40 sq cm but less than 80 sq cm | 55.99 | $4,675.17 | | 090 | Y | |
| **21184** | 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 greater than 80 sq cm | 62.15 | $5,189.53 | | 090 | Y | |
| **21188** | Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts) | 40.25 | $3,360.88 | | 090 | Y | |
| **21193** | Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft | 30.98 | $2,586.83 | | 090 | Y | |
| **21194** | Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft) | 34.58 | $2,887.43 | | 090 | Y | |
| **21195** | Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation | 33.10 | $2,763.85 | | 090 | Y | |
| **21196** | Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation | 35.68 | $2,979.28 | | 090 | Y | |
| **21198** | Osteotomy, mandible, segmental; | 27.69 | $2,312.12 | | 090 | Y | |
| **21199** | Osteotomy, mandible, segmental; with genioglossus advancement | 24.91 | $2,079.99 | | 090 | Y | |
| **21206** | Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard) | 27.43 | $2,290.41 | | 090 | Y | $1,075.50 |
| **21208** | Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant) | 35.97 | $3,003.50 | | 090 | Y | $1,492.50 |
| **21209** | Osteoplasty, facial bones; reduction | 18.92 | $1,579.82 | | 090 | Y | $1,075.50 |
| **21210** | Graft, bone; nasal, maxillary or malar areas (includes obtaining graft) | 41.13 | $3,434.36 | | 090 | N | $1,492.50 |
| **21215** | Graft, bone; mandible (includes obtaining graft) | 65.22 | $5,445.87 | | 090 | N | $1,492.50 |
| **21230** | Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft) | 19.01 | $1,587.34 | | 090 | Y | $1,492.50 |
| **21235** | Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft) | 17.03 | $1,422.01 | | 090 | N | $1,492.50 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| 21240 | Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft) | 27.88 | $2,327.98 | | 090 | Y | $945.00 |
| 21242 | Arthroplasty, temporomandibular joint, with allograft | 25.54 | $2,132.59 | | 090 | Y | $1,075.50 |
| 21243 | Arthroplasty, temporomandibular joint, with prosthetic joint replacement | 41.49 | $3,464.42 | | 090 | Y | $1,075.50 |
| 21244 | Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate) | 25.10 | $2,095.85 | | 090 | Y | $1,492.50 |
| 21245 | Reconstruction of mandible or maxilla, subperiosteal implant; partial | 26.94 | $2,249.49 | | 090 | Y | $1,492.50 |
| 21246 | Reconstruction of mandible or maxilla, subperiosteal implant; complete | 21.32 | $1,780.22 | | 090 | Y | $1,492.50 |
| 21247 | Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia) | 40.51 | $3,382.59 | | 090 | Y | |
| 21248 | Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial | 25.09 | $2,095.02 | | 090 | N | $1,492.50 |
| 21249 | Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete | 35.79 | $2,988.47 | | 090 | Y | $1,492.50 |
| 21255 | Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts) | 34.19 | $2,854.87 | | 090 | Y | |
| 21256 | Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia) | 28.53 | $2,382.26 | | 090 | Y | |
| 21260 | Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach | 28.85 | $2,408.98 | | 090 | Y | |
| 21261 | Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach | 55.66 | $4,647.61 | | 090 | Y | |
| 21263 | Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement | 48.06 | $4,013.01 | | 090 | Y | |
| 21267 | Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach | 39.01 | $3,257.34 | | 090 | Y | $1,492.50 |
| 21268 | Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach | 46.92 | $3,917.82 | | 090 | Y | |
| 21270 | Malar augmentation, prosthetic material | 21.73 | $1,814.46 | | 090 | Y | $1,075.50 |
| 21275 | Secondary revision of orbitocraniofacial reconstruction | 19.79 | $1,652.47 | | 090 | Y | $1,492.50 |
| 21280 | Medial canthopexy (separate procedure) | 12.56 | $1,048.76 | | 090 | N | $1,075.50 |
| 21282 | Lateral canthopexy | 8.40 | $701.40 | | 090 | N | $1,075.50 |
| 21295 | Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach | 4.35 | $363.23 | | 090 | Y | $499.50 |
| 21296 | Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); intraoral approach | 9.60 | $801.60 | | 090 | Y | $499.50 |
| 21299 | Unlisted craniofacial and maxillofacial procedure | 0.00 | BR | | 000 | N | |
| 21310 | Closed treatment of nasal bone fracture without manipulation | 2.77 | $231.30 | | 000 | N | $226.08 |
| 21315 | Closed treatment of nasal bone fracture; without stabilization | 6.03 | $503.51 | | 010 | N | $226.08 |
| 21320 | Closed treatment of nasal bone fracture; with stabilization | 5.80 | $484.30 | | 010 | N | $669.00 |
| 21325 | Open treatment of nasal fracture; uncomplicated | 12.13 | $1,012.86 | | 090 | N | $945.00 |
| 21330 | Open treatment of nasal fracture; complicated, with internal and/or external skeletal fixation | 14.83 | $1,238.31 | | 090 | Y | $1,075.50 |
| 21335 | Open treatment of nasal fracture; with concomitant open treatment of fractured septum | 17.93 | $1,497.16 | | 090 | N | $1,492.50 |
| 21336 | Open treatment of nasal septal fracture, with or without stabilization | 15.72 | $1,312.62 | | 090 | N | $945.00 |
| 21337 | Closed treatment of nasal septal fracture, with or without stabilization | 9.28 | $774.88 | | 090 | N | $669.00 |
| 21338 | Open treatment of nasoethmoid fracture; without external fixation | 19.85 | $1,657.48 | | 090 | Y | $945.00 |
| 21339 | Open treatment of nasoethmoid fracture; with external fixation | 21.64 | $1,806.94 | | 090 | Y | $1,075.50 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **21340** | Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus | 19.44 | $1,623.24 | | 090 | Y | $945.00 |
| **21343** | Open treatment of depressed frontal sinus fracture | 28.93 | $2,415.66 | | 090 | Y | |
| **21344** | Open treatment of complicated (eg, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches | 37.37 | $3,120.40 | | 090 | Y | |
| **21345** | Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint | 18.72 | $1,563.12 | | 090 | Y | $1,492.50 |
| **21346** | Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation | 23.23 | $1,939.71 | | 090 | Y | |
| **21347** | Open treatment of nasomaxillary complex fracture (LeFort II type); requiring multiple open approaches | 28.57 | $2,385.60 | | 090 | Y | |
| **21348** | Open treatment of nasomaxillary complex fracture (LeFort II type); with bone grafting (includes obtaining graft) | 28.01 | $2,338.84 | | 090 | Y | |
| **21355** | Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation | 10.31 | $860.89 | | 010 | Y | $765.00 |
| **21356** | Open treatment of depressed zygomatic arch fracture (eg, Gillies approach) | 11.74 | $980.29 | | 010 | Y | $765.00 |
| **21360** | Open treatment of depressed malar fracture, including zygomatic arch and malar tripod | 12.85 | $1,072.98 | | 090 | Y | |
| **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 | 26.96 | $2,251.16 | | 090 | Y | |
| **21366** | Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with bone grafting (includes obtaining graft) | 30.19 | $2,520.87 | | 090 | Y | |
| **21385** | Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation) | 17.44 | $1,456.24 | | 090 | Y | |
| **21386** | Open treatment of orbital floor blowout fracture; periorbital approach | 16.25 | $1,356.88 | | 090 | Y | |
| **21387** | Open treatment of orbital floor blowout fracture; combined approach | 18.63 | $1,555.61 | | 090 | Y | |
| **21390** | Open treatment of orbital floor blowout fracture; periorbital approach, with alloplastic or other implant | 18.50 | $1,544.75 | | 090 | Y | |
| **21395** | Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft) | 23.35 | $1,949.73 | | 090 | Y | |
| **21400** | Closed treatment of fracture of orbit, except blowout; without manipulation | 4.09 | $341.52 | | 090 | N | $669.00 |
| **21401** | Closed treatment of fracture of orbit, except blowout; with manipulation | 11.39 | $951.07 | | 090 | Y | $765.00 |
| **21406** | Open treatment of fracture of orbit, except blowout; without implant | 13.15 | $1,098.03 | | 090 | Y | |
| **21407** | Open treatment of fracture of orbit, except blowout; with implant | 15.59 | $1,301.77 | | 090 | Y | |
| **21408** | Open treatment of fracture of orbit, except blowout; with bone grafting (includes obtaining graft) | 21.52 | $1,796.92 | | 090 | Y | |
| **21421** | Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint | 15.98 | $1,334.33 | | 090 | Y | $945.00 |
| **21422** | Open treatment of palatal or maxillary fracture (LeFort I type); | 16.52 | $1,379.42 | | 090 | Y | |
| **21423** | Open treatment of palatal or maxillary fracture (LeFort I type); complicated (comminuted or involving cranial nerve foramina), multiple approaches | 19.74 | $1,648.29 | | 090 | Y | |
| **21431** | Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint | 17.15 | $1,432.03 | | 090 | Y | |
| **21432** | Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation | 16.55 | $1,381.93 | | 090 | Y | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| 21433 | Open treatment of craniofacial separation (LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches | 41.73 | $3,484.46 | | 090 | Y | |
| 21435 | Open treatment of craniofacial separation (LeFort III type); complicated, utilizing internal and/or external fixation techniques (eg, head cap, halo device, and/or intermaxillary fixation) | 32.21 | $2,689.54 | | 090 | Y | |
| 21436 | Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft) | 47.37 | $3,955.40 | | 090 | Y | |
| 21440 | Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure) | 11.23 | $937.71 | | 090 | Y | |
| 21445 | Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure) | 16.65 | $1,390.28 | | 090 | Y | $945.00 |
| 21450 | Closed treatment of mandibular fracture; without manipulation | 11.65 | $972.78 | | 090 | Y | $226.08 |
| 21451 | Closed treatment of mandibular fracture; with manipulation | 15.79 | $1,318.47 | | 090 | Y | $696.23 |
| 21452 | Percutaneous treatment of mandibular fracture, with external fixation | 15.03 | $1,255.01 | | 090 | Y | $669.00 |
| 21453 | Closed treatment of mandibular fracture with interdental fixation | 18.25 | $1,523.88 | | 090 | Y | $765.00 |
| 21454 | Open treatment of mandibular fracture with external fixation | 13.41 | $1,119.74 | | 090 | Y | $1,075.50 |
| 21461 | Open treatment of mandibular fracture; without interdental fixation | 37.78 | $3,154.63 | | 090 | Y | $945.00 |
| 21462 | Open treatment of mandibular fracture; with interdental fixation | 42.26 | $3,528.71 | | 090 | Y | $1,075.50 |
| 21465 | Open treatment of mandibular condylar fracture | 22.54 | $1,882.09 | | 090 | Y | $945.00 |
| 21470 | Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints | 29.06 | $2,426.51 | | 090 | Y | |
| 21480 | Closed treatment of temporomandibular dislocation; initial or subsequent | 2.31 | $192.89 | | 000 | N | $226.08 |
| 21485 | Closed treatment of temporomandibular dislocation; complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent | 13.84 | $1,155.64 | | 090 | N | $669.00 |
| 21490 | Open treatment of temporomandibular dislocation | 22.66 | $1,892.11 | | 090 | Y | $765.00 |
| 21495 | Open treatment of hyoid fracture | 15.08 | $1,259.18 | | 090 | Y | |
| 21497 | Interdental wiring, for condition other than fracture | 13.83 | $1,154.81 | | 090 | Y | $669.00 |
| 21499 | Unlisted musculoskeletal procedure, head | 0.00 | BR | | 000 | N | |
| 21501 | Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax; | 10.32 | $861.72 | | 090 | N | $669.00 |
| 21502 | Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax; with partial rib ostectomy | 13.07 | $1,091.35 | | 090 | Y | $669.00 |
| 21510 | Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax | 11.68 | $975.28 | | 090 | Y | |
| 21550 | Biopsy, soft tissue of neck or thorax | 5.78 | $482.63 | | 010 | N | |
| 21555 | Excision tumor, soft tissue of neck or thorax; subcutaneous | 10.09 | $842.52 | | 090 | N | $669.00 |
| 21556 | Excision tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular | 9.79 | $817.47 | | 090 | N | $669.00 |
| 21557 | Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or thorax | 14.22 | $1,187.37 | | 090 | Y | |
| 21600 | Excision of rib, partial | 13.16 | $1,098.86 | | 090 | Y | $669.00 |
| 21610 | Costotransversectomy (separate procedure) | 25.95 | $2,166.83 | | 090 | Y | $669.00 |
| 21615 | Excision first and/or cervical rib; | 17.10 | $1,427.85 | | 090 | Y | |
| 21616 | Excision first and/or cervical rib; with sympathectomy | 20.95 | $1,749.33 | | 090 | Y | |
| 21620 | Ostectomy of sternum, partial | 13.12 | $1,095.52 | | 090 | Y | |
| 21627 | Sternal debridement | 13.62 | $1,137.27 | | 090 | Y | |
| 21630 | Radical resection of sternum; | 31.26 | $2,610.21 | | 090 | Y | |
| 21632 | Radical resection of sternum; with mediastinal lymphadenectomy | 30.94 | $2,583.49 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **21685** | Hyoid myotomy and suspension | 23.93 | $1,998.16 | | 090 | Y | |
| | **21700** | Division of scalenus anticus; without resection of cervical rib | 10.26 | $856.71 | | 090 | Y | $669.00 |
| | **21705** | Division of scalenus anticus; with resection of cervical rib | 15.63 | $1,305.11 | | 090 | Y | |
| | **21720** | Division of sternocleidomastoid for torticollis, open operation; without cast application | 8.99 | $750.67 | | 090 | Y | $765.00 |
| | **21725** | Division of sternocleidomastoid for torticollis, open operation; with cast application | 12.83 | $1,071.31 | | 090 | Y | $132.69 |
| | **21740** | Reconstructive repair of pectus excavatum or carinatum; open | 26.68 | $2,227.78 | | 090 | Y | |
| | **21742** | Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy | 26.64 | $2,224.27 | | 090 | Y | |
| | **21743** | Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy | 35.05 | $2,926.68 | | 090 | Y | |
| | **21750** | Closure of median sternotomy separation with or without debridement (separate procedure) | 17.78 | $1,484.63 | | 090 | Y | |
| | **21800** | Closed treatment of rib fracture, uncomplicated, each | 2.31 | $192.89 | | 090 | N | $155.43 |
| | **21805** | Open treatment of rib fracture without fixation, each | 6.18 | $516.03 | | 090 | Y | $669.00 |
| | **21810** | Treatment of rib fracture requiring external fixation (flail chest) | 12.19 | $1,017.87 | | 090 | Y | |
| | **21820** | Closed treatment of sternum fracture | 3.16 | $263.86 | | 090 | N | $155.43 |
| | **21825** | Open treatment of sternum fracture with or without skeletal fixation | 14.15 | $1,181.53 | | 090 | Y | |
| | **21899** | Unlisted procedure, neck or thorax | 0.00 | BR | | 000 | N | |
| | **21920** | Biopsy, soft tissue of back or flank; superficial | 5.58 | $465.93 | | 010 | N | |
| | **21925** | Biopsy, soft tissue of back or flank; deep | 9.92 | $828.32 | | 090 | N | $669.00 |
| | **21930** | Excision, tumor, soft tissue of back or flank | 11.00 | $918.50 | | 090 | N | $669.00 |
| | **21935** | Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank | 28.38 | $2,369.73 | | 090 | N | $765.00 |
| | **22010** | Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic | 21.68 | $1,810.28 | | 090 | N | |
| | **22015** | Incision and drainage, open, of deep abscess (subfascial), posterior spine; lumbar, sacral, or lumbosacral | 21.50 | $1,795.25 | | 090 | N | |
| | **22100** | Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical | 19.52 | $1,629.92 | | 090 | Y | |
| | **22101** | Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; thoracic | 19.52 | $1,629.92 | | 090 | Y | |
| | **22102** | Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; lumbar | 19.57 | $1,634.10 | | 090 | Y | |
| + | **22103** | Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; each additional segment (List separately in addition to code for primary procedure) | 3.67 | $306.45 | | 000 | Y | |
| | **22110** | Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical | 24.34 | $2,032.39 | | 090 | Y | |
| | **22112** | Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; thoracic | 24.21 | $2,021.54 | | 090 | Y | |
| | **22114** | Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; lumbar | 24.33 | $2,031.56 | | 090 | Y | |
| + | **22116** | Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure) | 3.69 | $308.12 | | 000 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | 22210 | Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; cervical | 43.33 | $3,618.06 | | 090 | Y | |
| | 22212 | Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; thoracic | 35.65 | $2,976.78 | | 090 | Y | |
| | 22214 | Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; lumbar | 36.13 | $3,016.86 | | 090 | Y | |
| + | 22216 | Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; each additional vertebral segment (List separately in addition to primary procedure) | 9.66 | $806.61 | | 000 | Y | |
| | 22220 | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical | 39.10 | $3,264.85 | | 090 | Y | |
| | 22222 | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic | 36.09 | $3,013.52 | | 090 | Y | |
| | 22224 | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar | 38.71 | $3,232.29 | | 090 | Y | |
| + | 22226 | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure) | 9.57 | $799.10 | | 000 | Y | |
| | 22305 | Closed treatment of vertebral process fracture(s) | 4.53 | $378.26 | | 090 | N | $155.43 |
| | 22310 | Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing | 6.67 | $556.95 | | 090 | N | $155.43 |
| | 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 | 20.49 | $1,710.92 | | 090 | N | $155.43 |
| | 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 | 38.96 | $3,253.16 | | 090 | Y | |
| | 22319 | Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; with grafting | 43.25 | $3,611.38 | | 090 | Y | |
| | 22325 | Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebrae or dislocated segment; lumbar | 33.61 | $2,806.44 | | 090 | Y | |
| | 22326 | Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebrae or dislocated segment; cervical | 35.58 | $2,970.93 | | 090 | Y | |
| | 22327 | Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebrae or dislocated segment; thoracic | 34.81 | $2,906.64 | | 090 | Y | |
| + | 22328 | Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebrae or dislocated segment; each additional fractured vertebrae or dislocated segment (List separately in addition to code for primary procedure) | 7.23 | $603.71 | | 000 | Y | |
| | 22505 | Manipulation of spine requiring anesthesia, any region | 3.01 | $251.34 | | 010 | N | $669.00 |
| | 22520 | Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic | 66.80 | $5,577.80 | | 010 | Y | $2,008.50 |
| | 22521 | Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar | 62.20 | $5,193.70 | | 010 | N | $2,008.50 |
| + | 22522 | Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure) | 6.28 | $524.38 | | 000 | N | $2,008.50 |
| | 22523 | Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic | 15.60 | $1,302.60 | | 010 | N | |
| | 22524 | Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar | 14.92 | $1,245.82 | | 010 | N | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| + | 22525 | Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure) | 6.96 | $581.16 | | 000 | N | |
| ⊙ | 22526 | Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level | 53.13 | $4,436.36 | | 010 | N | |
| +⊙ | 22527 | Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; one or more additional levels (List separately in addition to code for primary procedure) | 43.20 | $3,607.20 | | 000 | N | |
| | 22532 | Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic | 42.16 | $3,520.36 | | 090 | Y | |
| | 22533 | Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar | 38.86 | $3,244.81 | | 090 | Y | |
| + | 22534 | Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure) | 9.50 | $793.25 | | 000 | Y | |
| | 22548 | Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process | 45.45 | $3,795.08 | | 090 | Y | |
| | 22554 | Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2 | 32.21 | $3,059.95 | | 090 | Y | |
| | 22556 | Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic | 40.73 | $3,400.96 | | 090 | Y | |
| | 22558 | Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar | 37.00 | $3,515.00 | | 090 | Y | |
| + | 22585 | Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure) | 8.83 | $838.85 | | 000 | Y | |
| | 22590 | Arthrodesis, posterior technique, craniocervical (occiput-C2) | 37.48 | $3,129.58 | | 090 | Y | |
| | 22595 | Arthrodesis, posterior technique, atlas-axis (C1-C2) | 35.60 | $2,972.60 | | 090 | Y | |
| | 22600 | Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment | 30.44 | $2,541.74 | | 090 | Y | |
| | 22610 | Arthrodesis, posterior or posterolateral technique, single level; thoracic (with or without lateral transverse technique) | 30.19 | $2,520.87 | | 090 | Y | |
| | 22612 | Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique) | 39.33 | $3,736.35 | | 090 | Y | |
| + | 22614 | Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure) | 10.31 | $979.45 | | 000 | Y | |
| | 22630 | Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar | 37.81 | $3,591.95 | | 090 | Y | |
| + | 22632 | Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure) | 8.36 | $698.06 | | 000 | Y | |
| | 22800 | Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments | 33.50 | $2,797.25 | | 090 | Y | |
| | 22802 | Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments | 53.63 | $4,478.11 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | 22804 | Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments | 62.15 | $5,189.53 | | 090 | Y | |
| | 22808 | Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments | 45.20 | $3,774.20 | | 090 | Y | |
| | 22810 | Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments | 50.82 | $4,243.47 | | 090 | Y | |
| | 22812 | Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments | 55.15 | $4,605.03 | | 090 | Y | |
| | 22818 | Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments | 55.55 | $4,638.43 | | 090 | Y | |
| | 22819 | Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments | 62.85 | $5,247.98 | | 090 | Y | |
| | 22830 | Exploration of spinal fusion | 20.07 | $1,906.65 | | 090 | Y | |
| ⊘ | 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) | 20.15 | $1,682.53 | | 000 | Y | |
| ⊘ | 22841 | Internal spinal fixation by wiring of spinous processes | 9.81 | $819.47 | | 000 | Y | |
| ⊘ | 22842 | Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments | 20.16 | $1,915.20 | | 000 | Y | |
| ⊘ | 22843 | Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments | 21.23 | $1,772.71 | | 000 | Y | |
| ⊘ | 22844 | Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments | 26.16 | $2,184.36 | | 000 | Y | |
| ⊘ | 22845 | Anterior instrumentation; 2 to 3 vertebral segments | 19.31 | $1,834.45 | | 000 | Y | |
| ⊘ | 22846 | Anterior instrumentation; 4 to 7 vertebral segments | 20.06 | $1,675.01 | | 000 | Y | |
| ⊘ | 22847 | Anterior instrumentation; 8 or more vertebral segments | 22.01 | $1,837.84 | | 000 | Y | |
| ⊘ | 22848 | Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum | 9.52 | $794.92 | | 000 | Y | |
| | 22849 | Reinsertion of spinal fixation device | 32.45 | $2,709.58 | | 090 | Y | |
| | 22850 | Removal of posterior nonsegmental instrumentation (eg, Harrington rod) | 17.69 | $1,477.12 | | 090 | Y | |
| ⊘ | 22851 | Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace | 10.70 | $1,016.50 | | 000 | Y | |
| | 22852 | Removal of posterior segmental instrumentation | 16.92 | $1,607.40 | | 090 | Y | |
| | 22855 | Removal of anterior instrumentation | 27.29 | $2,278.72 | | 090 | Y | |
| | 22857 | Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, single interspace | 36.58 | $3,054.43 | | 090 | Y | |
| | 22862 | Revision including replacement of total disc arthroplasty (artificial disc) anterior approach, lumbar, single interspace | 44.60 | $3,724.10 | | 090 | Y | |
| | 22865 | Removal of total disc arthroplasty (artificial disc), anterior approach, lumbar, single interspace | 43.43 | $3,626.41 | | 090 | Y | |
| | 22899 | Unlisted procedure, spine | 0.00 | BR | | 000 | N | |
| | 22900 | Excision, abdominal wall tumor, subfascial (eg, desmoid) | 9.58 | $799.93 | | 090 | Y | $945.00 |
| | 22999 | Unlisted procedure, abdomen, musculoskeletal system | 0.00 | BR | | 000 | N | |
| | 23000 | Removal of subdeltoid calcareous deposits, open | 12.98 | $1,083.83 | | 090 | Y | $669.00 |
| | 23020 | Capsular contracture release (eg, Sever type procedure) | 17.15 | $1,432.03 | | 090 | Y | $669.00 |
| | 23030 | Incision and drainage, shoulder area; deep abscess or hematoma | 10.77 | $899.30 | | 010 | N | $499.50 |
| | 23031 | Incision and drainage, shoulder area; infected bursa | 10.45 | $872.58 | | 010 | N | $765.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **23035** | Incision, bone cortex (eg, osteomyelitis or bone abscess), shoulder area | 17.56 | $1,466.26 | | 090 | Y | $765.00 |
| **23040** | Arthrotomy, glenohumeral joint, including exploration, drainage, or removal of foreign body | 17.86 | $1,491.31 | | 090 | Y | $765.00 |
| **23044** | Arthrotomy, acromioclavicular, sternoclavicular joint, including exploration, drainage, or removal of foreign body | 14.19 | $1,184.87 | | 090 | N | $945.00 |
| **23065** | Biopsy, soft tissue of shoulder area; superficial | 4.85 | $404.98 | | 010 | N | |
| **23066** | Biopsy, soft tissue of shoulder area; deep | 12.08 | $1,008.68 | | 090 | N | $669.00 |
| **23075** | Excision, soft tissue tumor, shoulder area; subcutaneous | 6.18 | $516.03 | | 010 | N | $669.00 |
| **23076** | Excision, soft tissue tumor, shoulder area; deep, subfascial, or intramuscular | 13.62 | $1,137.27 | | 090 | N | $669.00 |
| **23077** | Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area | 28.72 | $2,398.12 | | 090 | Y | $765.00 |
| **23100** | Arthrotomy, glenohumeral joint, including biopsy | 12.05 | $1,006.18 | | 090 | Y | $669.00 |
| **23101** | Arthrotomy, acromioclavicular joint or sternoclavicular joint, including biopsy and/or excision of torn cartilage | 11.16 | $931.86 | | 090 | Y | $1,492.50 |
| **23105** | Arthrotomy; glenohumeral joint, with synovectomy, with or without biopsy | 15.82 | $1,320.97 | | 090 | Y | $945.00 |
| **23106** | Arthrotomy; sternoclavicular joint, with synovectomy, with or without biopsy | 11.83 | $987.81 | | 090 | N | $945.00 |
| **23107** | Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body | 16.48 | $1,376.08 | | 090 | Y | $945.00 |
| **23120** | Claviculectomy; partial | 13.95 | $1,164.83 | | 090 | Y | $1,075.50 |
| **23125** | Claviculectomy; total | 17.45 | $1,457.08 | | 090 | Y | $1,075.50 |
| **23130** | Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release | 15.04 | $1,255.84 | | 090 | N | $1,075.50 |
| **23140** | Excision or curettage of bone cyst or benign tumor of clavicle or scapula; | 12.50 | $1,043.75 | | 090 | N | $945.00 |
| **23145** | Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with autograft (includes obtaining graft) | 16.88 | $1,409.48 | | 090 | Y | $1,075.50 |
| **23146** | Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with allograft | 15.34 | $1,280.89 | | 090 | Y | $1,075.50 |
| **23150** | Excision or curettage of bone cyst or benign tumor of proximal humerus; | 15.94 | $1,330.99 | | 090 | Y | $945.00 |
| **23155** | Excision or curettage of bone cyst or benign tumor of proximal humerus; with autograft (includes obtaining graft) | 19.54 | $1,631.59 | | 090 | Y | $1,075.50 |
| **23156** | Excision or curettage of bone cyst or benign tumor of proximal humerus; with allograft | 16.74 | $1,397.79 | | 090 | Y | $1,075.50 |
| **23170** | Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle | 13.30 | $1,110.55 | | 090 | N | $669.00 |
| **23172** | Sequestrectomy (eg, for osteomyelitis or bone abscess), scapula | 13.46 | $1,123.91 | | 090 | Y | $669.00 |
| **23174** | Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck | 18.65 | $1,557.28 | | 090 | Y | $669.00 |
| **23180** | Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), clavicle | 17.95 | $1,498.83 | | 090 | N | $945.00 |
| **23182** | Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), scapula | 17.13 | $1,430.36 | | 090 | Y | $945.00 |
| **23184** | Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), proximal humerus | 19.28 | $1,609.88 | | 090 | Y | $945.00 |
| **23190** | Ostectomy of scapula, partial (eg, superior medial angle) | 13.78 | $1,150.63 | | 090 | Y | $945.00 |
| **23195** | Resection, humeral head | 18.42 | $1,538.07 | | 090 | Y | $1,075.50 |
| **23200** | Radical resection for tumor; clavicle | 21.77 | $1,817.80 | | 090 | Y | |
| **23210** | Radical resection for tumor; scapula | 22.68 | $1,893.78 | | 090 | Y | |
| **23220** | Radical resection of bone tumor, proximal humerus; | 26.70 | $2,229.45 | | 090 | Y | |
| **23221** | Radical resection of bone tumor, proximal humerus; with autograft (includes obtaining graft) | 30.06 | $2,510.01 | | 090 | Y | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **23222** | Radical resection of bone tumor, proximal humerus; with prosthetic replacement | 42.08 | $3,513.68 | | 090 | Y | |
| **23330** | Removal of foreign body, shoulder; subcutaneous | 5.52 | $460.92 | | 010 | N | $499.50 |
| **23331** | Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal) | 14.59 | $1,218.27 | | 090 | Y | $499.50 |
| **23332** | Removal of foreign body, shoulder; complicated (eg, total shoulder) | 22.04 | $1,840.34 | | 090 | Y | |
| **23350** | Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography | 4.19 | $349.87 | | 000 | N | |
| **23395** | Muscle transfer, any type, shoulder or upper arm; single | 31.87 | $2,661.15 | | 090 | Y | $1,075.50 |
| **23397** | Muscle transfer, any type, shoulder or upper arm; multiple | 28.66 | $2,393.11 | | 090 | Y | $1,492.50 |
| **23400** | Scapulopexy (eg, Sprengels deformity or for paralysis) | 24.35 | $2,033.23 | | 090 | Y | $1,492.50 |
| **23405** | Tenotomy, shoulder area; single tendon | 15.72 | $1,312.62 | | 090 | Y | $669.00 |
| **23406** | Tenotomy, shoulder area; multiple tendons through same incision | 19.68 | $1,643.28 | | 090 | Y | $669.00 |
| **23410** | Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute | 22.55 | $1,882.93 | | 090 | Y | $1,075.50 |
| **23412** | Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic | 24.00 | $2,004.00 | | 090 | Y | $1,492.50 |
| **23415** | Coracoacromial ligament release, with or without acromioplasty | 18.46 | $1,541.41 | | 090 | N | $1,075.50 |
| **23420** | Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty) | 26.18 | $2,487.10 | | 090 | Y | $1,492.50 |
| **23430** | Tenodesis of long tendon of biceps | 18.56 | $1,763.20 | | 090 | Y | $945.00 |
| **23440** | Resection or transplantation of long tendon of biceps | 19.21 | $1,604.04 | | 090 | Y | $945.00 |
| **23450** | Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation | 23.98 | $2,002.33 | | 090 | Y | $1,075.50 |
| **23455** | Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure) | 25.58 | $2,135.93 | | 090 | Y | $1,492.50 |
| **23460** | Capsulorrhaphy, anterior, any type; with bone block | 27.65 | $2,308.78 | | 090 | Y | $1,075.50 |
| **23462** | Capsulorrhaphy, anterior, any type; with coracoid process transfer | 26.98 | $2,252.83 | | 090 | Y | $1,492.50 |
| **23465** | Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block | 28.10 | $2,346.35 | | 090 | Y | $1,075.50 |
| **23466** | Capsulorrhaphy, glenohumeral joint, any type multi-directional instability | 27.52 | $2,614.40 | | 090 | Y | $1,492.50 |
| **23470** | Arthroplasty, glenohumeral joint; hemiarthroplasty | 30.70 | $2,563.45 | | 090 | Y | |
| **23472** | Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)) | 37.77 | $3,153.80 | | 090 | Y | |
| **23480** | Osteotomy, clavicle, with or without internal fixation; | 20.65 | $1,724.28 | | 090 | N | $945.00 |
| **23485** | Osteotomy, clavicle, with or without internal fixation; with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation) | 24.25 | $2,024.88 | | 090 | Y | $1,492.50 |
| **23490** | Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; clavicle | 20.46 | $1,708.41 | | 090 | Y | $765.00 |
| **23491** | Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; proximal humerus | 25.69 | $2,145.12 | | 090 | Y | $765.00 |
| **23500** | Closed treatment of clavicular fracture; without manipulation | 5.03 | $420.01 | | 090 | N | $155.43 |
| **23505** | Closed treatment of clavicular fracture; with manipulation | 8.28 | $691.38 | | 090 | N | $155.43 |
| **23515** | Open treatment of clavicular fracture, with or without internal or external fixation | 14.32 | $1,195.72 | | 090 | Y | $765.00 |
| **23520** | Closed treatment of sternoclavicular dislocation; without manipulation | 5.13 | $428.36 | | 090 | N | $155.43 |
| **23525** | Closed treatment of sternoclavicular dislocation; with manipulation | 8.29 | $692.22 | | 090 | N | $155.43 |
| **23530** | Open treatment of sternoclavicular dislocation, acute or chronic; | 13.60 | $1,135.60 | | 090 | Y | $765.00 |
| **23532** | Open treatment of sternoclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft) | 15.40 | $1,285.90 | | 090 | Y | $945.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **23540** | Closed treatment of acromioclavicular dislocation; without manipulation | 5.14 | $429.19 | | 090 | N | $155.43 |
| **23545** | Closed treatment of acromioclavicular dislocation; with manipulation | 7.42 | $619.57 | | 090 | N | $155.43 |
| **23550** | Open treatment of acromioclavicular dislocation, acute or chronic; | 14.14 | $1,180.69 | | 090 | Y | $765.00 |
| **23552** | Open treatment of acromioclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft) | 16.34 | $1,364.39 | | 090 | Y | $945.00 |
| **23570** | Closed treatment of scapular fracture; without manipulation | 5.37 | $448.40 | | 090 | N | $155.43 |
| **23575** | Closed treatment of scapular fracture; with manipulation, with or without skeletal traction (with or without shoulder joint involvement) | 9.05 | $755.68 | | 090 | N | $155.43 |
| **23585** | Open treatment of scapular fracture (body, glenoid or acromion) with or without internal fixation | 17.14 | $1,431.19 | | 090 | Y | $765.00 |
| **23600** | Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation | 7.61 | $635.44 | | 090 | N | |
| **23605** | Closed treatment of proximal humeral (surgical or anatomical neck) fracture; with manipulation, with or without skeletal traction | 11.25 | $939.38 | | 090 | N | $155.43 |
| **23615** | Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(s); | 20.16 | $1,683.36 | | 090 | Y | $945.00 |
| **23616** | Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(s); with proximal humeral prosthetic replacement | 36.71 | $3,065.29 | | 090 | Y | $945.00 |
| **23620** | Closed treatment of greater humeral tuberosity fracture; without manipulation | 6.17 | $515.20 | | 090 | N | |
| **23625** | Closed treatment of greater humeral tuberosity fracture; with manipulation | 9.08 | $758.18 | | 090 | N | $155.43 |
| **23630** | Open treatment of greater humeral tuberosity fracture, with or without internal or external fixation | 14.39 | $1,201.57 | | 090 | Y | $1,075.50 |
| **23650** | Closed treatment of shoulder dislocation, with manipulation; without anesthesia | 7.04 | $587.84 | | 090 | N | $155.43 |
| **23655** | Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia | 9.03 | $754.01 | | 090 | N | $499.50 |
| **23660** | Open treatment of acute shoulder dislocation | 14.28 | $1,192.38 | | 090 | Y | $765.00 |
| **23665** | Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation | 10.00 | $835.00 | | 090 | N | $155.43 |
| **23670** | Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with or without internal or external fixation | 15.17 | $1,266.70 | | 090 | Y | $765.00 |
| **23675** | Closed treatment of shoulder dislocation, with surgical or anatomical neck fracture, with manipulation | 13.18 | $1,100.53 | | 090 | N | $155.43 |
| **23680** | Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, with or without internal or external fixation | 18.86 | $1,574.81 | | 090 | Y | $765.00 |
| **23700** | Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded) | 4.83 | $458.85 | | 010 | N | $499.50 |
| **23800** | Arthrodesis, glenohumeral joint; | 25.20 | $2,104.20 | | 090 | Y | $945.00 |
| **23802** | Arthrodesis, glenohumeral joint; with autogenous graft (includes obtaining graft) | 29.45 | $2,459.08 | | 090 | Y | $1,492.50 |
| **23900** | Interthoracoscapular amputation (forequarter) | 33.16 | $2,768.86 | | 090 | Y | |
| **23920** | Disarticulation of shoulder; | 26.73 | $2,231.96 | | 090 | Y | |
| **23921** | Disarticulation of shoulder; secondary closure or scar revision | 10.86 | $906.81 | | 090 | N | $484.92 |
| **23929** | Unlisted procedure, shoulder | 0.00 | BR | | 000 | N | |
| **23930** | Incision and drainage, upper arm or elbow area; deep abscess or hematoma | 9.07 | $757.35 | | 010 | N | $499.50 |
| **23931** | Incision and drainage, upper arm or elbow area; bursa | 7.42 | $619.57 | | 010 | N | $669.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **23935** | Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), humerus or elbow | 12.41 | $1,036.24 | | 090 | Y | $669.00 |
| **24000** | Arthrotomy, elbow, including exploration, drainage, or removal of foreign body | 11.62 | $970.27 | | 090 | Y | $945.00 |
| **24006** | Arthrotomy of the elbow, with capsular excision for capsular release (separate procedure) | 17.64 | $1,472.94 | | 090 | Y | $945.00 |
| **24065** | Biopsy, soft tissue of upper arm or elbow area; superficial | 5.51 | $460.09 | | 010 | N | |
| **24066** | Biopsy, soft tissue of upper arm or elbow area; deep (subfascial or intramuscular) | 14.29 | $1,193.22 | | 090 | N | $669.00 |
| **24075** | Excision, tumor, soft tissue of upper arm or elbow area; subcutaneous | 11.42 | $953.57 | | 090 | N | $669.00 |
| **24076** | Excision, tumor, soft tissue of upper arm or elbow area; deep (subfascial or intramuscular) | 11.47 | $957.75 | | 090 | N | $669.00 |
| **24077** | Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area | 20.04 | $1,673.34 | | 090 | Y | $765.00 |
| **24100** | Arthrotomy, elbow; with synovial biopsy only | 9.79 | $817.47 | | 090 | Y | $499.50 |
| **24101** | Arthrotomy, elbow; with joint exploration, with or without biopsy, with or without removal of loose or foreign body | 12.32 | $1,028.72 | | 090 | Y | $945.00 |
| **24102** | Arthrotomy, elbow; with synovectomy | 15.27 | $1,275.05 | | 090 | Y | $945.00 |
| **24105** | Excision, olecranon bursa | 8.21 | $685.54 | | 090 | N | $765.00 |
| **24110** | Excision or curettage of bone cyst or benign tumor, humerus; | 14.41 | $1,203.24 | | 090 | N | $669.00 |
| **24115** | Excision or curettage of bone cyst or benign tumor, humerus; with autograft (includes obtaining graft) | 17.79 | $1,485.47 | | 090 | Y | $765.00 |
| **24116** | Excision or curettage of bone cyst or benign tumor, humerus; with allograft | 21.68 | $1,810.28 | | 090 | Y | $765.00 |
| **24120** | Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; | 12.88 | $1,075.48 | | 090 | Y | $765.00 |
| **24125** | Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with autograft (includes obtaining graft) | 14.40 | $1,202.40 | | 090 | Y | $765.00 |
| **24126** | Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with allograft | 15.63 | $1,305.11 | | 090 | Y | $765.00 |
| **24130** | Excision, radial head | 12.52 | $1,045.42 | | 090 | N | $765.00 |
| **24134** | Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus | 19.24 | $1,606.54 | | 090 | Y | $669.00 |
| **24136** | Sequestrectomy (eg, for osteomyelitis or bone abscess), radial head or neck | 15.68 | $1,309.28 | | 090 | N | $669.00 |
| **24138** | Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process | 16.35 | $1,365.23 | | 090 | Y | $669.00 |
| **24140** | Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), humerus | 18.63 | $1,555.61 | | 090 | Y | $765.00 |
| **24145** | Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), radial head or neck | 15.81 | $1,320.14 | | 090 | N | $765.00 |
| **24147** | Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), olecranon process | 16.40 | $1,369.40 | | 090 | N | $669.00 |
| **24149** | Radical resection of capsule, soft tissue, and heterotopic bone, elbow, with contracture release (separate procedure) | 28.12 | $2,348.02 | | 090 | Y | |
| **24150** | Radical resection for tumor, shaft or distal humerus; | 24.29 | $2,028.22 | | 090 | Y | |
| **24151** | Radical resection for tumor, shaft or distal humerus; with autograft (includes obtaining graft) | 28.15 | $2,350.53 | | 090 | Y | |
| **24152** | Radical resection for tumor, radial head or neck; | 18.08 | $1,509.68 | | 090 | Y | |
| **24153** | Radical resection for tumor, radial head or neck; with autograft (includes obtaining graft) | 16.69 | $1,393.62 | | 090 | Y | |
| **24155** | Resection of elbow joint (arthrectomy) | 20.91 | $1,745.99 | | 090 | Y | $765.00 |
| **24160** | Implant removal; elbow joint | 15.03 | $1,255.01 | | 090 | N | $669.00 |
| **24164** | Implant removal; radial head | 12.29 | $1,026.22 | | 090 | N | $765.00 |
| **24200** | Removal of foreign body, upper arm or elbow area; subcutaneous | 5.05 | $421.68 | | 010 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **24201** | Removal of foreign body, upper arm or elbow area; deep (subfascial or intramuscular) | 14.19 | $1,184.87 | | 090 | N | $669.00 |
| **24220** | Injection procedure for elbow arthrography | 4.61 | $384.94 | | 000 | N | |
| **24300** | Manipulation, elbow, under anesthesia | 9.70 | $809.95 | | 090 | N | |
| **24301** | Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331) | 18.75 | $1,565.63 | | 090 | Y | $945.00 |
| **24305** | Tendon lengthening, upper arm or elbow, each tendon | 14.36 | $1,199.06 | | 090 | Y | $945.00 |
| **24310** | Tenotomy, open, elbow to shoulder, each tendon | 11.77 | $982.80 | | 090 | Y | $765.00 |
| **24320** | Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure) | 18.84 | $1,573.14 | | 090 | Y | $765.00 |
| **24330** | Flexor-plasty, elbow (eg, Steindler type advancement); | 17.88 | $1,492.98 | | 090 | Y | $765.00 |
| **24331** | Flexor-plasty, elbow (eg, Steindler type advancement); with extensor advancement | 19.67 | $1,642.45 | | 090 | Y | $765.00 |
| **24332** | Tenolysis, triceps | 14.75 | $1,231.63 | | 090 | N | |
| **24340** | Tenodesis of biceps tendon at elbow (separate procedure) | 15.26 | $1,274.21 | | 090 | Y | $765.00 |
| **24341** | Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff) | 17.50 | $1,461.25 | | 090 | Y | $765.00 |
| **24342** | Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft | 19.70 | $1,644.95 | | 090 | Y | $765.00 |
| **24343** | Repair lateral collateral ligament, elbow, with local tissue | 17.40 | $1,452.90 | | 090 | Y | |
| **24344** | Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft) | 27.00 | $2,254.50 | | 090 | Y | |
| **24345** | Repair medial collateral ligament, elbow, with local tissue | 17.30 | $1,444.55 | | 090 | Y | $669.00 |
| **24346** | Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft) | 26.83 | $2,240.31 | | 090 | Y | |
| **24350** | Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); | 11.06 | $1,050.70 | | 090 | N | $765.00 |
| **24351** | Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with extensor origin detachment | 12.09 | $1,009.52 | | 090 | N | $765.00 |
| **24352** | Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with annular ligament resection | 12.89 | $1,076.32 | | 090 | Y | $765.00 |
| **24354** | Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with stripping | 12.88 | $1,075.48 | | 090 | N | $765.00 |
| **24356** | Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with partial ostectomy | 13.24 | $1,257.80 | | 090 | Y | $765.00 |
| **24360** | Arthroplasty, elbow; with membrane (eg, fascial) | 22.44 | $1,873.74 | | 090 | Y | $1,075.50 |
| **24361** | Arthroplasty, elbow; with distal humeral prosthetic replacement | 25.17 | $2,101.70 | | 090 | Y | $1,075.50 |
| **24362** | Arthroplasty, elbow; with implant and fascia lata ligament reconstruction | 26.13 | $2,181.86 | | 090 | Y | $1,075.50 |
| **24363** | Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow) | 36.60 | $3,056.10 | | 090 | Y | $1,492.50 |
| **24365** | Arthroplasty, radial head; | 15.95 | $1,331.83 | | 090 | Y | $1,075.50 |
| **24366** | Arthroplasty, radial head; with implant | 17.08 | $1,426.18 | | 090 | Y | $1,075.50 |
| **24400** | Osteotomy, humerus, with or without internal fixation | 20.54 | $1,715.09 | | 090 | Y | $945.00 |
| **24410** | Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure) | 26.12 | $2,181.02 | | 090 | Y | $945.00 |
| **24420** | Osteoplasty, humerus (eg, shortening or lengthening) (excluding 64876) | 24.52 | $2,047.42 | | 090 | Y | $765.00 |
| **24430** | Repair of nonunion or malunion, humerus; without graft (eg, compression technique) | 25.41 | $2,121.74 | | 090 | Y | $765.00 |
| **24435** | Repair of nonunion or malunion, humerus; with iliac or other autograft (includes obtaining graft) | 26.18 | $2,186.03 | | 090 | Y | $945.00 |
| **24470** | Hemiepiphyseal arrest (eg, cubitus varus or valgus, distal humerus) | 16.80 | $1,402.80 | | 090 | Y | $765.00 |
| **24495** | Decompression fasciotomy, forearm, with brachial artery exploration | 16.87 | $1,408.65 | | 090 | Y | $669.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **24498** | Prophylactic treatment (nailing, pinning, plating or wiring), with or without methylmethacrylate, humeral shaft | 21.90 | $1,828.65 | | 090 | Y | $765.00 |
| **24500** | Closed treatment of humeral shaft fracture; without manipulation | 8.21 | $685.54 | | 090 | N | $155.43 |
| **24505** | Closed treatment of humeral shaft fracture; with manipulation, with or without skeletal traction | 12.03 | $1,004.51 | | 090 | N | $155.43 |
| **24515** | Open treatment of humeral shaft fracture with plate/screws, with or without cerclage | 21.87 | $1,826.15 | | 090 | Y | $945.00 |
| **24516** | Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws | 21.66 | $1,808.61 | | 090 | Y | $945.00 |
| **24530** | Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; without manipulation | 8.86 | $739.81 | | 090 | N | $155.43 |
| **24535** | Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; with manipulation, with or without skin or skeletal traction | 15.03 | $1,255.01 | | 090 | N | $155.43 |
| **24538** | Percutaneous skeletal fixation of supracondylar or transcondylar humeral fracture, with or without intercondylar extension | 18.64 | $1,556.44 | | 090 | N | $669.00 |
| **24545** | Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation; without intercondylar extension | 19.78 | $1,651.63 | | 090 | Y | $945.00 |
| **24546** | Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation; with intercondylar extension | 28.00 | $2,338.00 | | 090 | Y | $1,075.50 |
| **24560** | Closed treatment of humeral epicondylar fracture, medial or lateral; without manipulation | 7.39 | $617.07 | | 090 | N | $155.43 |
| **24565** | Closed treatment of humeral epicondylar fracture, medial or lateral; with manipulation | 12.42 | $1,037.07 | | 090 | N | $155.43 |
| **24566** | Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation | 17.14 | $1,431.19 | | 090 | N | $669.00 |
| **24575** | Open treatment of humeral epicondylar fracture, medial or lateral, with or without internal or external fixation | 19.91 | $1,662.49 | | 090 | Y | $765.00 |
| **24576** | Closed treatment of humeral condylar fracture, medial or lateral; without manipulation | 7.78 | $649.63 | | 090 | N | $155.43 |
| **24577** | Closed treatment of humeral condylar fracture, medial or lateral; with manipulation | 12.93 | $1,079.66 | | 090 | N | $155.43 |
| **24579** | Open treatment of humeral condylar fracture, medial or lateral, with or without internal or external fixation | 21.39 | $1,786.07 | | 090 | Y | $765.00 |
| **24582** | Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral, with manipulation | 19.27 | $1,609.05 | | 090 | N | $669.00 |
| **24586** | Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius); | 27.50 | $2,296.25 | | 090 | Y | $945.00 |
| **24587** | Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius); with implant arthroplasty | 27.23 | $2,273.71 | | 090 | Y | $1,075.50 |
| **24600** | Treatment of closed elbow dislocation; without anesthesia | 8.96 | $748.16 | | 090 | N | $155.43 |
| **24605** | Treatment of closed elbow dislocation; requiring anesthesia | 11.10 | $926.85 | | 090 | N | $669.00 |
| **24615** | Open treatment of acute or chronic elbow dislocation | 17.86 | $1,491.31 | | 090 | Y | $765.00 |
| **24620** | Closed treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with manipulation | 13.49 | $1,126.42 | | 090 | Y | $155.43 |
| **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 | 27.59 | $2,303.77 | | 090 | Y | $765.00 |
| **24640** | Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation | 2.97 | $248.00 | | 010 | N | |
| **24650** | Closed treatment of radial head or neck fracture; without manipulation | 6.04 | $504.34 | | 090 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **24655** | Closed treatment of radial head or neck fracture; with manipulation | 10.49 | $875.92 | | 090 | N | $155.43 |
| **24665** | Open treatment of radial head or neck fracture, with or without internal fixation or radial head excision; | 16.07 | $1,341.85 | | 090 | Y | $945.00 |
| **24666** | Open treatment of radial head or neck fracture, with or without internal fixation or radial head excision; with radial head prosthetic replacement | 18.19 | $1,518.87 | | 090 | Y | $945.00 |
| **24670** | Closed treatment of ulnar fracture, proximal end (olecranon process); without manipulation | 6.77 | $565.30 | | 090 | N | $155.43 |
| **24675** | Closed treatment of ulnar fracture, proximal end (olecranon process); with manipulation | 10.95 | $914.33 | | 090 | N | $155.43 |
| **24685** | Open treatment of ulnar fracture proximal end (olecranon process), with or without internal or external fixation | 16.81 | $1,403.64 | | 090 | Y | $765.00 |
| **24800** | Arthrodesis, elbow joint; local | 20.25 | $1,690.88 | | 090 | Y | $945.00 |
| **24802** | Arthrodesis, elbow joint; with autogenous graft (includes obtaining graft) | 25.07 | $2,093.35 | | 090 | Y | $1,075.50 |
| **24900** | Amputation, arm through humerus; with primary closure | 17.48 | $1,459.58 | | 090 | Y | |
| **24920** | Amputation, arm through humerus; open, circular (guillotine) | 17.45 | $1,457.08 | | 090 | Y | |
| **24925** | Amputation, arm through humerus; secondary closure or scar revision | 13.41 | $1,119.74 | | 090 | Y | $765.00 |
| **24930** | Amputation, arm through humerus; re-amputation | 18.23 | $1,522.21 | | 090 | Y | |
| **24931** | Amputation, arm through humerus; with implant | 20.28 | $1,693.38 | | 090 | Y | |
| **24935** | Stump elongation, upper extremity | 25.04 | $2,090.84 | | 090 | Y | |
| **24940** | Cineplasty, upper extremity, complete procedure | 21.03 | $1,756.01 | | 090 | Y | |
| **24999** | Unlisted procedure, humerus or elbow | 0.00 | BR | | 000 | N | |
| **25000** | Incision, extensor tendon sheath, wrist (eg, deQuervains disease) | 10.06 | $840.01 | | 090 | N | $765.00 |
| **25001** | Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis) | 8.00 | $668.00 | | 090 | N | |
| **25020** | Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; without debridement of nonviable muscle and/or nerve | 15.20 | $1,269.20 | | 090 | N | $765.00 |
| **25023** | Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; with debridement of nonviable muscle and/or nerve | 28.44 | $2,374.74 | | 090 | Y | $765.00 |
| **25024** | Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; without debridement of nonviable muscle and/or nerve | 18.33 | $1,530.56 | | 090 | N | $765.00 |
| **25025** | Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve | 27.57 | $2,302.10 | | 090 | Y | $765.00 |
| **25028** | Incision and drainage, forearm and/or wrist; deep abscess or hematoma | 13.26 | $1,107.21 | | 090 | N | $499.50 |
| **25031** | Incision and drainage, forearm and/or wrist; bursa | 11.70 | $976.95 | | 090 | Y | $669.00 |
| **25035** | Incision, deep, bone cortex, forearm and/or wrist (eg, osteomyelitis or bone abscess) | 20.43 | $1,705.91 | | 090 | Y | $669.00 |
| **25040** | Arthrotomy, radiocarpal or midcarpal joint, with exploration, drainage, or removal of foreign body | 14.77 | $1,233.30 | | 090 | Y | $1,075.50 |
| **25065** | Biopsy, soft tissue of forearm and/or wrist; superficial | 5.45 | $455.08 | | 010 | N | |
| **25066** | Biopsy, soft tissue of forearm and/or wrist; deep (subfascial or intramuscular) | 11.06 | $923.51 | | 090 | N | $669.00 |
| **25075** | Excision, tumor, soft tissue of forearm and/or wrist area; subcutaneous | 9.59 | $800.77 | | 090 | N | $669.00 |
| **25076** | Excision, tumor, soft tissue of forearm and/or wrist area; deep (subfascial or intramuscular) | 14.09 | $1,176.52 | | 090 | N | $765.00 |
| **25077** | Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area | 21.62 | $1,805.27 | | 090 | Y | $765.00 |
| **25085** | Capsulotomy, wrist (eg, contracture) | 12.55 | $1,047.93 | | 090 | Y | $765.00 |
| **25100** | Arthrotomy, wrist joint; with biopsy | 9.16 | $764.86 | | 090 | Y | $669.00 |

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|---|---|---|---|---|---|---|---|
| **25101** | Arthrotomy, wrist joint; with joint exploration, with or without biopsy, with or without removal of loose or foreign body | 10.64 | $888.44 | | 090 | Y | $765.00 |
| **25105** | Arthrotomy, wrist joint; with synovectomy | 13.18 | $1,100.53 | | 090 | Y | $945.00 |
| **25107** | Arthrotomy, distal radioulnar joint including repair of triangular cartilage, complex | 15.80 | $1,319.30 | | 090 | Y | $765.00 |
| **25109** | Excision of tendon, forearm and/or wrist, flexor or extensor, each | 12.40 | $1,035.40 | | 090 | N | |
| **25110** | Excision, lesion of tendon sheath, forearm and/or wrist | 10.79 | $900.97 | | 090 | N | $765.00 |
| **25111** | Excision of ganglion, wrist (dorsal or volar); primary | 8.17 | $682.20 | | 090 | N | $765.00 |
| **25112** | Excision of ganglion, wrist (dorsal or volar); recurrent | 9.90 | $826.65 | | 090 | N | $945.00 |
| **25115** | Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors | 23.30 | $1,945.55 | | 090 | N | $945.00 |
| **25116** | Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum | 19.88 | $1,659.98 | | 090 | Y | $945.00 |
| **25118** | Synovectomy, extensor tendon sheath, wrist, single compartment; | 10.13 | $845.86 | | 090 | N | $669.00 |
| **25119** | Synovectomy, extensor tendon sheath, wrist, single compartment; with resection of distal ulna | 13.62 | $1,137.27 | | 090 | Y | $765.00 |
| **25120** | Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); | 17.58 | $1,467.93 | | 090 | Y | $765.00 |
| **25125** | Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with autograft (includes obtaining graft) | 19.67 | $1,642.45 | | 090 | Y | $765.00 |
| **25126** | Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with allograft | 20.08 | $1,676.68 | | 090 | Y | $765.00 |
| **25130** | Excision or curettage of bone cyst or benign tumor of carpal bones; | 11.70 | $976.95 | | 090 | Y | $765.00 |
| **25135** | Excision or curettage of bone cyst or benign tumor of carpal bones; with autograft (includes obtaining graft) | 14.46 | $1,207.41 | | 090 | Y | $765.00 |
| **25136** | Excision or curettage of bone cyst or benign tumor of carpal bones; with allograft | 12.78 | $1,067.13 | | 090 | Y | $765.00 |
| **25145** | Sequestrectomy (eg, for osteomyelitis or bone abscess), forearm and/or wrist | 17.87 | $1,492.15 | | 090 | Y | $669.00 |
| **25150** | Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); ulna | 15.44 | $1,289.24 | | 090 | N | $669.00 |
| **25151** | Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); radius | 19.66 | $1,641.61 | | 090 | Y | $669.00 |
| **25170** | Radical resection for tumor, radius or ulna | 25.98 | $2,169.33 | | 090 | Y | |
| **25210** | Carpectomy; one bone | 12.78 | $1,067.13 | | 090 | Y | $765.00 |
| **25215** | Carpectomy; all bones of proximal row | 16.68 | $1,392.78 | | 090 | Y | $945.00 |
| **25230** | Radial styloidectomy (separate procedure) | 11.39 | $951.07 | | 090 | N | $945.00 |
| **25240** | Excision distal ulna partial or complete (eg, Darrach type or matched resection) | 12.04 | $1,005.34 | | 090 | Y | $945.00 |
| **25246** | Injection procedure for wrist arthrography | 4.61 | $384.94 | | 000 | N | |
| **25248** | Exploration with removal of deep foreign body, forearm or wrist | 13.43 | $1,121.41 | | 090 | N | $669.00 |
| **25250** | Removal of wrist prosthesis; (separate procedure) | 12.92 | $1,078.82 | | 090 | Y | $499.50 |
| **25251** | Removal of wrist prosthesis; complicated, including total wrist | 17.61 | $1,470.44 | | 090 | Y | $499.50 |
| **25259** | Manipulation, wrist, under anesthesia | 9.67 | $807.45 | | 090 | N | |
| **25260** | Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle | 20.59 | $1,719.27 | | 090 | N | $945.00 |
| **25263** | Repair, tendon or muscle, flexor, forearm and/or wrist; secondary, single, each tendon or muscle | 20.49 | $1,710.92 | | 090 | Y | $669.00 |

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|---|---|---|---|---|---|---|---|
| **25265** | Repair, tendon or muscle, flexor, forearm and/or wrist; secondary, with free graft (includes obtaining graft), each tendon or muscle | 23.68 | $1,977.28 | | 090 | Y | $765.00 |
| **25270** | Repair, tendon or muscle, extensor, forearm and/or wrist; primary, single, each tendon or muscle | 17.40 | $1,452.90 | | 090 | Y | $945.00 |
| **25272** | Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, single, each tendon or muscle | 19.19 | $1,602.37 | | 090 | Y | $765.00 |
| **25274** | Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, with free graft (includes obtaining graft), each tendon or muscle | 21.82 | $1,821.97 | | 090 | Y | $945.00 |
| **25275** | Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation) | 16.57 | $1,383.60 | | 090 | Y | $945.00 |
| **25280** | Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single, each tendon | 19.23 | $1,605.71 | | 090 | Y | $945.00 |
| **25290** | Tenotomy, open, flexor or extensor tendon, forearm and/or wrist, single, each tendon | 19.15 | $1,599.03 | | 090 | N | $765.00 |
| **25295** | Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each tendon | 18.11 | $1,512.19 | | 090 | N | $765.00 |
| **25300** | Tenodesis at wrist; flexors of fingers | 17.41 | $1,453.74 | | 090 | Y | $765.00 |
| **25301** | Tenodesis at wrist; extensors of fingers | 16.66 | $1,391.11 | | 090 | Y | $765.00 |
| **25310** | Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon | 20.63 | $1,722.61 | | 090 | Y | $765.00 |
| **25312** | Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; with tendon graft(s) (includes obtaining graft), each tendon | 23.00 | $1,920.50 | | 090 | Y | $945.00 |
| **25315** | Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist; | 24.40 | $2,037.40 | | 090 | Y | $765.00 |
| **25316** | Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist; with tendon(s) transfer | 28.17 | $2,352.20 | | 090 | Y | $765.00 |
| **25320** | Capsulorrhaphy or reconstruction, wrist, open (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability | 23.90 | $1,995.65 | | 090 | Y | $765.00 |
| **25332** | Arthroplasty, wrist, with or without interposition, with or without external or internal fixation | 21.10 | $1,761.85 | | 090 | Y | $1,075.50 |
| **25335** | Centralization of wrist on ulna (eg, radial club hand) | 24.31 | $2,029.89 | | 090 | Y | $765.00 |
| **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 | 22.57 | $1,884.60 | | 090 | N | $1,075.50 |
| **25350** | Osteotomy, radius; distal third | 22.33 | $1,864.56 | | 090 | Y | $765.00 |
| **25355** | Osteotomy, radius; middle or proximal third | 24.58 | $2,052.43 | | 090 | Y | $765.00 |
| **25360** | Osteotomy; ulna | 21.84 | $1,823.64 | | 090 | Y | $765.00 |
| **25365** | Osteotomy; radius AND ulna | 28.15 | $2,350.53 | | 090 | Y | $765.00 |
| **25370** | Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna | 29.86 | $2,493.31 | | 090 | Y | $765.00 |
| **25375** | Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius AND ulna | 29.48 | $2,461.58 | | 090 | Y | $945.00 |
| **25390** | Osteoplasty, radius OR ulna; shortening | 24.60 | $2,054.10 | | 090 | Y | $765.00 |
| **25391** | Osteoplasty, radius OR ulna; lengthening with autograft | 30.28 | $2,528.38 | | 090 | Y | $945.00 |
| **25392** | Osteoplasty, radius AND ulna; shortening (excluding 64876) | 30.04 | $2,508.34 | | 090 | Y | $765.00 |
| **25393** | Osteoplasty, radius AND ulna; lengthening with autograft | 34.09 | $2,846.52 | | 090 | Y | $945.00 |
| **25394** | Osteoplasty, carpal bone, shortening | 18.98 | $1,584.83 | | 090 | Y | |
| **25400** | Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique) | 25.81 | $2,155.14 | | 090 | Y | $765.00 |
| **25405** | Repair of nonunion or malunion, radius OR ulna; with autograft (includes obtaining graft) | 31.64 | $2,641.94 | | 090 | Y | $945.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **25415** | Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique) | 29.61 | $2,472.44 | | 090 | Y | $765.00 |
| **25420** | Repair of nonunion or malunion, radius AND ulna; with autograft (includes obtaining graft) | 34.72 | $2,899.12 | | 090 | Y | $945.00 |
| **25425** | Repair of defect with autograft; radius OR ulna | 33.89 | $2,829.82 | | 090 | Y | $765.00 |
| **25426** | Repair of defect with autograft; radius AND ulna | 32.76 | $2,735.46 | | 090 | Y | $945.00 |
| **25430** | Insertion of vascular pedicle into carpal bone (eg, Hori procedure) | 17.16 | $1,432.86 | | 090 | Y | |
| **25431** | Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone | 19.71 | $1,645.79 | | 090 | Y | |
| **25440** | Repair of nonunion, scaphoid carpal (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation) | 20.07 | $1,675.85 | | 090 | Y | $945.00 |
| **25441** | Arthroplasty with prosthetic replacement; distal radius | 23.57 | $1,968.10 | | 090 | Y | $1,075.50 |
| **25442** | Arthroplasty with prosthetic replacement; distal ulna | 19.93 | $1,664.16 | | 090 | Y | $1,075.50 |
| **25443** | Arthroplasty with prosthetic replacement; scaphoid carpal (navicular) | 19.08 | $1,593.18 | | 090 | Y | $1,075.50 |
| **25444** | Arthroplasty with prosthetic replacement; lunate | 20.58 | $1,718.43 | | 090 | Y | $1,075.50 |
| **25445** | Arthroplasty with prosthetic replacement; trapezium | 18.02 | $1,504.67 | | 090 | Y | $1,075.50 |
| **25446** | Arthroplasty with prosthetic replacement; distal radius and partial or entire carpus (total wrist) | 29.35 | $2,450.73 | | 090 | Y | $1,492.50 |
| **25447** | Arthroplasty, interposition, intercarpal or carpometacarpal joints | 19.94 | $1,664.99 | | 090 | Y | $1,075.50 |
| **25449** | Revision of arthroplasty, including removal of implant, wrist joint | 25.83 | $2,156.81 | | 090 | Y | $1,075.50 |
| **25450** | Epiphyseal arrest by epiphysiodesis or stapling; distal radius OR ulna | 17.96 | $1,499.66 | | 090 | N | $765.00 |
| **25455** | Epiphyseal arrest by epiphysiodesis or stapling; distal radius AND ulna | 19.32 | $1,613.22 | | 090 | N | $765.00 |
| **25490** | Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radius | 22.74 | $1,898.79 | | 090 | Y | $765.00 |
| **25491** | Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; ulna | 23.89 | $1,994.82 | | 090 | Y | $765.00 |
| **25492** | Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radius AND ulna | 27.53 | $2,298.76 | | 090 | Y | $765.00 |
| **25500** | Closed treatment of radial shaft fracture; without manipulation | 6.12 | $511.02 | | 090 | N | |
| **25505** | Closed treatment of radial shaft fracture; with manipulation | 12.04 | $1,005.34 | | 090 | N | $155.43 |
| **25515** | Open treatment of radial shaft fracture, with or without internal or external fixation | 17.31 | $1,445.39 | | 090 | Y | $765.00 |
| **25520** | Closed treatment of radial shaft fracture and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation) | 13.44 | $1,122.24 | | 090 | N | $155.43 |
| **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 | 23.23 | $1,939.71 | | 090 | Y | $945.00 |
| **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 radioulnar joint (Galeazzi fracture/dislocation), includes repair of triangular fibrocartilage complex | 26.97 | $2,252.00 | | 090 | Y | $1,075.50 |
| **25530** | Closed treatment of ulnar shaft fracture; without manipulation | 5.96 | $497.66 | | 090 | N | |
| **25535** | Closed treatment of ulnar shaft fracture; with manipulation | 11.51 | $961.09 | | 090 | N | $155.43 |
| **25545** | Open treatment of ulnar shaft fracture, with or without internal or external fixation | 17.12 | $1,429.52 | | 090 | Y | $765.00 |
| **25560** | Closed treatment of radial and ulnar shaft fractures; without manipulation | 6.21 | $518.54 | | 090 | N | |
| **25565** | Closed treatment of radial and ulnar shaft fractures; with manipulation | 12.59 | $1,051.27 | | 090 | N | $155.43 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **25574** | Open treatment of radial AND ulnar shaft fractures, with internal or external fixation; of radius OR ulna | 14.99 | $1,251.67 | | 090 | Y | $765.00 |
| **25575** | Open treatment of radial AND ulnar shaft fractures, with internal or external fixation; of radius AND ulna | 22.02 | $1,838.67 | | 090 | Y | $765.00 |
| **25600** | Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; without manipulation | 6.83 | $570.31 | | 090 | N | |
| **25605** | Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation | 14.46 | $1,207.41 | | 090 | N | $155.43 |
| **25606** | Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation | 16.96 | $1,416.16 | | 090 | N | $765.00 |
| **25607** | Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation | 17.03 | $1,422.01 | | 090 | Y | $1,075.50 |
| **25608** | Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments | 19.49 | $1,627.42 | | 090 | Y | $1,075.50 |
| **25609** | Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments | 24.85 | $2,074.98 | | 090 | Y | $1,075.50 |
| **25622** | Closed treatment of carpal scaphoid (navicular) fracture; without manipulation | 7.00 | $584.50 | | 090 | N | |
| **25624** | Closed treatment of carpal scaphoid (navicular) fracture; with manipulation | 11.04 | $921.84 | | 090 | N | $155.43 |
| **25628** | Open treatment of carpal scaphoid (navicular) fracture, with or without internal or external fixation | 17.62 | $1,471.27 | | 090 | Y | $765.00 |
| **25630** | Closed treatment of carpal bone fracture (excluding carpal scaphoid (navicular)); without manipulation, each bone | 7.17 | $598.70 | | 090 | N | |
| **25635** | Closed treatment of carpal bone fracture (excluding carpal scaphoid (navicular)); with manipulation, each bone | 10.56 | $881.76 | | 090 | N | $155.43 |
| **25645** | Open treatment of carpal bone fracture (other than carpal scaphoid (navicular)), each bone | 14.20 | $1,185.70 | | 090 | Y | $765.00 |
| **25650** | Closed treatment of ulnar styloid fracture | 7.46 | $622.91 | | 090 | N | |
| **25651** | Percutaneous skeletal fixation of ulnar styloid fracture | 11.37 | $949.40 | | 090 | Y | |
| **25652** | Open treatment of ulnar styloid fracture | 15.14 | $1,264.19 | | 090 | N | |
| **25660** | Closed treatment of radiocarpal or intercarpal dislocation, one or more bones, with manipulation | 9.59 | $800.77 | | 090 | Y | $155.43 |
| **25670** | Open treatment of radiocarpal or intercarpal dislocation, one or more bones | 15.21 | $1,270.04 | | 090 | Y | $765.00 |
| **25671** | Percutaneous skeletal fixation of distal radioulnar dislocation | 12.68 | $1,058.78 | | 090 | N | $499.50 |
| **25675** | Closed treatment of distal radioulnar dislocation with manipulation | 10.35 | $864.23 | | 090 | Y | $155.43 |
| **25676** | Open treatment of distal radioulnar dislocation, acute or chronic | 15.74 | $1,314.29 | | 090 | Y | $669.00 |
| **25680** | Closed treatment of trans-scaphoperilunar type of fracture dislocation, with manipulation | 10.91 | $910.99 | | 090 | Y | $155.43 |
| **25685** | Open treatment of trans-scaphoperilunar type of fracture dislocation | 18.11 | $1,512.19 | | 090 | Y | $765.00 |
| **25690** | Closed treatment of lunate dislocation, with manipulation | 11.24 | $938.54 | | 090 | Y | $155.43 |
| **25695** | Open treatment of lunate dislocation | 15.75 | $1,315.13 | | 090 | Y | $669.00 |
| **25800** | Arthrodesis, wrist; complete, without bone graft (includes radiocarpal and/or intercarpal and/or carpometacarpal joints) | 19.17 | $1,600.70 | | 090 | Y | $945.00 |
| **25805** | Arthrodesis, wrist; with sliding graft | 21.98 | $1,835.33 | | 090 | Y | $1,075.50 |
| **25810** | Arthrodesis, wrist; with iliac or other autograft (includes obtaining graft) | 21.83 | $1,822.81 | | 090 | Y | $1,075.50 |
| **25820** | Arthrodesis, wrist; limited, without bone graft (eg, intercarpal or radiocarpal) | 15.45 | $1,290.08 | | 090 | Y | $945.00 |
| **25825** | Arthrodesis, wrist; with autograft (includes obtaining graft) | 18.82 | $1,571.47 | | 090 | Y | $1,075.50 |
| **25830** | Arthrodesis, distal radioulnar joint with segmental resection of ulna, with or without bone graft (eg, Sauve-Kapandji procedure) | 24.59 | $2,053.27 | | 090 | Y | $1,075.50 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **25900** | Amputation, forearm, through radius and ulna; | 21.55 | $1,799.43 | | 090 | Y | |
| | **25905** | Amputation, forearm, through radius and ulna; open, circular (guillotine) | 21.27 | $1,776.05 | | 090 | Y | |
| | **25907** | Amputation, forearm, through radius and ulna; secondary closure or scar revision | 19.05 | $1,590.68 | | 090 | Y | $765.00 |
| | **25909** | Amputation, forearm, through radius and ulna; re-amputation | 21.18 | $1,768.53 | | 090 | Y | |
| | **25915** | Krukenberg procedure | 34.76 | $2,902.46 | | 090 | Y | |
| | **25920** | Disarticulation through wrist; | 16.95 | $1,415.33 | | 090 | Y | |
| | **25922** | Disarticulation through wrist; secondary closure or scar revision | 14.83 | $1,238.31 | | 090 | Y | $765.00 |
| | **25924** | Disarticulation through wrist; re-amputation | 16.90 | $1,411.15 | | 090 | Y | |
| | **25927** | Transmetacarpal amputation; | 20.27 | $1,692.55 | | 090 | Y | |
| | **25929** | Transmetacarpal amputation; secondary closure or scar revision | 13.84 | $1,155.64 | | 090 | Y | $765.00 |
| | **25931** | Transmetacarpal amputation; re-amputation | 19.02 | $1,588.17 | | 090 | N | |
| | **25999** | Unlisted procedure, forearm or wrist | 0.00 | BR | | 000 | N | |
| | **26010** | Drainage of finger abscess; simple | 6.75 | $563.63 | | 010 | N | |
| | **26011** | Drainage of finger abscess; complicated (eg, felon) | 10.49 | $875.92 | | 010 | N | $499.50 |
| | **26020** | Drainage of tendon sheath, digit and/or palm, each | 10.41 | $869.24 | | 090 | N | $669.00 |
| | **26025** | Drainage of palmar bursa; single, bursa | 10.21 | $852.54 | | 090 | Y | $499.50 |
| | **26030** | Drainage of palmar bursa; multiple bursa | 12.01 | $1,002.84 | | 090 | Y | $669.00 |
| | **26034** | Incision, bone cortex, hand or finger (eg, osteomyelitis or bone abscess) | 13.01 | $1,086.34 | | 090 | N | $669.00 |
| | **26035** | Decompression fingers and/or hand, injection injury (eg, grease gun) | 19.42 | $1,621.57 | | 090 | Y | |
| | **26037** | Decompressive fasciotomy, hand (excludes 26035) | 13.99 | $1,168.17 | | 090 | Y | |
| | **26040** | Fasciotomy, palmar (eg, Dupuytren's contracture); percutaneous | 7.52 | $627.92 | | 090 | N | $945.00 |
| | **26045** | Fasciotomy, palmar (eg, Dupuytren's contracture); open, partial | 11.44 | $955.24 | | 090 | N | $765.00 |
| | **26055** | Tendon sheath incision (eg, for trigger finger) | 16.15 | $1,348.53 | | 090 | N | $669.00 |
| | **26060** | Tenotomy, percutaneous, single, each digit | 6.41 | $535.24 | | 090 | N | $669.00 |
| | **26070** | Arthrotomy, with exploration, drainage, or removal of loose or foreign body; carpometacarpal joint | 7.11 | $593.69 | | 090 | N | $669.00 |
| | **26075** | Arthrotomy, with exploration, drainage, or removal of loose or foreign body; metacarpophalangeal joint, each | 7.66 | $639.61 | | 090 | N | $945.00 |
| | **26080** | Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each | 9.31 | $777.39 | | 090 | N | $945.00 |
| | **26100** | Arthrotomy with biopsy; carpometacarpal joint, each | 7.87 | $657.15 | | 090 | N | $669.00 |
| | **26105** | Arthrotomy with biopsy; metacarpophalangeal joint, each | 8.07 | $673.85 | | 090 | N | $499.50 |
| | **26110** | Arthrotomy with biopsy; interphalangeal joint, each | 7.68 | $641.28 | | 090 | N | $499.50 |
| | **26115** | Excision, tumor or vascular malformation, soft tissue of hand or finger; subcutaneous | 16.39 | $1,368.57 | | 090 | N | $669.00 |
| | **26116** | Excision, tumor or vascular malformation, soft tissue of hand or finger; deep (subfascial or intramuscular) | 11.73 | $979.46 | | 090 | N | $669.00 |
| | **26117** | Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger | 15.88 | $1,325.98 | | 090 | N | $765.00 |
| | **26121** | Fasciectomy, palm only, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft) | 14.73 | $1,229.96 | | 090 | N | $945.00 |
| | **26123** | Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft); | 19.71 | $1,645.79 | | 090 | N | $945.00 |
| + | **26125** | Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft); each additional digit (List separately in addition to code for primary procedure) | 7.15 | $597.03 | | 000 | N | $945.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **26130** | Synovectomy, carpometacarpal joint | 11.10 | $926.85 | | 090 | N | $765.00 |
| **26135** | Synovectomy, metacarpophalangeal joint including intrinsic release and extensor hood reconstruction, each digit | 13.61 | $1,136.44 | | 090 | Y | $945.00 |
| **26140** | Synovectomy, proximal interphalangeal joint, including extensor reconstruction, each interphalangeal joint | 12.36 | $1,032.06 | | 090 | N | $669.00 |
| **26145** | Synovectomy, tendon sheath, radical (tenosynovectomy), flexor tendon, palm and/or finger, each tendon | 12.56 | $1,048.76 | | 090 | N | $765.00 |
| **26160** | Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger | 15.13 | $1,263.36 | | 090 | N | $765.00 |
| **26170** | Excision of tendon, palm, flexor or extensor, single, each tendon | 9.84 | $821.64 | | 090 | N | $765.00 |
| **26180** | Excision of tendon, finger, flexor or extensor, each tendon | 10.75 | $897.63 | | 090 | N | $765.00 |
| **26185** | Sesamoidectomy, thumb or finger (separate procedure) | 12.47 | $1,041.25 | | 090 | Y | $945.00 |
| **26200** | Excision or curettage of bone cyst or benign tumor of metacarpal; | 11.04 | $921.84 | | 090 | N | $669.00 |
| **26205** | Excision or curettage of bone cyst or benign tumor of metacarpal; with autograft (includes obtaining graft) | 14.87 | $1,241.65 | | 090 | N | $765.00 |
| **26210** | Excision or curettage of bone cyst or benign tumor of proximal, middle, or distal phalanx of finger; | 10.74 | $896.79 | | 090 | N | $669.00 |
| **26215** | Excision or curettage of bone cyst or benign tumor of proximal, middle, or distal phalanx of finger; with autograft (includes obtaining graft) | 13.55 | $1,131.43 | | 090 | N | $765.00 |
| **26230** | Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); metacarpal | 12.45 | $1,039.58 | | 090 | N | $1,489.43 |
| **26235** | Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); proximal or middle phalanx of finger | 12.17 | $1,016.20 | | 090 | N | $765.00 |
| **26236** | Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); distal phalanx of finger | 10.78 | $900.13 | | 090 | N | $765.00 |
| **26250** | Radical resection, metacarpal (eg, tumor); | 14.04 | $1,172.34 | | 090 | Y | $765.00 |
| **26255** | Radical resection, metacarpal (eg, tumor); with autograft (includes obtaining graft) | 22.36 | $1,867.06 | | 090 | Y | $765.00 |
| **26260** | Radical resection, proximal or middle phalanx of finger (eg, tumor); | 13.38 | $1,117.23 | | 090 | Y | $765.00 |
| **26261** | Radical resection, proximal or middle phalanx of finger (eg, tumor); with autograft (includes obtaining graft) | 15.88 | $1,325.98 | | 090 | Y | $765.00 |
| **26262** | Radical resection, distal phalanx of finger (eg, tumor) | 11.19 | $934.37 | | 090 | Y | $669.00 |
| **26320** | Removal of implant from finger or hand | 8.40 | $701.40 | | 090 | N | $669.00 |
| **26340** | Manipulation, finger joint, under anesthesia, each joint | 7.57 | $632.10 | | 090 | N | |
| **26350** | Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land); primary or secondary without free graft, each tendon | 19.72 | $1,646.62 | | 090 | N | $499.50 |
| **26352** | Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land); secondary with free graft (includes obtaining graft), each tendon | 22.13 | $1,847.86 | | 090 | Y | $945.00 |
| **26356** | Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon | 27.62 | $2,306.27 | | 090 | N | $945.00 |
| **26357** | Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, without free graft, each tendon | 23.40 | $1,953.90 | | 090 | Y | $945.00 |
| **26358** | Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, with free graft (includes obtaining graft), each tendon | 24.86 | $2,075.81 | | 090 | Y | $945.00 |
| **26370** | Repair or advancement of profundus tendon, with intact superficialis tendon; primary, each tendon | 21.28 | $1,776.88 | | 090 | Y | $945.00 |
| **26372** | Repair or advancement of profundus tendon, with intact superficialis tendon; secondary with free graft (includes obtaining graft), each tendon | 24.43 | $2,039.91 | | 090 | Y | $945.00 |
| **26373** | Repair or advancement of profundus tendon, with intact superficialis tendon; secondary without free graft, each tendon | 23.27 | $1,943.05 | | 090 | Y | $765.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| 26390 | Excision flexor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod | 22.01 | $1,837.84 | | 090 | Y | $945.00 |
| 26392 | Removal of synthetic rod and insertion of flexor tendon graft, hand or finger (includes obtaining graft), each rod | 26.22 | $2,189.37 | | 090 | Y | $765.00 |
| 26410 | Repair, extensor tendon, hand, primary or secondary; without free graft, each tendon | 15.79 | $1,318.47 | | 090 | N | $765.00 |
| 26412 | Repair, extensor tendon, hand, primary or secondary; with free graft (includes obtaining graft), each tendon | 18.79 | $1,568.97 | | 090 | Y | $765.00 |
| 26415 | Excision of extensor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod | 19.05 | $1,590.68 | | 090 | Y | $945.00 |
| 26416 | Removal of synthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each rod | 22.40 | $1,870.40 | | 090 | N | $765.00 |
| 26418 | Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon | 15.82 | $1,320.97 | | 090 | N | $945.00 |
| 26420 | Repair, extensor tendon, finger, primary or secondary; with free graft (includes obtaining graft) each tendon | 19.62 | $1,638.27 | | 090 | Y | $945.00 |
| 26426 | Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); using local tissue(s), including lateral band(s), each finger | 18.55 | $1,548.93 | | 090 | N | $765.00 |
| 26428 | Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); with free graft (includes obtaining graft), each finger | 20.36 | $1,700.06 | | 090 | Y | $765.00 |
| 26432 | Closed treatment of distal extensor tendon insertion, with or without percutaneous pinning (eg, mallet finger) | 13.67 | $1,141.45 | | 090 | N | $765.00 |
| 26433 | Repair of extensor tendon, distal insertion, primary or secondary; without graft (eg, mallet finger) | 14.70 | $1,227.45 | | 090 | N | $765.00 |
| 26434 | Repair of extensor tendon, distal insertion, primary or secondary; with free graft (includes obtaining graft) | 17.09 | $1,427.02 | | 090 | Y | $765.00 |
| 26437 | Realignment of extensor tendon, hand, each tendon | 16.79 | $1,401.97 | | 090 | N | $765.00 |
| 26440 | Tenolysis, flexor tendon; palm OR finger, each tendon | 17.49 | $1,460.42 | | 090 | N | $765.00 |
| 26442 | Tenolysis, flexor tendon; palm AND finger, each tendon | 24.61 | $2,054.94 | | 090 | N | $765.00 |
| 26445 | Tenolysis, extensor tendon, hand OR finger, each tendon | 16.45 | $1,373.58 | | 090 | N | $765.00 |
| 26449 | Tenolysis, complex, extensor tendon, finger, including forearm, each tendon | 23.22 | $1,938.87 | | 090 | Y | $765.00 |
| 26450 | Tenotomy, flexor, palm, open, each tendon | 10.71 | $894.29 | | 090 | N | $765.00 |
| 26455 | Tenotomy, flexor, finger, open, each tendon | 10.62 | $886.77 | | 090 | N | $765.00 |
| 26460 | Tenotomy, extensor, hand or finger, open, each tendon | 10.31 | $860.89 | | 090 | N | $765.00 |
| 26471 | Tenodesis; of proximal interphalangeal joint, each joint | 16.44 | $1,372.74 | | 090 | Y | $669.00 |
| 26474 | Tenodesis; of distal joint, each joint | 16.02 | $1,337.67 | | 090 | Y | $669.00 |
| 26476 | Lengthening of tendon, extensor, hand or finger, each tendon | 15.55 | $1,298.43 | | 090 | N | $499.50 |
| 26477 | Shortening of tendon, extensor, hand or finger, each tendon | 15.67 | $1,308.45 | | 090 | N | $499.50 |
| 26478 | Lengthening of tendon, flexor, hand or finger, each tendon | 16.96 | $1,416.16 | | 090 | N | $499.50 |
| 26479 | Shortening of tendon, flexor, hand or finger, each tendon | 16.74 | $1,397.79 | | 090 | Y | $499.50 |
| 26480 | Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon | 20.78 | $1,735.13 | | 090 | Y | $765.00 |
| 26483 | Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; with free tendon graft (includes obtaining graft), each tendon | 22.96 | $1,917.16 | | 090 | Y | $765.00 |
| 26485 | Transfer or transplant of tendon, palmar; without free tendon graft, each tendon | 22.15 | $1,849.53 | | 090 | Y | $669.00 |
| 26489 | Transfer or transplant of tendon, palmar; with free tendon graft (includes obtaining graft), each tendon | 21.64 | $1,806.94 | | 090 | Y | $765.00 |
| 26490 | Opponensplasty; superficialis tendon transfer type, each tendon | 20.69 | $1,727.62 | | 090 | Y | $765.00 |
| 26492 | Opponensplasty; tendon transfer with graft (includes obtaining graft), each tendon | 22.78 | $1,902.13 | | 090 | Y | $765.00 |
| 26494 | Opponensplasty; hypothenar muscle transfer | 20.94 | $1,748.49 | | 090 | Y | $765.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **26496** | Opponensplasty; other methods | 22.44 | $1,873.74 | | 090 | Y | $765.00 |
| **26497** | Transfer of tendon to restore intrinsic function; ring and small finger | 22.62 | $1,888.77 | | 090 | Y | $765.00 |
| **26498** | Transfer of tendon to restore intrinsic function; all four fingers | 29.78 | $2,486.63 | | 090 | Y | $945.00 |
| **26499** | Correction claw finger, other methods | 21.47 | $1,792.75 | | 090 | Y | $765.00 |
| **26500** | Reconstruction of tendon pulley, each tendon; with local tissues (separate procedure) | 16.85 | $1,406.98 | | 090 | Y | $945.00 |
| **26502** | Reconstruction of tendon pulley, each tendon; with tendon or fascial graft (includes obtaining graft) (separate procedure) | 18.72 | $1,563.12 | | 090 | Y | $945.00 |
| **26508** | Release of thenar muscle(s) (eg, thumb contracture) | 17.14 | $1,431.19 | | 090 | N | $765.00 |
| **26510** | Cross intrinsic transfer, each tendon | 16.13 | $1,346.86 | | 090 | Y | $765.00 |
| **26516** | Capsulodesis, metacarpophalangeal joint; single digit | 18.81 | $1,570.64 | | 090 | Y | $499.50 |
| **26517** | Capsulodesis, metacarpophalangeal joint; two digits | 21.92 | $1,830.32 | | 090 | Y | $765.00 |
| **26518** | Capsulodesis, metacarpophalangeal joint; three or four digits | 21.93 | $1,831.16 | | 090 | Y | $765.00 |
| **26520** | Capsulectomy or capsulotomy; metacarpophalangeal joint, each joint | 18.24 | $1,523.04 | | 090 | N | $765.00 |
| **26525** | Capsulectomy or capsulotomy; interphalangeal joint, each joint | 18.35 | $1,532.23 | | 090 | N | $765.00 |
| **26530** | Arthroplasty, metacarpophalangeal joint; each joint | 13.09 | $1,093.02 | | 090 | Y | $765.00 |
| **26531** | Arthroplasty, metacarpophalangeal joint; with prosthetic implant, each joint | 15.26 | $1,274.21 | | 090 | Y | $1,492.50 |
| **26535** | Arthroplasty, interphalangeal joint; each joint | 9.31 | $777.39 | | 090 | N | $1,075.50 |
| **26536** | Arthroplasty, interphalangeal joint; with prosthetic implant, each joint | 16.28 | $1,359.38 | | 090 | Y | $1,075.50 |
| **26540** | Repair of collateral ligament, metacarpophalangeal or interphalangeal joint | 17.74 | $1,481.29 | | 090 | Y | $945.00 |
| **26541** | Reconstruction, collateral ligament, metacarpophalangeal joint, single; with tendon or fascial graft (includes obtaining graft) | 21.41 | $1,787.74 | | 090 | Y | $1,492.50 |
| **26542** | Reconstruction, collateral ligament, metacarpophalangeal joint, single; with local tissue (eg, adductor advancement) | 18.23 | $1,522.21 | | 090 | Y | $945.00 |
| **26545** | Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint | 18.53 | $1,547.26 | | 090 | Y | $945.00 |
| **26546** | Repair non-union, metacarpal or phalanx, (includes obtaining bone graft with or without external or internal fixation) | 25.05 | $2,091.68 | | 090 | Y | $945.00 |
| **26548** | Repair and reconstruction, finger, volar plate, interphalangeal joint | 20.34 | $1,698.39 | | 090 | Y | $945.00 |
| **26550** | Pollicization of a digit | 38.89 | $3,247.32 | | 090 | Y | $669.00 |
| **26551** | Transfer, toe-to-hand with microvascular anastomosis; great toe wrap-around with bone graft | 81.12 | $6,773.52 | | 090 | Y | |
| **26553** | Transfer, toe-to-hand with microvascular anastomosis; other than great toe, single | 67.70 | $5,652.95 | | 090 | Y | |
| **26554** | Transfer, toe-to-hand with microvascular anastomosis; other than great toe, double | 93.45 | $7,803.08 | | 090 | Y | |
| **26555** | Transfer, finger to another position without microvascular anastomosis | 34.85 | $2,909.98 | | 090 | Y | $765.00 |
| **26556** | Transfer, free toe joint, with microvascular anastomosis | 76.49 | $6,386.92 | | 090 | Y | |
| **26560** | Repair of syndactyly (web finger) each web space; with skin flaps | 14.86 | $1,240.81 | | 090 | Y | $669.00 |
| **26561** | Repair of syndactyly (web finger) each web space; with skin flaps and grafts | 22.96 | $1,917.16 | | 090 | Y | $765.00 |
| **26562** | Repair of syndactyly (web finger) each web space; complex (eg, involving bone, nails) | 33.38 | $2,787.23 | | 090 | Y | $945.00 |
| **26565** | Osteotomy; metacarpal, each | 18.11 | $1,512.19 | | 090 | Y | $1,075.50 |
| **26567** | Osteotomy; phalanx of finger, each | 18.24 | $1,523.04 | | 090 | Y | $1,075.50 |
| **26568** | Osteoplasty, lengthening, metacarpal or phalanx | 23.84 | $1,990.64 | | 090 | Y | $765.00 |
| **26580** | Repair cleft hand | 32.90 | $2,747.15 | | 090 | Y | $1,075.50 |
| **26587** | Reconstruction of polydactylous digit, soft tissue and bone | 23.48 | $1,960.58 | | 090 | Y | $1,075.50 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **26590** | Repair macrodactylia, each digit | 32.52 | $2,715.42 | | 090 | Y | $1,075.50 |
| **26591** | Repair, intrinsic muscles of hand, each muscle | 12.24 | $1,022.04 | | 090 | Y | $765.00 |
| **26593** | Release, intrinsic muscles of hand, each muscle | 15.91 | $1,328.49 | | 090 | N | $765.00 |
| **26596** | Excision of constricting ring of finger, with multiple Z-plasties | 18.03 | $1,505.51 | | 090 | Y | $669.00 |
| **26600** | Closed treatment of metacarpal fracture, single; without manipulation, each bone | 6.20 | $517.70 | | 090 | N | |
| **26605** | Closed treatment of metacarpal fracture, single; with manipulation, each bone | 7.56 | $631.26 | | 090 | N | $155.43 |
| **26607** | Closed treatment of metacarpal fracture, with manipulation, with external fixation, each bone | 11.66 | $973.61 | | 090 | Y | $155.43 |
| **26608** | Percutaneous skeletal fixation of metacarpal fracture, each bone | 11.77 | $982.80 | | 090 | N | $945.00 |
| **26615** | Open treatment of metacarpal fracture, single, with or without internal or external fixation, each bone | 10.87 | $907.65 | | 090 | N | $945.00 |
| **26641** | Closed treatment of carpometacarpal dislocation, thumb, with manipulation | 8.47 | $707.25 | | 090 | N | |
| **26645** | Closed treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation | 9.72 | $811.62 | | 090 | N | $155.43 |
| **26650** | Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation, with or without external fixation | 12.59 | $1,051.27 | | 090 | N | $669.00 |
| **26665** | Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external fixation | 14.28 | $1,192.38 | | 090 | N | $945.00 |
| **26670** | Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; without anesthesia | 7.83 | $653.81 | | 090 | N | |
| **26675** | Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; requiring anesthesia | 10.33 | $862.56 | | 090 | N | $155.43 |
| **26676** | Percutaneous skeletal fixation of carpometacarpal dislocation, other than thumb, with manipulation, each joint | 12.37 | $1,032.90 | | 090 | N | $669.00 |
| **26685** | Open treatment of carpometacarpal dislocation, other than thumb; with or without internal or external fixation, each joint | 13.44 | $1,122.24 | | 090 | N | $765.00 |
| **26686** | Open treatment of carpometacarpal dislocation, other than thumb; complex, multiple or delayed reduction | 15.21 | $1,270.04 | | 090 | Y | $765.00 |
| **26700** | Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia | 7.36 | $614.56 | | 090 | N | |
| **26705** | Closed treatment of metacarpophalangeal dislocation, single, with manipulation; requiring anesthesia | 9.69 | $809.12 | | 090 | N | $155.43 |
| **26706** | Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation | 10.48 | $875.08 | | 090 | N | $155.43 |
| **26715** | Open treatment of metacarpophalangeal dislocation, single, with or without internal or external fixation | 11.49 | $959.42 | | 090 | N | $945.00 |
| **26720** | Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each | 4.50 | $375.75 | | 090 | N | |
| **26725** | Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; with manipulation, with or without skin or skeletal traction, each | 8.18 | $683.03 | | 090 | N | |
| **26727** | Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each | 11.59 | $967.77 | | 090 | N | $1,492.50 |
| **26735** | Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external fixation, each | 11.79 | $984.47 | | 090 | N | $945.00 |
| **26740** | Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; without manipulation, each | 5.19 | $433.37 | | 090 | N | |
| **26742** | Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; with manipulation, each | 8.92 | $744.82 | | 090 | N | $155.43 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **26746** | Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, with or without internal or external fixation, each | 11.60 | $968.60 | | 090 | N | $1,075.50 |
| | **26750** | Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each | 4.20 | $350.70 | | 090 | N | |
| | **26755** | Closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, each | 7.52 | $627.92 | | 090 | N | |
| | **26756** | Percutaneous skeletal fixation of distal phalangeal fracture, finger or thumb, each | 10.23 | $854.21 | | 090 | N | $669.00 |
| | **26765** | Open treatment of distal phalangeal fracture, finger or thumb, with or without internal or external fixation, each | 8.75 | $730.63 | | 090 | N | $945.00 |
| | **26770** | Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia | 6.33 | $528.56 | | 090 | N | |
| | **26775** | Closed treatment of interphalangeal joint dislocation, single, with manipulation; requiring anesthesia | 8.97 | $749.00 | | 090 | N | |
| | **26776** | Percutaneous skeletal fixation of interphalangeal joint dislocation, single, with manipulation | 10.91 | $910.99 | | 090 | N | $669.00 |
| | **26785** | Open treatment of interphalangeal joint dislocation, with or without internal or external fixation, single | 8.92 | $744.82 | | 090 | N | $669.00 |
| | **26820** | Fusion in opposition, thumb, with autogenous graft (includes obtaining graft) | 20.91 | $1,745.99 | | 090 | Y | $1,075.50 |
| | **26841** | Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation; | 19.76 | $1,649.96 | | 090 | Y | $945.00 |
| | **26842** | Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation; with autograft (includes obtaining graft) | 21.12 | $1,763.52 | | 090 | Y | $945.00 |
| | **26843** | Arthrodesis, carpometacarpal joint, digit, other than thumb, each; | 19.36 | $1,616.56 | | 090 | Y | $765.00 |
| | **26844** | Arthrodesis, carpometacarpal joint, digit, other than thumb, each; with autograft (includes obtaining graft) | 21.62 | $1,805.27 | | 090 | Y | $765.00 |
| | **26850** | Arthrodesis, metacarpophalangeal joint, with or without internal fixation; | 18.61 | $1,553.94 | | 090 | Y | $945.00 |
| | **26852** | Arthrodesis, metacarpophalangeal joint, with or without internal fixation; with autograft (includes obtaining graft) | 20.91 | $1,745.99 | | 090 | Y | $945.00 |
| | **26860** | Arthrodesis, interphalangeal joint, with or without internal fixation; | 15.29 | $1,276.72 | | 090 | N | $765.00 |
| + | **26861** | Arthrodesis, interphalangeal joint, with or without internal fixation; each additional interphalangeal joint (List separately in addition to code for primary procedure) | 2.71 | $226.29 | | 000 | N | $669.00 |
| | **26862** | Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft) | 19.23 | $1,605.71 | | 090 | Y | $945.00 |
| + | **26863** | Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft), each additional joint (List separately in addition to code for primary procedure) | 6.05 | $505.18 | | 000 | Y | $765.00 |
| | **26910** | Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseous transfer | 18.56 | $1,549.76 | | 090 | N | $765.00 |
| | **26951** | Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure | 15.68 | $1,309.28 | | 090 | N | $669.00 |
| | **26952** | Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with local advancement flaps (V-Y, hood) | 17.42 | $1,454.57 | | 090 | N | $945.00 |
| | **26989** | Unlisted procedure, hands or fingers | 0.00 | BR | | 000 | N | |
| | **26990** | Incision and drainage, pelvis or hip joint area; deep abscess or hematoma | 15.25 | $1,273.38 | | 090 | N | $499.50 |
| | **26991** | Incision and drainage, pelvis or hip joint area; infected bursa | 17.89 | $1,493.82 | | 090 | N | $499.50 |
| | **26992** | Incision, bone cortex, pelvis and/or hip joint (eg, osteomyelitis or bone abscess) | 24.14 | $2,015.69 | | 090 | Y | |
| | **27000** | Tenotomy, adductor of hip, percutaneous (separate procedure) | 11.17 | $932.70 | | 090 | N | $669.00 |
| | **27001** | Tenotomy, adductor of hip, open | 13.46 | $1,123.91 | | 090 | Y | $765.00 |
| | **27003** | Tenotomy, adductor, subcutaneous, open, with obturator neurectomy | 14.37 | $1,199.90 | | 090 | Y | $765.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **27005** | Tenotomy, hip flexor(s), open (separate procedure) | 18.26 | $1,524.71 | | 090 | Y | |
| **27006** | Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure) | 18.39 | $1,535.57 | | 090 | Y | |
| **27025** | Fasciotomy, hip or thigh, any type | 21.68 | $1,810.28 | | 090 | Y | |
| **27030** | Arthrotomy, hip, with drainage (eg, infection) | 23.72 | $1,980.62 | | 090 | Y | |
| **27033** | Arthrotomy, hip, including exploration or removal of loose or foreign body | 24.47 | $2,043.25 | | 090 | Y | $765.00 |
| **27035** | Denervation, hip joint, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral, or obturator nerves | 28.52 | $2,381.42 | | 090 | Y | $945.00 |
| **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) | 24.77 | $2,068.30 | | 090 | Y | |
| **27040** | Biopsy, soft tissue of pelvis and hip area; superficial | 8.04 | $671.34 | | 010 | N | $499.50 |
| **27041** | Biopsy, soft tissue of pelvis and hip area; deep, subfascial or intramuscular | 16.82 | $1,404.47 | | 090 | N | $627.74 |
| **27047** | Excision, tumor, pelvis and hip area; subcutaneous tissue | 14.88 | $1,242.48 | | 090 | N | $669.00 |
| **27048** | Excision, tumor, pelvis and hip area; deep, subfascial, intramuscular | 11.47 | $957.75 | | 090 | Y | $765.00 |
| **27049** | Radical resection of tumor, soft tissue of pelvis and hip area (eg, malignant neoplasm) | 24.10 | $2,012.35 | | 090 | Y | $765.00 |
| **27050** | Arthrotomy, with biopsy; sacroiliac joint | 9.04 | $754.84 | | 090 | Y | $765.00 |
| **27052** | Arthrotomy, with biopsy; hip joint | 13.45 | $1,123.08 | | 090 | Y | $765.00 |
| **27054** | Arthrotomy with synovectomy, hip joint | 16.78 | $1,401.13 | | 090 | Y | |
| **27060** | Excision; ischial bursa | 10.39 | $867.57 | | 090 | N | $1,075.50 |
| **27062** | Excision; trochanteric bursa or calcification | 11.07 | $924.35 | | 090 | N | $1,075.50 |
| **27065** | Excision of bone cyst or benign tumor; superficial (wing of ilium, symphysis pubis, or greater trochanter of femur) with or without autograft | 12.16 | $1,015.36 | | 090 | Y | $1,075.50 |
| **27066** | Excision of bone cyst or benign tumor; deep, with or without autograft | 19.95 | $1,665.83 | | 090 | Y | $1,075.50 |
| **27067** | Excision of bone cyst or benign tumor; with autograft requiring separate incision | 25.16 | $2,100.86 | | 090 | Y | $1,075.50 |
| **27070** | Partial excision (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial (eg, wing of ilium, symphysis pubis, or greater trochanter of femur) | 20.88 | $1,743.48 | | 090 | Y | |
| **27071** | Partial excision (craterization, saucerization) (eg, osteomyelitis or bone abscess); deep (subfascial or intramuscular) | 22.68 | $1,893.78 | | 090 | Y | |
| **27075** | Radical resection of tumor or infection; wing of ilium, one pubic or ischial ramus or symphysis pubis | 57.32 | $4,786.22 | | 090 | Y | |
| **27076** | Radical resection of tumor or infection; ilium, including acetabulum, both pubic rami, or ischium and acetabulum | 39.61 | $3,307.44 | | 090 | Y | |
| **27077** | Radical resection of tumor or infection; innominate bone, total | 66.42 | $5,546.07 | | 090 | Y | |
| **27078** | Radical resection of tumor or infection; ischial tuberosity and greater trochanter of femur | 24.98 | $2,085.83 | | 090 | Y | |
| **27079** | Radical resection of tumor or infection; ischial tuberosity and greater trochanter of femur, with skin flaps | 24.39 | $2,036.57 | | 090 | Y | |
| **27080** | Coccygectomy, primary | 11.86 | $990.31 | | 090 | Y | $669.00 |
| **27086** | Removal of foreign body, pelvis or hip; subcutaneous tissue | 6.30 | $526.05 | | 010 | N | $499.50 |
| **27087** | Removal of foreign body, pelvis or hip; deep (subfascial or intramuscular) | 15.60 | $1,302.60 | | 090 | Y | $765.00 |
| **27090** | Removal of hip prosthesis; (separate procedure) | 20.81 | $1,737.64 | | 090 | Y | |
| **27091** | Removal of hip prosthesis; complicated, including total hip prosthesis, methylmethacrylate with or without insertion of spacer | 39.34 | $3,284.89 | | 090 | Y | |
| **27093** | Injection procedure for hip arthrography; without anesthesia | 5.39 | $450.07 | | 000 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **27095** | Injection procedure for hip arthrography; with anesthesia | 6.68 | $557.78 | | 000 | N | |
| **27096** | Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid | 5.22 | $435.87 | | 000 | N | |
| **27097** | Release or recession, hamstring, proximal | 16.21 | $1,353.54 | | 090 | Y | $765.00 |
| **27098** | Transfer, adductor to ischium | 15.71 | $1,311.79 | | 090 | Y | $765.00 |
| **27100** | Transfer external oblique muscle to greater trochanter including fascial or tendon extension (graft) | 20.29 | $1,694.22 | | 090 | Y | $945.00 |
| **27105** | Transfer paraspinal muscle to hip (includes fascial or tendon extension graft) | 21.29 | $1,777.72 | | 090 | Y | $945.00 |
| **27110** | Transfer iliopsoas; to greater trochanter of femur | 23.45 | $1,958.08 | | 090 | Y | $945.00 |
| **27111** | Transfer iliopsoas; to femoral neck | 22.05 | $1,841.18 | | 090 | Y | $945.00 |
| **27120** | Acetabuloplasty; (eg, Whitman, Colonna, Haygroves, or cup type) | 31.86 | $2,660.31 | | 090 | Y | |
| **27122** | Acetabuloplasty; resection, femoral head (eg, Girdlestone procedure) | 27.64 | $2,307.94 | | 090 | Y | |
| **27125** | Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty) | 27.75 | $2,317.13 | | 090 | Y | |
| **27130** | Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft | 35.91 | $2,998.49 | | 090 | Y | |
| **27132** | Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft | 42.11 | $3,516.19 | | 090 | Y | |
| **27134** | Revision of total hip arthroplasty; both components, with or without autograft or allograft | 49.13 | $4,102.36 | | 090 | Y | |
| **27137** | Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft | 37.38 | $3,121.23 | | 090 | Y | |
| **27138** | Revision of total hip arthroplasty; femoral component only, with or without allograft | 38.90 | $3,248.15 | | 090 | Y | |
| **27140** | Osteotomy and transfer of greater trochanter of femur (separate procedure) | 22.53 | $1,881.26 | | 090 | Y | |
| **27146** | Osteotomy, iliac, acetabular or innominate bone; | 31.60 | $2,638.60 | | 090 | Y | |
| **27147** | Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip | 36.20 | $3,022.70 | | 090 | Y | |
| **27151** | Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy | 34.52 | $2,882.42 | | 090 | Y | |
| **27156** | Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip | 43.08 | $3,597.18 | | 090 | Y | |
| **27158** | Osteotomy, pelvis, bilateral (eg, congenital malformation) | 31.97 | $2,669.50 | | 090 | Y | |
| **27161** | Osteotomy, femoral neck (separate procedure) | 30.60 | $2,555.10 | | 090 | Y | |
| **27165** | Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast | 33.78 | $2,820.63 | | 090 | Y | |
| **27170** | Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft) | 29.46 | $2,459.91 | | 090 | Y | |
| **27175** | Treatment of slipped femoral epiphysis; by traction, without reduction | 16.28 | $1,359.38 | | 090 | N | |
| **27176** | Treatment of slipped femoral epiphysis; by single or multiple pinning, in situ | 22.55 | $1,882.93 | | 090 | Y | |
| **27177** | Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft (includes obtaining graft) | 27.56 | $2,301.26 | | 090 | Y | |
| **27178** | Open treatment of slipped femoral epiphysis; closed manipulation with single or multiple pinning | 21.97 | $1,834.50 | | 090 | Y | |
| **27179** | Open treatment of slipped femoral epiphysis; osteoplasty of femoral neck (Heyman type procedure) | 24.34 | $2,032.39 | | 090 | Y | |
| **27181** | Open treatment of slipped femoral epiphysis; osteotomy and internal fixation | 26.06 | $2,176.01 | | 090 | Y | |
| **27185** | Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur | 18.42 | $1,538.07 | | 090 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **27187** | Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femoral neck and proximal femur | 24.98 | $2,085.83 | | 090 | Y | |
| **27193** | Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulation | 11.32 | $945.22 | | 090 | N | $155.43 |
| **27194** | Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation, requiring more than local anesthesia | 18.12 | $1,513.02 | | 090 | Y | $669.00 |
| **27200** | Closed treatment of coccygeal fracture | 4.15 | $346.53 | | 090 | N | |
| **27202** | Open treatment of coccygeal fracture | 23.01 | $1,921.34 | | 090 | Y | $669.00 |
| **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 | 18.33 | $1,530.56 | | 090 | Y | |
| **27216** | Percutaneous skeletal fixation of posterior pelvic ring fracture and/or dislocation (includes ilium, sacroiliac joint and/or sacrum) | 26.31 | $2,196.89 | | 090 | Y | |
| **27217** | Open treatment of anterior ring fracture and/or dislocation with internal fixation (includes pubic symphysis and/or rami) | 25.39 | $2,120.07 | | 090 | Y | |
| **27218** | Open treatment of posterior ring fracture and/or dislocation with internal fixation (includes ilium, sacroiliac joint and/or sacrum) | 33.72 | $2,815.62 | | 090 | Y | |
| **27220** | Closed treatment of acetabulum (hip socket) fracture(s); without manipulation | 12.72 | $1,062.12 | | 090 | N | |
| **27222** | Closed treatment of acetabulum (hip socket) fracture(s); with manipulation, with or without skeletal traction | 24.37 | $2,034.90 | | 090 | N | |
| **27226** | Open treatment of posterior or anterior acetabular wall fracture, with internal fixation | 24.51 | $2,046.59 | | 090 | Y | |
| **27227** | Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation | 41.66 | $3,478.61 | | 090 | Y | |
| **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 | 47.86 | $3,996.31 | | 090 | Y | |
| **27230** | Closed treatment of femoral fracture, proximal end, neck; without manipulation | 11.45 | $956.08 | | 090 | N | $155.43 |
| **27232** | Closed treatment of femoral fracture, proximal end, neck; with manipulation, with or without skeletal traction | 19.23 | $1,605.71 | | 090 | N | |
| **27235** | Percutaneous skeletal fixation of femoral fracture, proximal end, neck | 22.81 | $1,904.64 | | 090 | N | |
| **27236** | Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement | 29.25 | $2,442.38 | | 090 | Y | |
| **27238** | Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; without manipulation | 10.99 | $917.67 | | 090 | N | $155.43 |
| **27240** | Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with manipulation, with or without skin or skeletal traction | 23.59 | $1,969.77 | | 090 | N | |
| **27244** | Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage | 29.05 | $2,425.68 | | 090 | Y | |
| **27245** | Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage | 35.69 | $3,390.55 | | 090 | Y | |
| **27246** | Closed treatment of greater trochanteric fracture, without manipulation | 9.41 | $785.74 | | 090 | N | $155.43 |
| **27248** | Open treatment of greater trochanteric fracture, with or without internal or external fixation | 19.45 | $1,624.08 | | 090 | Y | |
| **27250** | Closed treatment of hip dislocation, traumatic; without anesthesia | 11.64 | $971.94 | | 090 | N | $155.43 |
| **27252** | Closed treatment of hip dislocation, traumatic; requiring anesthesia | 18.69 | $1,560.62 | | 090 | N | $669.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **27253** | Open treatment of hip dislocation, traumatic, without internal fixation | 23.77 | $1,984.80 | | 090 | Y | |
| **27254** | Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation | 31.76 | $2,651.96 | | 090 | Y | |
| **27256** | Treatment of spontaneous hip dislocation (developmental, including congenital or pathological), by abduction, splint or traction; without anesthesia, without manipulation | 7.52 | $627.92 | | 010 | N | |
| **27257** | Treatment of spontaneous hip dislocation (developmental, including congenital or pathological), by abduction, splint or traction; with manipulation, requiring anesthesia | 8.25 | $688.88 | | 010 | N | $765.00 |
| **27258** | Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc); | 27.61 | $2,305.44 | | 090 | Y | |
| **27259** | Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc); with femoral shaft shortening | 38.29 | $3,197.22 | | 090 | Y | |
| **27265** | Closed treatment of post hip arthroplasty dislocation; without anesthesia | 9.82 | $819.97 | | 090 | N | $155.43 |
| **27266** | Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia | 14.34 | $1,197.39 | | 090 | N | $669.00 |
| **27275** | Manipulation, hip joint, requiring general anesthesia | 4.50 | $375.75 | | 010 | N | $669.00 |
| **27280** | Arthrodesis, sacroiliac joint (including obtaining graft) | 25.54 | $2,132.59 | | 090 | Y | |
| **27282** | Arthrodesis, symphysis pubis (including obtaining graft) | 20.37 | $1,700.90 | | 090 | Y | |
| **27284** | Arthrodesis, hip joint (including obtaining graft); | 40.63 | $3,392.61 | | 090 | Y | |
| **27286** | Arthrodesis, hip joint (including obtaining graft); with subtrochanteric osteotomy | 40.82 | $3,408.47 | | 090 | Y | |
| **27290** | Interpelviabdominal amputation (hindquarter amputation) | 39.06 | $3,261.51 | | 090 | Y | |
| **27295** | Disarticulation of hip | 31.47 | $2,627.75 | | 090 | Y | |
| **27299** | Unlisted procedure, pelvis or hip joint | 0.00 | BR | | 000 | N | |
| **27301** | Incision and drainage, deep abscess, bursa, or hematoma, thigh or knee region | 16.64 | $1,389.44 | | 090 | N | $765.00 |
| **27303** | Incision, deep, with opening of bone cortex, femur or knee (eg, osteomyelitis or bone abscess) | 15.85 | $1,323.48 | | 090 | Y | |
| **27305** | Fasciotomy, iliotibial (tenotomy), open | 11.53 | $962.76 | | 090 | Y | $669.00 |
| **27306** | Tenotomy, percutaneous, adductor or hamstring; single tendon (separate procedure) | 9.60 | $801.60 | | 090 | Y | $765.00 |
| **27307** | Tenotomy, percutaneous, adductor or hamstring; multiple tendons | 11.65 | $972.78 | | 090 | Y | $765.00 |
| **27310** | Arthrotomy, knee, with exploration, drainage, or removal of foreign body (eg, infection) | 17.90 | $1,494.65 | | 090 | Y | $945.00 |
| **27323** | Biopsy, soft tissue of thigh or knee area; superficial | 5.97 | $498.50 | | 010 | N | $499.50 |
| **27324** | Biopsy, soft tissue of thigh or knee area; deep (subfascial or intramuscular) | 9.30 | $776.55 | | 090 | N | $499.50 |
| **27325** | Neurectomy, hamstring muscle | 12.55 | $1,047.93 | | 090 | Y | $669.00 |
| **27326** | Neurectomy, popliteal (gastrocnemius) | 11.90 | $993.65 | | 090 | Y | $669.00 |
| **27327** | Excision, tumor, thigh or knee area; subcutaneous | 10.71 | $894.29 | | 090 | N | $669.00 |
| **27328** | Excision, tumor, thigh or knee area; deep, subfascial, or intramuscular | 10.18 | $850.03 | | 090 | N | $765.00 |
| **27329** | Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area | 25.16 | $2,100.86 | | 090 | Y | $945.00 |
| **27330** | Arthrotomy, knee; with synovial biopsy only | 9.83 | $820.81 | | 090 | N | $945.00 |
| **27331** | Arthrotomy, knee; including joint exploration, biopsy, or removal of loose or foreign bodies | 11.70 | $976.95 | | 090 | Y | $945.00 |
| **27332** | Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral | 15.81 | $1,320.14 | | 090 | Y | $945.00 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **27333** | Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral | 14.38 | $1,200.73 | | 090 | Y | $945.00 |
| | **27334** | Arthrotomy, with synovectomy, knee; anterior OR posterior | 16.86 | $1,407.81 | | 090 | Y | $945.00 |
| | **27335** | Arthrotomy, with synovectomy, knee; anterior AND posterior including popliteal area | 19.07 | $1,592.35 | | 090 | Y | $945.00 |
| | **27340** | Excision, prepatellar bursa | 8.95 | $747.33 | | 090 | N | $765.00 |
| | **27345** | Excision of synovial cyst of popliteal space (eg, Baker's cyst) | 11.82 | $986.97 | | 090 | Y | $945.00 |
| | **27347** | Excision of lesion of meniscus or capsule (eg, cyst, ganglion), knee | 12.28 | $1,025.38 | | 090 | Y | $945.00 |
| | **27350** | Patellectomy or hemipatellectomy | 16.10 | $1,344.35 | | 090 | Y | $945.00 |
| | **27355** | Excision or curettage of bone cyst or benign tumor of femur; | 14.97 | $1,250.00 | | 090 | Y | $765.00 |
| | **27356** | Excision or curettage of bone cyst or benign tumor of femur; with allograft | 18.23 | $1,522.21 | | 090 | Y | $945.00 |
| | **27357** | Excision or curettage of bone cyst or benign tumor of femur; with autograft (includes obtaining graft) | 20.29 | $1,694.22 | | 090 | Y | $1,075.50 |
| + | **27358** | Excision or curettage of bone cyst or benign tumor of femur; with internal fixation (List in addition to code for primary procedure) | 7.44 | $621.24 | | 000 | Y | $1,075.50 |
| | **27360** | Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess) | 21.24 | $1,773.54 | | 090 | Y | $1,075.50 |
| | **27365** | Radical resection of tumor, bone, femur or knee | 30.33 | $2,532.56 | | 090 | Y | |
| | **27370** | Injection procedure for knee arthrography | 4.41 | $368.24 | | 000 | N | |
| | **27372** | Removal of foreign body, deep, thigh region or knee area | 15.05 | $1,256.68 | | 090 | Y | $1,492.50 |
| | **27380** | Suture of infrapatellar tendon; primary | 14.82 | $1,237.47 | | 090 | Y | $499.50 |
| | **27381** | Suture of infrapatellar tendon; secondary reconstruction, including fascial or tendon graft | 20.08 | $1,676.68 | | 090 | Y | $765.00 |
| | **27385** | Suture of quadriceps or hamstring muscle rupture; primary | 15.88 | $1,325.98 | | 090 | Y | $765.00 |
| | **27386** | Suture of quadriceps or hamstring muscle rupture; secondary reconstruction, including fascial or tendon graft | 20.87 | $1,742.65 | | 090 | Y | $765.00 |
| | **27390** | Tenotomy, open, hamstring, knee to hip; single tendon | 10.79 | $900.97 | | 090 | Y | $499.50 |
| | **27391** | Tenotomy, open, hamstring, knee to hip; multiple tendons, one leg | 14.18 | $1,184.03 | | 090 | Y | $669.00 |
| | **27392** | Tenotomy, open, hamstring, knee to hip; multiple tendons, bilateral | 17.50 | $1,461.25 | | 090 | Y | $765.00 |
| | **27393** | Lengthening of hamstring tendon; single tendon | 12.58 | $1,050.43 | | 090 | Y | $669.00 |
| | **27394** | Lengthening of hamstring tendon; multiple tendons, one leg | 16.25 | $1,356.88 | | 090 | Y | $765.00 |
| | **27395** | Lengthening of hamstring tendon; multiple tendons, bilateral | 21.93 | $1,831.16 | | 090 | Y | $765.00 |
| | **27396** | Transplant, hamstring tendon to patella; single tendon | 15.31 | $1,278.39 | | 090 | Y | $765.00 |
| | **27397** | Transplant, hamstring tendon to patella; multiple tendons | 21.93 | $1,831.16 | | 090 | Y | $765.00 |
| | **27400** | Transfer, tendon or muscle, hamstrings to femur (eg, Egger's type procedure) | 16.58 | $1,384.43 | | 090 | Y | $765.00 |
| | **27403** | Arthrotomy with meniscus repair, knee | 16.00 | $1,336.00 | | 090 | Y | $945.00 |
| | **27405** | Repair, primary, torn ligament and/or capsule, knee; collateral | 16.80 | $1,402.80 | | 090 | Y | $945.00 |
| | **27407** | Repair, primary, torn ligament and/or capsule, knee; cruciate | 19.34 | $1,614.89 | | 090 | Y | $945.00 |
| | **27409** | Repair, primary, torn ligament and/or capsule, knee; collateral and cruciate ligaments | 24.03 | $2,006.51 | | 090 | Y | $945.00 |
| | **27412** | Autologous chondrocyte implantation, knee | 40.95 | $3,419.33 | | 090 | Y | |
| | **27415** | Osteochondral allograft, knee, open | 34.55 | $2,884.93 | | 090 | Y | |
| | **27418** | Anterior tibial tubercleplasty (eg, Maquet type procedure) | 20.79 | $1,735.97 | | 090 | Y | $765.00 |
| | **27420** | Reconstruction of dislocating patella; (eg, Hauser type procedure) | 18.67 | $1,558.95 | | 090 | Y | $765.00 |
| | **27422** | Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure) | 18.60 | $1,553.10 | | 090 | Y | $1,492.50 |
| | **27424** | Reconstruction of dislocating patella; with patellectomy | 18.61 | $1,553.94 | | 090 | Y | $765.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **27425** | Lateral retinacular release, open | 10.97 | $916.00 | | 090 | N | $1,492.50 |
| **27427** | Ligamentous reconstruction (augmentation), knee; extra-articular | 17.86 | $1,491.31 | | 090 | Y | $765.00 |
| **27428** | Ligamentous reconstruction (augmentation), knee; intra-articular (open) | 27.19 | $2,270.37 | | 090 | Y | $945.00 |
| **27429** | Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular | 30.37 | $2,535.90 | | 090 | Y | $945.00 |
| **27430** | Quadricepsplasty (eg, Bennett or Thompson type) | 18.46 | $1,541.41 | | 090 | Y | $945.00 |
| **27435** | Capsulotomy, posterior capsular release, knee | 19.60 | $1,636.60 | | 090 | Y | $945.00 |
| **27437** | Arthroplasty, patella; without prosthesis | 16.41 | $1,370.24 | | 090 | N | $945.00 |
| **27438** | Arthroplasty, patella; with prosthesis | 20.86 | $1,741.81 | | 090 | Y | $1,075.50 |
| **27440** | Arthroplasty, knee, tibial plateau; | 17.98 | $1,501.33 | | 090 | Y | |
| **27441** | Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy | 19.08 | $1,593.18 | | 090 | Y | $1,075.50 |
| **27442** | Arthroplasty, femoral condyles or tibial plateau(s), knee; | 21.76 | $1,816.96 | | 090 | Y | $1,075.50 |
| **27443** | Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy | 20.46 | $1,708.41 | | 090 | Y | $1,075.50 |
| **27445** | Arthroplasty, knee, hinge prosthesis (eg, Walldius type) | 31.66 | $2,643.61 | | 090 | Y | |
| **27446** | Arthroplasty, knee, condyle and plateau; medial OR lateral compartment | 28.24 | $2,358.04 | | 090 | Y | |
| **27447** | Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) | 38.66 | $3,228.11 | | 090 | Y | |
| **27448** | Osteotomy, femur, shaft or supracondylar; without fixation | 20.60 | $1,720.10 | | 090 | Y | |
| **27450** | Osteotomy, femur, shaft or supracondylar; with fixation | 25.59 | $2,136.77 | | 090 | Y | |
| **27454** | Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft (eg, Sofield type procedure) | 32.26 | $2,693.71 | | 090 | Y | |
| **27455** | Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus (bowleg) or genu valgus (knock-knee)); before epiphyseal closure | 23.68 | $1,977.28 | | 090 | Y | |
| **27457** | Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus (bowleg) or genu valgus (knock-knee)); after epiphyseal closure | 24.38 | $2,035.73 | | 090 | Y | |
| **27465** | Osteoplasty, femur; shortening (excluding 64876) | 29.33 | $2,449.06 | | 090 | Y | |
| **27466** | Osteoplasty, femur; lengthening | 29.61 | $2,472.44 | | 090 | Y | |
| **27468** | Osteoplasty, femur; combined, lengthening and shortening with femoral segment transfer | 33.24 | $2,775.54 | | 090 | Y | |
| **27470** | Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique) | 29.47 | $2,460.75 | | 090 | Y | |
| **27472** | Repair, nonunion or malunion, femur, distal to head and neck; with iliac or other autogenous bone graft (includes obtaining graft) | 31.98 | $2,670.33 | | 090 | Y | |
| **27475** | Arrest, epiphyseal, any method (eg, epiphysiodesis); distal femur | 16.42 | $1,371.07 | | 090 | N | |
| **27477** | Arrest, epiphyseal, any method (eg, epiphysiodesis); tibia and fibula, proximal | 18.23 | $1,522.21 | | 090 | N | |
| **27479** | Arrest, epiphyseal, any method (eg, epiphysiodesis); combined distal femur, proximal tibia and fibula | 23.02 | $1,922.17 | | 090 | Y | |
| **27485** | Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (eg, genu varus or valgus) | 16.76 | $1,399.46 | | 090 | N | |
| **27486** | Revision of total knee arthroplasty, with or without allograft; one component | 35.26 | $2,944.21 | | 090 | Y | |
| **27487** | Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component | 44.57 | $3,721.60 | | 090 | Y | |
| **27488** | Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee | 29.77 | $2,485.80 | | 090 | Y | |
| **27495** | Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femur | 28.46 | $2,376.41 | | 090 | Y | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **27496** | Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor); | 12.44 | $1,038.74 | | 090 | N | $1,075.50 |
| **27497** | Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor); with debridement of nonviable muscle and/or nerve | 13.32 | $1,112.22 | | 090 | Y | $765.00 |
| **27498** | Decompression fasciotomy, thigh and/or knee, multiple compartments; | 14.73 | $1,229.96 | | 090 | Y | $765.00 |
| **27499** | Decompression fasciotomy, thigh and/or knee, multiple compartments; with debridement of nonviable muscle and/or nerve | 16.42 | $1,371.07 | | 090 | Y | $765.00 |
| **27500** | Closed treatment of femoral shaft fracture, without manipulation | 12.56 | $1,048.76 | | 090 | N | $155.43 |
| **27501** | Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, without manipulation | 12.34 | $1,030.39 | | 090 | N | $155.43 |
| **27502** | Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction | 19.72 | $1,646.62 | | 090 | N | $155.43 |
| **27503** | Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, with manipulation, with or without skin or skeletal traction | 19.90 | $1,661.65 | | 090 | Y | $155.43 |
| **27506** | Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws | 32.91 | $2,747.99 | | 090 | Y | |
| **27507** | Open treatment of femoral shaft fracture with plate/screws, with or without cerclage | 24.81 | $2,071.64 | | 090 | Y | |
| **27508** | Closed treatment of femoral fracture, distal end, medial or lateral condyle, without manipulation | 12.71 | $1,061.29 | | 090 | N | $155.43 |
| **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 | 16.16 | $1,349.36 | | 090 | Y | $765.00 |
| **27510** | Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation | 17.33 | $1,447.06 | | 090 | N | $155.43 |
| **27511** | Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, with or without internal or external fixation | 25.60 | $2,137.60 | | 090 | Y | |
| **27513** | Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, with or without internal or external fixation | 34.00 | $2,839.00 | | 090 | Y | |
| **27514** | Open treatment of femoral fracture, distal end, medial or lateral condyle, with or without internal or external fixation | 33.20 | $2,772.20 | | 090 | Y | |
| **27516** | Closed treatment of distal femoral epiphyseal separation; without manipulation | 11.90 | $993.65 | | 090 | N | $155.43 |
| **27517** | Closed treatment of distal femoral epiphyseal separation; with manipulation, with or without skin or skeletal traction | 16.41 | $1,370.24 | | 090 | Y | $155.43 |
| **27519** | Open treatment of distal femoral epiphyseal separation, with or without internal or external fixation | 27.94 | $2,332.99 | | 090 | Y | |
| **27520** | Closed treatment of patellar fracture, without manipulation | 7.54 | $629.59 | | 090 | N | $155.43 |
| **27524** | Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair | 18.89 | $1,577.32 | | 090 | Y | |
| **27530** | Closed treatment of tibial fracture, proximal (plateau); without manipulation | 9.41 | $785.74 | | 090 | N | $155.43 |
| **27532** | Closed treatment of tibial fracture, proximal (plateau); with or without manipulation, with skeletal traction | 15.07 | $1,258.35 | | 090 | N | $155.43 |
| **27535** | Open treatment of tibial fracture, proximal (plateau); unicondylar, with or without internal or external fixation | 22.27 | $1,859.55 | | 090 | Y | |
| **27536** | Open treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal fixation | 29.49 | $2,462.42 | | 090 | Y | |
| **27538** | Closed treatment of intercondylar spine(s) and/or tuberosity fracture(s) of knee, with or without manipulation | 11.27 | $941.05 | | 090 | N | $155.43 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **27540** | Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without internal or external fixation | 23.53 | $1,964.76 | | 090 | Y | |
| **27550** | Closed treatment of knee dislocation; without anesthesia | 11.85 | $989.48 | | 090 | N | $155.43 |
| **27552** | Closed treatment of knee dislocation; requiring anesthesia | 15.34 | $1,280.89 | | 090 | Y | $499.50 |
| **27556** | Open treatment of knee dislocation, with or without internal or external fixation; without primary ligamentous repair or augmentation/reconstruction | 27.04 | $2,257.84 | | 090 | Y | |
| **27557** | Open treatment of knee dislocation, with or without internal or external fixation; with primary ligamentous repair | 31.05 | $2,592.68 | | 090 | Y | |
| **27558** | Open treatment of knee dislocation, with or without internal or external fixation; with primary ligamentous repair, with augmentation/reconstruction | 31.74 | $2,650.29 | | 090 | Y | |
| **27560** | Closed treatment of patellar dislocation; without anesthesia | 8.50 | $709.75 | | 090 | N | $155.43 |
| **27562** | Closed treatment of patellar dislocation; requiring anesthesia | 10.90 | $910.15 | | 090 | N | $499.50 |
| **27566** | Open treatment of patellar dislocation, with or without partial or total patellectomy | 22.41 | $1,871.24 | | 090 | Y | $669.00 |
| **27570** | Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices) | 3.61 | $301.44 | | 010 | N | $499.50 |
| **27580** | Arthrodesis, knee, any technique | 36.38 | $3,037.73 | | 090 | Y | |
| **27590** | Amputation, thigh, through femur, any level; | 20.29 | $1,694.22 | | 090 | Y | |
| **27591** | Amputation, thigh, through femur, any level; immediate fitting technique including first cast | 22.80 | $1,903.80 | | 090 | Y | |
| **27592** | Amputation, thigh, through femur, any level; open, circular (guillotine) | 17.22 | $1,437.87 | | 090 | Y | |
| **27594** | Amputation, thigh, through femur, any level; secondary closure or scar revision | 12.54 | $1,047.09 | | 090 | N | $765.00 |
| **27596** | Amputation, thigh, through femur, any level; re-amputation | 18.22 | $1,521.37 | | 090 | N | |
| **27598** | Disarticulation at knee | 18.47 | $1,542.25 | | 090 | Y | |
| **27599** | Unlisted procedure, femur or knee | 0.00 | BR | | 000 | N | |
| **27600** | Decompression fasciotomy, leg; anterior and/or lateral compartments only | 10.56 | $881.76 | | 090 | N | $765.00 |
| **27601** | Decompression fasciotomy, leg; posterior compartment(s) only | 10.84 | $905.14 | | 090 | N | $765.00 |
| **27602** | Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s) | 12.97 | $1,083.00 | | 090 | Y | $765.00 |
| **27603** | Incision and drainage, leg or ankle; deep abscess or hematoma | 12.71 | $1,061.29 | | 090 | N | $669.00 |
| **27604** | Incision and drainage, leg or ankle; infected bursa | 10.93 | $912.66 | | 090 | N | $669.00 |
| **27605** | Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia | 10.09 | $842.52 | | 010 | N | $499.50 |
| **27606** | Tenotomy, percutaneous, Achilles tendon (separate procedure); general anesthesia | 7.61 | $635.44 | | 010 | N | $499.50 |
| **27607** | Incision (eg, osteomyelitis or bone abscess), leg or ankle | 15.04 | $1,255.84 | | 090 | N | $669.00 |
| **27610** | Arthrotomy, ankle, including exploration, drainage, or removal of foreign body | 16.30 | $1,361.05 | | 090 | N | $669.00 |
| **27612** | Arthrotomy, posterior capsular release, ankle, with or without Achilles tendon lengthening | 14.25 | $1,189.88 | | 090 | Y | $765.00 |
| **27613** | Biopsy, soft tissue of leg or ankle area; superficial | 5.56 | $464.26 | | 010 | N | |
| **27614** | Biopsy, soft tissue of leg or ankle area; deep (subfascial or intramuscular) | 13.24 | $1,105.54 | | 090 | N | $669.00 |
| **27615** | Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area | 22.54 | $1,882.09 | | 090 | Y | $765.00 |
| **27618** | Excision, tumor, leg or ankle area; subcutaneous tissue | 11.44 | $955.24 | | 090 | N | $669.00 |
| **27619** | Excision, tumor, leg or ankle area; deep (subfascial or intramuscular) | 18.52 | $1,546.42 | | 090 | N | $765.00 |
| **27620** | Arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of loose or foreign body | 11.65 | $972.78 | | 090 | Y | $945.00 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **27625** | Arthrotomy, with synovectomy, ankle; | 15.06 | $1,257.51 | | 090 | Y | $945.00 |
| | **27626** | Arthrotomy, with synovectomy, ankle; including tenosynovectomy | 16.25 | $1,356.88 | | 090 | Y | $945.00 |
| | **27630** | Excision of lesion of tendon sheath or capsule (eg, cyst or ganglion), leg and/or ankle | 12.76 | $1,065.46 | | 090 | N | $765.00 |
| | **27635** | Excision or curettage of bone cyst or benign tumor, tibia or fibula; | 14.90 | $1,244.15 | | 090 | N | $765.00 |
| | **27637** | Excision or curettage of bone cyst or benign tumor, tibia or fibula; with autograft (includes obtaining graft) | 18.83 | $1,572.31 | | 090 | Y | $765.00 |
| | **27638** | Excision or curettage of bone cyst or benign tumor, tibia or fibula; with allograft | 19.60 | $1,636.60 | | 090 | Y | $765.00 |
| | **27640** | Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis or exostosis); tibia | 22.56 | $1,883.76 | | 090 | N | $669.00 |
| | **27641** | Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis or exostosis); fibula | 18.17 | $1,517.20 | | 090 | N | $669.00 |
| | **27645** | Radical resection of tumor, bone; tibia | 27.13 | $2,265.36 | | 090 | Y | |
| | **27646** | Radical resection of tumor, bone; fibula | 24.33 | $2,031.56 | | 090 | Y | |
| | **27647** | Radical resection of tumor, bone; talus or calcaneus | 20.70 | $1,728.45 | | 090 | Y | $765.00 |
| | **27648** | Injection procedure for ankle arthrography | 4.24 | $354.04 | | 000 | N | |
| | **27650** | Repair, primary, open or percutaneous, ruptured Achilles tendon; | 17.75 | $1,482.13 | | 090 | Y | $765.00 |
| | **27652** | Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft) | 18.94 | $1,581.49 | | 090 | N | $765.00 |
| | **27654** | Repair, secondary, Achilles tendon, with or without graft | 17.72 | $1,479.62 | | 090 | Y | $765.00 |
| | **27656** | Repair, fascial defect of leg | 13.26 | $1,107.21 | | 090 | Y | $669.00 |
| | **27658** | Repair, flexor tendon, leg; primary, without graft, each tendon | 9.71 | $810.79 | | 090 | Y | $499.50 |
| | **27659** | Repair, flexor tendon, leg; secondary, with or without graft, each tendon | 12.84 | $1,072.14 | | 090 | Y | $669.00 |
| | **27664** | Repair, extensor tendon, leg; primary, without graft, each tendon | 9.33 | $779.06 | | 090 | N | $669.00 |
| | **27665** | Repair, extensor tendon, leg; secondary, with or without graft, each tendon | 10.65 | $889.28 | | 090 | Y | $669.00 |
| | **27675** | Repair, dislocating peroneal tendons; without fibular osteotomy | 13.11 | $1,094.69 | | 090 | Y | $669.00 |
| | **27676** | Repair, dislocating peroneal tendons; with fibular osteotomy | 15.62 | $1,304.27 | | 090 | Y | $765.00 |
| | **27680** | Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon | 11.07 | $924.35 | | 090 | N | $765.00 |
| | **27681** | Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision(s)) | 13.02 | $1,087.17 | | 090 | N | $669.00 |
| | **27685** | Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure) | 14.56 | $1,215.76 | | 090 | Y | $765.00 |
| | **27686** | Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each | 14.33 | $1,196.56 | | 090 | N | $765.00 |
| | **27687** | Gastrocnemius recession (eg, Strayer procedure) | 11.79 | $984.47 | | 090 | Y | $765.00 |
| | **27690** | Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot) | 15.54 | $1,297.59 | | 090 | Y | $945.00 |
| | **27691** | Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot) | 18.40 | $1,536.40 | | 090 | Y | $945.00 |
| + | **27692** | Transfer or transplant of single tendon (with muscle redirection or rerouting); each additional tendon (List separately in addition to code for primary procedure) | 2.88 | $240.48 | | 000 | Y | $765.00 |
| | **27695** | Repair, primary, disrupted ligament, ankle; collateral | 12.63 | $1,054.61 | | 090 | N | $669.00 |
| | **27696** | Repair, primary, disrupted ligament, ankle; both collateral ligaments | 15.08 | $1,259.18 | | 090 | N | $669.00 |
| | **27698** | Repair, secondary, disrupted ligament, ankle, collateral (eg, Watson-Jones procedure) | 16.71 | $1,395.29 | | 090 | Y | $669.00 |
| | **27700** | Arthroplasty, ankle; | 15.44 | $1,289.24 | | 090 | Y | $1,075.50 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **27702** | Arthroplasty, ankle; with implant (total ankle) | 25.26 | $2,109.21 | | 090 | Y | |
| **27703** | Arthroplasty, ankle; revision, total ankle | 28.78 | $2,403.13 | | 090 | Y | |
| **27704** | Removal of ankle implant | 13.81 | $1,153.14 | | 090 | N | $669.00 |
| **27705** | Osteotomy; tibia | 19.34 | $1,614.89 | | 090 | Y | $669.00 |
| **27707** | Osteotomy; fibula | 9.79 | $817.47 | | 090 | N | $669.00 |
| **27709** | Osteotomy; tibia and fibula | 25.92 | $2,164.32 | | 090 | Y | $669.00 |
| **27712** | Osteotomy; multiple, with realignment on intramedullary rod (eg, Sofield type procedure) | 26.93 | $2,248.66 | | 090 | Y | |
| **27715** | Osteoplasty, tibia and fibula, lengthening or shortening | 26.65 | $2,225.28 | | 090 | Y | |
| **27720** | Repair of nonunion or malunion, tibia; without graft, (eg, compression technique) | 22.09 | $1,844.52 | | 090 | Y | |
| **27722** | Repair of nonunion or malunion, tibia; with sliding graft | 22.00 | $1,837.00 | | 090 | Y | |
| **27724** | Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft) | 32.29 | $2,696.22 | | 090 | Y | |
| **27725** | Repair of nonunion or malunion, tibia; by synostosis, with fibula, any method | 29.73 | $2,482.46 | | 090 | Y | |
| **27727** | Repair of congenital pseudarthrosis, tibia | 25.57 | $2,135.10 | | 090 | Y | |
| **27730** | Arrest, epiphyseal (epiphysiodesis), open; distal tibia | 14.71 | $1,228.29 | | 090 | N | $669.00 |
| **27732** | Arrest, epiphyseal (epiphysiodesis), open; distal fibula | 10.47 | $874.25 | | 090 | N | $669.00 |
| **27734** | Arrest, epiphyseal (epiphysiodesis), open; distal tibia and fibula | 15.46 | $1,290.91 | | 090 | N | $669.00 |
| **27740** | Arrest, epiphyseal (epiphysiodesis), any method, combined, proximal and distal tibia and fibula; | 17.82 | $1,487.97 | | 090 | Y | $669.00 |
| **27742** | Arrest, epiphyseal (epiphysiodesis), any method, combined, proximal and distal tibia and fibula; and distal femur | 16.88 | $1,409.48 | | 090 | Y | $669.00 |
| **27745** | Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, tibia | 18.98 | $1,584.83 | | 090 | Y | $765.00 |
| **27750** | Closed treatment of tibial shaft fracture (with or without fibular fracture); without manipulation | 8.13 | $678.86 | | 090 | N | $155.43 |
| **27752** | Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation, with or without skeletal traction | 13.02 | $1,087.17 | | 090 | N | $155.43 |
| **27756** | Percutaneous skeletal fixation of tibial shaft fracture (with or without fibular fracture) (eg, pins or screws) | 14.05 | $1,173.18 | | 090 | Y | $765.00 |
| **27758** | Open treatment of tibial shaft fracture, (with or without fibular fracture) with plate/screws, with or without cerclage | 22.10 | $1,845.35 | | 090 | Y | $945.00 |
| **27759** | Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage | 25.18 | $2,102.53 | | 090 | Y | $945.00 |
| **27760** | Closed treatment of medial malleolus fracture; without manipulation | 7.84 | $654.64 | | 090 | N | $155.43 |
| **27762** | Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction | 11.78 | $983.63 | | 090 | N | $155.43 |
| **27766** | Open treatment of medial malleolus fracture, with or without internal or external fixation | 16.28 | $1,359.38 | | 090 | N | $765.00 |
| **27780** | Closed treatment of proximal fibula or shaft fracture; without manipulation | 6.97 | $582.00 | | 090 | N | $155.43 |
| **27781** | Closed treatment of proximal fibula or shaft fracture; with manipulation | 10.11 | $844.19 | | 090 | N | $155.43 |
| **27784** | Open treatment of proximal fibula or shaft fracture, with or without internal or external fixation | 14.15 | $1,181.53 | | 090 | N | $765.00 |
| **27786** | Closed treatment of distal fibular fracture (lateral malleolus); without manipulation | 7.44 | $621.24 | | 090 | N | $155.43 |
| **27788** | Closed treatment of distal fibular fracture (lateral malleolus); with manipulation | 10.29 | $859.22 | | 090 | N | $155.43 |
| **27792** | Open treatment of distal fibular fracture (lateral malleolus), with or without internal or external fixation | 15.14 | $1,264.19 | | 090 | N | $765.00 |
| **27808** | Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation | 7.78 | $649.63 | | 090 | N | $155.43 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **27810** | Closed treatment of bimalleolar ankle fracture, (including Potts); with manipulation | 11.55 | $964.43 | | 090 | N | $155.43 |
| **27814** | Open treatment of bimalleolar ankle fracture, with or without internal or external fixation | 20.09 | $1,908.55 | | 090 | Y | $765.00 |
| **27816** | Closed treatment of trimalleolar ankle fracture; without manipulation | 7.38 | $616.23 | | 090 | N | $155.43 |
| **27818** | Closed treatment of trimalleolar ankle fracture; with manipulation | 11.97 | $999.50 | | 090 | N | $155.43 |
| **27822** | Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; without fixation of posterior lip | 23.03 | $1,923.01 | | 090 | Y | $765.00 |
| **27823** | Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip | 26.08 | $2,177.68 | | 090 | Y | $765.00 |
| **27824** | Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; without manipulation | 7.31 | $610.39 | | 090 | N | $155.43 |
| **27825** | Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation | 13.38 | $1,117.23 | | 090 | N | $155.43 |
| **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 | 17.91 | $1,495.49 | | 090 | Y | $765.00 |
| **27827** | Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of tibia only | 28.89 | $2,412.32 | | 090 | Y | $765.00 |
| **27828** | Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of both tibia and fibula | 32.73 | $2,732.96 | | 090 | Y | $945.00 |
| **27829** | Open treatment of distal tibiofibular joint (syndesmosis) disruption, with or without internal or external fixation | 12.53 | $1,046.26 | | 090 | Y | $669.00 |
| **27830** | Closed treatment of proximal tibiofibular joint dislocation; without anesthesia | 8.37 | $698.90 | | 090 | N | $155.43 |
| **27831** | Closed treatment of proximal tibiofibular joint dislocation; requiring anesthesia | 9.24 | $771.54 | | 090 | N | $155.43 |
| **27832** | Open treatment of proximal tibiofibular joint dislocation, with or without internal or external fixation, or with excision of proximal fibula | 12.85 | $1,072.98 | | 090 | Y | $669.00 |
| **27840** | Closed treatment of ankle dislocation; without anesthesia | 8.37 | $698.90 | | 090 | N | $155.43 |
| **27842** | Closed treatment of ankle dislocation; requiring anesthesia, with or without percutaneous skeletal fixation | 11.77 | $982.80 | | 090 | N | $499.50 |
| **27846** | Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; without repair or internal fixation | 18.52 | $1,546.42 | | 090 | Y | $765.00 |
| **27848** | Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; with repair or internal or external fixation | 21.57 | $1,801.10 | | 090 | Y | $765.00 |
| **27860** | Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus) | 4.42 | $369.07 | | 010 | Y | $499.50 |
| **27870** | Arthrodesis, ankle, open | 26.25 | $2,191.88 | | 090 | Y | $945.00 |
| **27871** | Arthrodesis, tibiofibular joint, proximal or distal | 17.38 | $1,451.23 | | 090 | Y | $945.00 |
| **27880** | Amputation, leg, through tibia and fibula; | 22.51 | $1,879.59 | | 090 | Y | |
| **27881** | Amputation, leg, through tibia and fibula; with immediate fitting technique including application of first cast | 22.47 | $1,876.25 | | 090 | Y | |
| **27882** | Amputation, leg, through tibia and fibula; open, circular (guillotine) | 16.23 | $1,355.21 | | 090 | Y | |
| **27884** | Amputation, leg, through tibia and fibula; secondary closure or scar revision | 14.58 | $1,217.43 | | 090 | N | $765.00 |
| **27886** | Amputation, leg, through tibia and fibula; re-amputation | 16.61 | $1,386.94 | | 090 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **27888** | Amputation, ankle, through malleoli of tibia and fibula (eg, Syme, Pirogoff type procedures), with plastic closure and resection of nerves | 17.90 | $1,494.65 | | 090 | Y | |
| **27889** | Ankle disarticulation | 17.29 | $1,443.72 | | 090 | N | $765.00 |
| **27892** | Decompression fasciotomy, leg; anterior and/or lateral compartments only, with debridement of nonviable muscle and/or nerve | 13.54 | $1,130.59 | | 090 | Y | $765.00 |
| **27893** | Decompression fasciotomy, leg; posterior compartment(s) only, with debridement of nonviable muscle and/or nerve | 13.48 | $1,125.58 | | 090 | Y | $765.00 |
| **27894** | Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s), with debridement of nonviable muscle and/or nerve | 20.49 | $1,710.92 | | 090 | Y | $765.00 |
| **27899** | Unlisted procedure, leg or ankle | 0.00 | BR | | 000 | N | |
| **28001** | Incision and drainage, bursa, foot | 6.05 | $505.18 | | 010 | N | |
| **28002** | Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space | 11.25 | $939.38 | | 010 | N | $765.00 |
| **28003** | Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas | 15.81 | $1,320.14 | | 090 | N | $765.00 |
| **28005** | Incision, bone cortex (eg, osteomyelitis or bone abscess), foot | 15.44 | $1,289.24 | | 090 | N | $765.00 |
| **28008** | Fasciotomy, foot and/or toe | 9.59 | $800.77 | | 090 | N | $765.00 |
| **28010** | Tenotomy, percutaneous, toe; single tendon | 5.46 | $455.91 | | 090 | N | |
| **28011** | Tenotomy, percutaneous, toe; multiple tendons | 7.80 | $651.30 | | 090 | N | $765.00 |
| **28020** | Arthrotomy, including exploration, drainage, or removal of loose or foreign body; intertarsal or tarsometatarsal joint | 11.67 | $974.45 | | 090 | N | $669.00 |
| **28022** | Arthrotomy, including exploration, drainage, or removal of loose or foreign body; metatarsophalangeal joint | 10.50 | $876.75 | | 090 | N | $669.00 |
| **28024** | Arthrotomy, including exploration, drainage, or removal of loose or foreign body; interphalangeal joint | 10.15 | $847.53 | | 090 | N | $669.00 |
| **28035** | Release, tarsal tunnel (posterior tibial nerve decompression) | 11.59 | $967.77 | | 090 | N | $945.00 |
| **28043** | Excision, tumor, foot; subcutaneous tissue | 7.75 | $647.13 | | 090 | N | $669.00 |
| **28045** | Excision, tumor, foot; deep, subfascial, intramuscular | 10.73 | $895.96 | | 090 | N | $765.00 |
| **28046** | Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot | 20.05 | $1,674.18 | | 090 | N | $765.00 |
| **28050** | Arthrotomy with biopsy; intertarsal or tarsometatarsal joint | 9.87 | $824.15 | | 090 | N | $669.00 |
| **28052** | Arthrotomy with biopsy; metatarsophalangeal joint | 9.41 | $785.74 | | 090 | N | $669.00 |
| **28054** | Arthrotomy with biopsy; interphalangeal joint | 8.70 | $726.45 | | 090 | N | $669.00 |
| **28055** | Neurectomy, intrinsic musculature of foot | 9.94 | $829.99 | | 090 | Y | $945.00 |
| **28060** | Fasciectomy, plantar fascia; partial (separate procedure) | 11.36 | $948.56 | | 090 | N | $669.00 |
| **28062** | Fasciectomy, plantar fascia; radical (separate procedure) | 13.62 | $1,137.27 | | 090 | N | $765.00 |
| **28070** | Synovectomy; intertarsal or tarsometatarsal joint, each | 11.09 | $926.02 | | 090 | N | $765.00 |
| **28072** | Synovectomy; metatarsophalangeal joint, each | 10.89 | $909.32 | | 090 | N | $765.00 |
| **28080** | Excision, interdigital (Morton) neuroma, single, each | 10.42 | $870.07 | | 090 | N | $765.00 |
| **28086** | Synovectomy, tendon sheath, foot; flexor | 13.04 | $1,088.84 | | 090 | Y | $669.00 |
| **28088** | Synovectomy, tendon sheath, foot; extensor | 10.18 | $850.03 | | 090 | N | $669.00 |
| **28090** | Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (eg, cyst or ganglion); foot | 10.17 | $849.20 | | 090 | N | $765.00 |
| **28092** | Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (eg, cyst or ganglion); toe(s), each | 9.36 | $781.56 | | 090 | N | $765.00 |
| **28100** | Excision or curettage of bone cyst or benign tumor, talus or calcaneus; | 13.99 | $1,168.17 | | 090 | Y | $669.00 |
| **28102** | Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with iliac or other autograft (includes obtaining graft) | 13.87 | $1,158.15 | | 090 | Y | $765.00 |
| **28103** | Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with allograft | 11.32 | $945.22 | | 090 | Y | $765.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **28104** | Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; | 11.29 | $942.72 | | 090 | Y | $669.00 |
| **28106** | Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with iliac or other autograft (includes obtaining graft) | 11.92 | $995.32 | | 090 | Y | $765.00 |
| **28107** | Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with allograft | 12.66 | $1,057.11 | | 090 | Y | $765.00 |
| **28108** | Excision or curettage of bone cyst or benign tumor, phalanges of foot | 9.37 | $782.40 | | 090 | N | $669.00 |
| **28110** | Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure) | 9.91 | $827.49 | | 090 | N | $765.00 |
| **28111** | Ostectomy, complete excision; first metatarsal head | 11.77 | $982.80 | | 090 | N | $765.00 |
| **28112** | Ostectomy, complete excision; other metatarsal head (second, third or fourth) | 10.87 | $907.65 | | 090 | N | $765.00 |
| **28113** | Ostectomy, complete excision; fifth metatarsal head | 12.58 | $1,050.43 | | 090 | N | $765.00 |
| **28114** | Ostectomy, complete excision; all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (eg, Clayton type procedure) | 23.93 | $1,998.16 | | 090 | Y | $765.00 |
| **28116** | Ostectomy, excision of tarsal coalition | 16.56 | $1,382.76 | | 090 | N | $765.00 |
| **28118** | Ostectomy, calcaneus; | 12.93 | $1,079.66 | | 090 | Y | $945.00 |
| **28119** | Ostectomy, calcaneus; for spur, with or without plantar fascial release | 11.49 | $959.42 | | 090 | N | $945.00 |
| **28120** | Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus | 13.34 | $1,113.89 | | 090 | N | $1,492.50 |
| **28122** | Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus | 15.05 | $1,256.68 | | 090 | Y | $765.00 |
| **28124** | Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe | 10.45 | $872.58 | | 090 | N | |
| **28126** | Resection, partial or complete, phalangeal base, each toe | 8.31 | $693.89 | | 090 | N | $765.00 |
| **28130** | Talectomy (astragalectomy) | 16.14 | $1,347.69 | | 090 | Y | $765.00 |
| **28140** | Metatarsectomy | 14.63 | $1,221.61 | | 090 | N | $765.00 |
| **28150** | Phalangectomy, toe, each toe | 9.49 | $792.42 | | 090 | N | $765.00 |
| **28153** | Resection, condyle(s), distal end of phalanx, each toe | 8.60 | $718.10 | | 090 | N | $765.00 |
| **28160** | Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each | 8.93 | $745.66 | | 090 | N | $765.00 |
| **28171** | Radical resection of tumor, bone; tarsal (except talus or calcaneus) | 15.61 | $1,303.44 | | 090 | Y | $765.00 |
| **28173** | Radical resection of tumor, bone; metatarsal | 17.18 | $1,434.53 | | 090 | N | $765.00 |
| **28175** | Radical resection of tumor, bone; phalanx of toe | 12.36 | $1,032.06 | | 090 | N | $765.00 |
| **28190** | Removal of foreign body, foot; subcutaneous | 5.55 | $463.43 | | 010 | N | |
| **28192** | Removal of foreign body, foot; deep | 10.63 | $887.61 | | 090 | N | $669.00 |
| **28193** | Removal of foreign body, foot; complicated | 11.99 | $1,001.17 | | 090 | N | $627.74 |
| **28200** | Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon | 10.35 | $864.23 | | 090 | N | $765.00 |
| **28202** | Repair, tendon, flexor, foot; secondary with free graft, each tendon (includes obtaining graft) | 14.59 | $1,218.27 | | 090 | Y | $765.00 |
| **28208** | Repair, tendon, extensor, foot; primary or secondary, each tendon | 9.85 | $822.48 | | 090 | N | $765.00 |
| **28210** | Repair, tendon, extensor, foot; secondary with free graft, each tendon (includes obtaining graft) | 13.14 | $1,097.19 | | 090 | Y | $765.00 |
| **28220** | Tenolysis, flexor, foot; single tendon | 9.81 | $819.14 | | 090 | N | |
| **28222** | Tenolysis, flexor, foot; multiple tendons | 11.46 | $956.91 | | 090 | N | $499.50 |
| **28225** | Tenolysis, extensor, foot; single tendon | 8.52 | $711.42 | | 090 | N | $499.50 |

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|---|---|---|---|---|---|---|---|
| **28226** | Tenolysis, extensor, foot; multiple tendons | 10.05 | $839.18 | | 090 | N | $499.50 |
| **28230** | Tenotomy, open, tendon flexor; foot, single or multiple tendon(s) (separate procedure) | 9.49 | $792.42 | | 090 | N | |
| **28232** | Tenotomy, open, tendon flexor; toe, single tendon (separate procedure) | 8.41 | $702.24 | | 090 | N | |
| **28234** | Tenotomy, open, extensor, foot or toe, each tendon | 8.61 | $718.94 | | 090 | N | $669.00 |
| **28238** | Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure) | 15.66 | $1,307.61 | | 090 | Y | $765.00 |
| **28240** | Tenotomy, lengthening, or release, abductor hallucis muscle | 9.63 | $804.11 | | 090 | N | $669.00 |
| **28250** | Division of plantar fascia and muscle (eg, Steindler stripping) (separate procedure) | 12.28 | $1,025.38 | | 090 | Y | $765.00 |
| **28260** | Capsulotomy, midfoot; medial release only (separate procedure) | 15.32 | $1,279.22 | | 090 | Y | $765.00 |
| **28261** | Capsulotomy, midfoot; with tendon lengthening | 22.35 | $1,866.23 | | 090 | Y | $765.00 |
| **28262** | Capsulotomy, midfoot; extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (eg, resistant clubfoot deformity) | 31.97 | $2,669.50 | | 090 | Y | $945.00 |
| **28264** | Capsulotomy, midtarsal (eg, Heyman type procedure) | 19.43 | $1,622.41 | | 090 | Y | $499.50 |
| **28270** | Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure) | 10.38 | $866.73 | | 090 | N | $765.00 |
| **28272** | Capsulotomy; interphalangeal joint, each joint (separate procedure) | 8.52 | $711.42 | | 090 | N | |
| **28280** | Syndactylization, toes (eg, webbing or Kelikian type procedure) | 11.97 | $999.50 | | 090 | N | $669.00 |
| **28285** | Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy) | 10.11 | $844.19 | | 090 | N | $765.00 |
| **28286** | Correction, cock-up fifth toe, with plastic skin closure (eg, Ruiz-Mora type procedure) | 9.95 | $830.83 | | 090 | N | $945.00 |
| **28288** | Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head | 12.50 | $1,043.75 | | 090 | N | $765.00 |
| **28289** | Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint | 16.68 | $1,392.78 | | 090 | Y | $765.00 |
| **28290** | Correction, hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (eg, Silver type procedure) | 12.71 | $1,061.29 | | 090 | N | $669.00 |
| **28292** | Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride, or Mayo type procedure | 16.96 | $1,416.16 | | 090 | Y | $669.00 |
| **28293** | Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant | 22.83 | $1,906.31 | | 090 | Y | $765.00 |
| **28294** | Correction, hallux valgus (bunion), with or without sesamoidectomy; with tendon transplants (eg, Joplin type procedure) | 16.73 | $1,396.96 | | 090 | Y | $765.00 |
| **28296** | Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures) | 18.10 | $1,511.35 | | 090 | Y | $765.00 |
| **28297** | Correction, hallux valgus (bunion), with or without sesamoidectomy; Lapidus-type procedure | 19.03 | $1,589.01 | | 090 | Y | $765.00 |
| **28298** | Correction, hallux valgus (bunion), with or without sesamoidectomy; by phalanx osteotomy | 15.99 | $1,335.17 | | 090 | Y | $765.00 |
| **28299** | Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy | 20.85 | $1,740.98 | | 090 | Y | $1,075.50 |
| **28300** | Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation | 16.99 | $1,418.67 | | 090 | Y | $669.00 |
| **28302** | Osteotomy; talus | 16.68 | $1,392.78 | | 090 | Y | $669.00 |
| **28304** | Osteotomy, tarsal bones, other than calcaneus or talus; | 17.99 | $1,502.17 | | 090 | Y | $669.00 |
| **28305** | Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (eg, Fowler type) | 17.30 | $1,444.55 | | 090 | Y | $765.00 |
| **28306** | Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal | 13.38 | $1,117.23 | | 090 | Y | $945.00 |

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|---|---|---|---|---|---|---|---|
| **28307** | Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe) | 17.30 | $1,444.55 | | 090 | Y | $945.00 |
| **28308** | Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each | 11.82 | $986.97 | | 090 | Y | $669.00 |
| **28309** | Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure) | 22.54 | $1,882.09 | | 090 | Y | $945.00 |
| **28310** | Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure) | 11.83 | $987.81 | | 090 | N | $765.00 |
| **28312** | Osteotomy, shortening, angular or rotational correction; other phalanges, any toe | 10.70 | $893.45 | | 090 | N | $765.00 |
| **28313** | Reconstruction, angular deformity of toe, soft tissue procedures only (eg, overlapping second toe, fifth toe, curly toes) | 11.08 | $925.18 | | 090 | N | $669.00 |
| **28315** | Sesamoidectomy, first toe (separate procedure) | 10.41 | $869.24 | | 090 | N | $945.00 |
| **28320** | Repair, nonunion or malunion; tarsal bones | 16.24 | $1,356.04 | | 090 | Y | $945.00 |
| **28322** | Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft) | 18.22 | $1,521.37 | | 090 | Y | $945.00 |
| **28340** | Reconstruction, toe, macrodactyly; soft tissue resection | 14.03 | $1,171.51 | | 090 | N | $945.00 |
| **28341** | Reconstruction, toe, macrodactyly; requiring bone resection | 16.13 | $1,346.86 | | 090 | N | $945.00 |
| **28344** | Reconstruction, toe(s); polydactyly | 10.40 | $868.40 | | 090 | N | $945.00 |
| **28345** | Reconstruction, toe(s); syndactyly, with or without skin graft(s), each web | 12.78 | $1,067.13 | | 090 | N | $945.00 |
| **28360** | Reconstruction, cleft foot | 24.93 | $2,081.66 | | 090 | Y | |
| **28400** | Closed treatment of calcaneal fracture; without manipulation | 5.92 | $494.32 | | 090 | N | $155.43 |
| **28405** | Closed treatment of calcaneal fracture; with manipulation | 9.65 | $805.78 | | 090 | N | $155.43 |
| **28406** | Percutaneous skeletal fixation of calcaneal fracture, with manipulation | 13.42 | $1,120.57 | | 090 | N | $669.00 |
| **28415** | Open treatment of calcaneal fracture, with or without internal or external fixation; | 31.16 | $2,601.86 | | 090 | Y | $765.00 |
| **28420** | Open treatment of calcaneal fracture, with or without internal or external fixation; with primary iliac or other autogenous bone graft (includes obtaining graft) | 30.41 | $2,539.24 | | 090 | Y | $945.00 |
| **28430** | Closed treatment of talus fracture; without manipulation | 5.56 | $464.26 | | 090 | N | |
| **28435** | Closed treatment of talus fracture; with manipulation | 7.51 | $627.09 | | 090 | N | $155.43 |
| **28436** | Percutaneous skeletal fixation of talus fracture, with manipulation | 10.80 | $901.80 | | 090 | N | $669.00 |
| **28445** | Open treatment of talus fracture, with or without internal or external fixation | 28.66 | $2,393.11 | | 090 | Y | $765.00 |
| **28450** | Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each | 5.10 | $425.85 | | 090 | N | |
| **28455** | Treatment of tarsal bone fracture (except talus and calcaneus); with manipulation, each | 6.76 | $564.46 | | 090 | N | |
| **28456** | Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus), with manipulation, each | 6.93 | $578.66 | | 090 | N | $669.00 |
| **28465** | Open treatment of tarsal bone fracture (except talus and calcaneus), with or without internal or external fixation, each | 13.52 | $1,128.92 | | 090 | N | $765.00 |
| **28470** | Closed treatment of metatarsal fracture; without manipulation, each | 5.14 | $429.19 | | 090 | N | |
| **28475** | Closed treatment of metatarsal fracture; with manipulation, each | 6.40 | $534.40 | | 090 | N | |
| **28476** | Percutaneous skeletal fixation of metatarsal fracture, with manipulation, each | 8.48 | $708.08 | | 090 | N | $669.00 |
| **28485** | Open treatment of metatarsal fracture, with or without internal or external fixation, each | 11.25 | $939.38 | | 090 | N | $945.00 |
| **28490** | Closed treatment of fracture great toe, phalanx or phalanges; without manipulation | 3.19 | $266.37 | | 090 | N | |

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|---|---|---|---|---|---|---|---|
| **28495** | Closed treatment of fracture great toe, phalanx or phalanges; with manipulation | 3.91 | $326.49 | | 090 | N | |
| **28496** | Percutaneous skeletal fixation of fracture great toe, phalanx or phalanges, with manipulation | 10.50 | $876.75 | | 090 | N | $669.00 |
| **28505** | Open treatment of fracture great toe, phalanx or phalanges, with or without internal or external fixation | 11.98 | $1,000.33 | | 090 | N | $765.00 |
| **28510** | Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each | 2.72 | $227.12 | | 090 | N | |
| **28515** | Closed treatment of fracture, phalanx or phalanges, other than great toe; with manipulation, each | 3.51 | $293.09 | | 090 | N | |
| **28525** | Open treatment of fracture, phalanx or phalanges, other than great toe, with or without internal or external fixation, each | 10.88 | $908.48 | | 090 | N | $765.00 |
| **28530** | Closed treatment of sesamoid fracture | 2.60 | $217.10 | | 090 | N | |
| **28531** | Open treatment of sesamoid fracture, with or without internal fixation | 9.51 | $794.09 | | 090 | N | $765.00 |
| **28540** | Closed treatment of tarsal bone dislocation, other than talotarsal; without anesthesia | 4.65 | $388.28 | | 090 | N | |
| **28545** | Closed treatment of tarsal bone dislocation, other than talotarsal; requiring anesthesia | 5.22 | $435.87 | | 090 | N | $499.50 |
| **28546** | Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation | 10.57 | $882.60 | | 090 | N | $669.00 |
| **28555** | Open treatment of tarsal bone dislocation, with or without internal or external fixation | 16.69 | $1,393.62 | | 090 | Y | $669.00 |
| **28570** | Closed treatment of talotarsal joint dislocation; without anesthesia | 4.23 | $353.21 | | 090 | N | |
| **28575** | Closed treatment of talotarsal joint dislocation; requiring anesthesia | 7.49 | $625.42 | | 090 | N | $155.43 |
| **28576** | Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation | 8.86 | $739.81 | | 090 | N | $765.00 |
| **28585** | Open treatment of talotarsal joint dislocation, with or without internal or external fixation | 16.58 | $1,384.43 | | 090 | Y | $765.00 |
| **28600** | Closed treatment of tarsometatarsal joint dislocation; without anesthesia | 4.88 | $407.48 | | 090 | N | |
| **28605** | Closed treatment of tarsometatarsal joint dislocation; requiring anesthesia | 6.18 | $516.03 | | 090 | N | $155.43 |
| **28606** | Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation | 9.89 | $825.82 | | 090 | N | $669.00 |
| **28615** | Open treatment of tarsometatarsal joint dislocation, with or without internal or external fixation | 17.15 | $1,432.03 | | 090 | Y | $765.00 |
| **28630** | Closed treatment of metatarsophalangeal joint dislocation; without anesthesia | 3.42 | $285.57 | | 010 | N | |
| **28635** | Closed treatment of metatarsophalangeal joint dislocation; requiring anesthesia | 4.09 | $341.52 | | 010 | N | $499.50 |
| **28636** | Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation | 6.91 | $576.99 | | 010 | N | $765.00 |
| **28645** | Open treatment of metatarsophalangeal joint dislocation, with or without internal or external fixation | 9.85 | $822.48 | | 090 | N | $765.00 |
| **28660** | Closed treatment of interphalangeal joint dislocation; without anesthesia | 2.52 | $210.42 | | 010 | N | |
| **28665** | Closed treatment of interphalangeal joint dislocation; requiring anesthesia | 3.54 | $295.59 | | 010 | N | $499.50 |
| **28666** | Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation | 5.24 | $437.54 | | 010 | N | $765.00 |
| **28675** | Open treatment of interphalangeal joint dislocation, with or without internal or external fixation | 10.15 | $847.53 | | 090 | N | $765.00 |
| **28705** | Arthrodesis; pantalar | 33.23 | $2,774.71 | | 090 | Y | $945.00 |
| **28715** | Arthrodesis; triple | 24.58 | $2,052.43 | | 090 | Y | $945.00 |
| **28725** | Arthrodesis; subtalar | 20.57 | $1,717.60 | | 090 | Y | $945.00 |

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|---|---|---|---|---|---|---|---|
| **28730** | Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; | 21.01 | $1,754.34 | | 090 | Y | $945.00 |
| **28735** | Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction) | 20.14 | $1,681.69 | | 090 | Y | $945.00 |
| **28737** | Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure) | 17.86 | $1,491.31 | | 090 | Y | $1,075.50 |
| **28740** | Arthrodesis, midtarsal or tarsometatarsal, single joint | 20.29 | $1,694.22 | | 090 | Y | $945.00 |
| **28750** | Arthrodesis, great toe; metatarsophalangeal joint | 20.31 | $1,695.89 | | 090 | N | $945.00 |
| **28755** | Arthrodesis, great toe; interphalangeal joint | 11.36 | $948.56 | | 090 | N | $945.00 |
| **28760** | Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure) | 17.58 | $1,467.93 | | 090 | Y | $945.00 |
| **28800** | Amputation, foot; midtarsal (eg, Chopart type procedure) | 14.55 | $1,214.93 | | 090 | Y | |
| **28805** | Amputation, foot; transmetatarsal | 18.21 | $1,520.54 | | 090 | Y | |
| **28810** | Amputation, metatarsal, with toe, single | 11.11 | $927.69 | | 090 | N | $669.00 |
| **28820** | Amputation, toe; metatarsophalangeal joint | 12.61 | $1,052.94 | | 090 | N | $669.00 |
| **28825** | Amputation, toe; interphalangeal joint | 10.88 | $908.48 | | 090 | N | $669.00 |
| **28890** | Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia | 8.91 | $743.99 | | 090 | Y | |
| **28899** | Unlisted procedure, foot or toes | 0.00 | BR | | 000 | N | |
| **29000** | Application of halo type body cast (see 20661-20663 for insertion) | 5.83 | $486.81 | | 000 | Y | |
| **29010** | Application of Risser jacket, localizer, body; only | 5.60 | $467.60 | | 000 | Y | |
| **29015** | Application of Risser jacket, localizer, body; including head | 5.52 | $460.92 | | 000 | Y | |
| **29020** | Application of turnbuckle jacket, body; only | 5.52 | $460.92 | | 000 | Y | |
| **29025** | Application of turnbuckle jacket, body; including head | 5.86 | $489.31 | | 000 | Y | |
| **29035** | Application of body cast, shoulder to hips; | 5.50 | $459.25 | | 000 | Y | |
| **29040** | Application of body cast, shoulder to hips; including head, Minerva type | 5.11 | $426.69 | | 000 | Y | |
| **29044** | Application of body cast, shoulder to hips; including one thigh | 6.22 | $519.37 | | 000 | Y | |
| **29046** | Application of body cast, shoulder to hips; including both thighs | 6.06 | $506.01 | | 000 | Y | |
| **29049** | Application, cast; figure-of-eight | 2.19 | $182.87 | | 000 | N | |
| **29055** | Application, cast; shoulder spica | 4.86 | $405.81 | | 000 | Y | |
| **29058** | Application, cast; plaster Velpeau | 2.83 | $236.31 | | 000 | N | |
| **29065** | Application, cast; shoulder to hand (long arm) | 2.25 | $187.88 | | 000 | N | |
| **29075** | Application, cast; elbow to finger (short arm) | 2.07 | $172.85 | | 000 | N | |
| **29085** | Application, cast; hand and lower forearm (gauntlet) | 2.20 | $183.70 | | 000 | N | |
| **29086** | Application, cast; finger (eg, contracture) | 1.61 | $134.44 | | 000 | N | |
| **29105** | Application of long arm splint (shoulder to hand) | 2.10 | $175.35 | | 000 | N | |
| **29125** | Application of short arm splint (forearm to hand); static | 1.61 | $134.44 | | 000 | N | |
| **29126** | Application of short arm splint (forearm to hand); dynamic | 1.92 | $160.32 | | 000 | N | |
| **29130** | Application of finger splint; static | 0.97 | $81.00 | | 000 | N | |
| **29131** | Application of finger splint; dynamic | 1.23 | $102.71 | | 000 | N | |
| **29200** | Strapping; thorax | 1.31 | $109.39 | | 000 | N | |
| **29220** | Strapping; low back | 1.31 | $109.39 | | 000 | N | |
| **29240** | Strapping; shoulder (eg, Velpeau) | 1.51 | $126.09 | | 000 | N | |
| **29260** | Strapping; elbow or wrist | 1.26 | $105.21 | | 000 | N | |
| **29280** | Strapping; hand or finger | 1.26 | $105.21 | | 000 | N | |
| **29305** | Application of hip spica cast; one leg | 5.53 | $461.76 | | 000 | Y | |
| **29325** | Application of hip spica cast; one and one-half spica or both legs | 6.06 | $506.01 | | 000 | Y | |
| **29345** | Application of long leg cast (thigh to toes); | 3.24 | $270.54 | | 000 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **29355** | Application of long leg cast (thigh to toes); walker or ambulatory type | 3.33 | $278.06 | | 000 | N | |
| **29358** | Application of long leg cast brace | 3.60 | $300.60 | | 000 | N | |
| **29365** | Application of cylinder cast (thigh to ankle) | 2.90 | $242.15 | | 000 | N | |
| **29405** | Application of short leg cast (below knee to toes); | 2.13 | $177.86 | | 000 | N | |
| **29425** | Application of short leg cast (below knee to toes); walking or ambulatory type | 2.29 | $191.22 | | 000 | N | |
| **29435** | Application of patellar tendon bearing (PTB) cast | 2.81 | $234.64 | | 000 | N | |
| **29440** | Adding walker to previously applied cast | 1.26 | $105.21 | | 000 | N | |
| **29445** | Application of rigid total contact leg cast | 3.63 | $303.11 | | 000 | N | |
| **29450** | Application of clubfoot cast with molding or manipulation, long or short leg | 3.63 | $303.11 | | 000 | N | |
| **29505** | Application of long leg splint (thigh to ankle or toes) | 1.85 | $154.48 | | 000 | N | |
| **29515** | Application of short leg splint (calf to foot) | 1.64 | $136.94 | | 000 | N | |
| **29520** | Strapping; hip | 1.33 | $111.06 | | 000 | N | |
| **29530** | Strapping; knee | 1.31 | $109.39 | | 000 | N | |
| **29540** | Strapping; ankle and/or foot | 0.97 | $81.00 | | 000 | N | |
| **29550** | Strapping; toes | 0.94 | $78.49 | | 000 | N | |
| **29580** | Strapping; Unna boot | 1.23 | $102.71 | | 000 | N | |
| **29590** | Denis-Browne splint strapping | 1.31 | $109.39 | | 000 | N | |
| **29700** | Removal or bivalving; gauntlet, boot or body cast | 1.50 | $125.25 | | 000 | N | |
| **29705** | Removal or bivalving; full arm or full leg cast | 1.62 | $135.27 | | 000 | N | |
| **29710** | Removal or bivalving; shoulder or hip spica, Minerva, or Risser jacket, etc. | 2.92 | $243.82 | | 000 | N | |
| **29715** | Removal or bivalving; turnbuckle jacket | 2.10 | $175.35 | | 000 | N | |
| **29720** | Repair of spica, body cast or jacket | 1.89 | $157.82 | | 000 | N | |
| **29730** | Windowing of cast | 1.59 | $132.77 | | 000 | N | |
| **29740** | Wedging of cast (except clubfoot casts) | 2.32 | $193.72 | | 000 | N | |
| **29750** | Wedging of clubfoot cast | 2.37 | $197.90 | | 000 | N | |
| **29799** | Unlisted procedure, casting or strapping | 0.00 | BR | | 000 | N | |
| **29800** | Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure) | 13.51 | $1,128.09 | | 090 | Y | $765.00 |
| **29804** | Arthroscopy, temporomandibular joint, surgical | 16.35 | $1,365.23 | | 090 | Y | $765.00 |
| **29805** | Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure) | 11.80 | $985.30 | | 090 | N | $765.00 |
| **29806** | Arthroscopy, shoulder, surgical; capsulorrhaphy | 26.68 | $2,227.78 | | 090 | N | $765.00 |
| **29807** | Arthroscopy, shoulder, surgical; repair of SLAP lesion | 26.01 | $2,470.95 | | 090 | N | $765.00 |
| **29819** | Arthroscopy, shoulder, surgical; with removal of loose body or foreign body | 14.74 | $1,230.79 | | 090 | N | $765.00 |
| **29820** | Arthroscopy, shoulder, surgical; synovectomy, partial | 13.59 | $1,134.77 | | 090 | Y | $765.00 |
| **29821** | Arthroscopy, shoulder, surgical; synovectomy, complete | 14.86 | $1,240.81 | | 090 | Y | $765.00 |
| **29822** | Arthroscopy, shoulder, surgical; debridement, limited | 14.45 | $1,206.58 | | 090 | Y | $765.00 |
| **29823** | Arthroscopy, shoulder, surgical; debridement, extensive | 15.76 | $1,497.20 | | 090 | Y | $765.00 |
| **29824** | Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure) | 16.65 | $1,581.75 | | 090 | Y | $1,075.50 |
| **29825** | Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation | 14.72 | $1,229.12 | | 090 | Y | $765.00 |
| **29826** | Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release | 16.90 | $1,605.50 | | 090 | Y | $765.00 |
| **29827** | Arthroscopy, shoulder, surgical; with rotator cuff repair | 27.57 | $2,619.15 | | 090 | Y | $1,075.50 |

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|---|---|---|---|---|---|---|---|
| **29830** | Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure) | 11.35 | $947.73 | | 090 | N | $765.00 |
| **29834** | Arthroscopy, elbow, surgical; with removal of loose body or foreign body | 12.37 | $1,032.90 | | 090 | Y | $765.00 |
| **29835** | Arthroscopy, elbow, surgical; synovectomy, partial | 12.66 | $1,057.11 | | 090 | Y | $765.00 |
| **29836** | Arthroscopy, elbow, surgical; synovectomy, complete | 14.55 | $1,214.93 | | 090 | Y | $765.00 |
| **29837** | Arthroscopy, elbow, surgical; debridement, limited | 13.30 | $1,110.55 | | 090 | Y | $765.00 |
| **29838** | Arthroscopy, elbow, surgical; debridement, extensive | 14.89 | $1,414.55 | | 090 | Y | $765.00 |
| **29840** | Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure) | 11.03 | $921.01 | | 090 | Y | $765.00 |
| **29843** | Arthroscopy, wrist, surgical; for infection, lavage and drainage | 11.82 | $986.97 | | 090 | Y | $765.00 |
| **29844** | Arthroscopy, wrist, surgical; synovectomy, partial | 12.42 | $1,037.07 | | 090 | Y | $765.00 |
| **29845** | Arthroscopy, wrist, surgical; synovectomy, complete | 14.05 | $1,173.18 | | 090 | Y | $765.00 |
| **29846** | Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement | 13.01 | $1,086.34 | | 090 | Y | $765.00 |
| **29847** | Arthroscopy, wrist, surgical; internal fixation for fracture or instability | 13.44 | $1,122.24 | | 090 | Y | $765.00 |
| **29848** | Endoscopy, wrist, surgical, with release of transverse carpal ligament | 12.00 | $1,002.00 | | 090 | N | $2,008.50 |
| **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) | 13.71 | $1,144.79 | | 090 | Y | $945.00 |
| **29851** | Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; with internal or external fixation (includes arthroscopy) | 23.53 | $1,964.76 | | 090 | Y | $945.00 |
| **29855** | Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar, with or without internal or external fixation (includes arthroscopy) | 19.80 | $1,653.30 | | 090 | Y | $945.00 |
| **29856** | Arthroscopically aided treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal or external fixation (includes arthroscopy) | 25.29 | $2,111.72 | | 090 | Y | $945.00 |
| **29860** | Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure) | 16.10 | $1,344.35 | | 090 | Y | $945.00 |
| **29861** | Arthroscopy, hip, surgical; with removal of loose body or foreign body | 17.71 | $1,478.79 | | 090 | Y | $945.00 |
| **29862** | Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum | 19.82 | $1,654.97 | | 090 | Y | $2,008.50 |
| **29863** | Arthroscopy, hip, surgical; with synovectomy | 19.56 | $1,633.26 | | 090 | Y | $945.00 |
| **29866** | Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft) | 26.33 | $2,198.56 | | 090 | N | |
| **29867** | Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty) | 31.88 | $2,661.98 | | 090 | N | |
| **29868** | Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral | 42.84 | $3,577.14 | | 090 | N | |
| **29870** | Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure) | 10.17 | $849.20 | | 090 | N | $765.00 |
| **29871** | Arthroscopy, knee, surgical; for infection, lavage and drainage | 12.74 | $1,063.79 | | 090 | N | $765.00 |
| **29873** | Arthroscopy, knee, surgical; with lateral release | 12.85 | $1,072.98 | | 090 | N | $765.00 |
| **29874** | Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation) | 13.35 | $1,114.73 | | 090 | Y | $765.00 |
| **29875** | Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure) | 12.43 | $1,037.91 | | 090 | Y | $945.00 |
| **29876** | Arthroscopy, knee, surgical; synovectomy, major, two or more compartments (eg, medial or lateral) | 16.04 | $1,339.34 | | 090 | N | $945.00 |
| **29877** | Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty) | 15.17 | $1,266.70 | | 090 | Y | $945.00 |

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|---|---|---|---|---|---|---|---|
| **29879** | Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture | 16.25 | $1,543.75 | | 090 | Y | $765.00 |
| **29880** | Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) | 16.97 | $1,612.15 | | 090 | Y | $945.00 |
| **29881** | Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) | 15.81 | $1,501.95 | | 090 | Y | $945.00 |
| **29882** | Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral) | 17.06 | $1,424.51 | | 090 | N | $765.00 |
| **29883** | Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral) | 21.08 | $1,760.18 | | 090 | Y | $765.00 |
| **29884** | Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure) | 15.11 | $1,261.69 | | 090 | Y | $765.00 |
| **29885** | Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion) | 18.35 | $1,532.23 | | 090 | Y | $765.00 |
| **29886** | Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion | 15.46 | $1,290.91 | | 090 | N | $765.00 |
| **29887** | Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation | 18.26 | $1,524.71 | | 090 | Y | $765.00 |
| **29888** | Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction | 24.89 | $2,078.32 | | 090 | Y | $765.00 |
| **29889** | Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction | 30.23 | $2,524.21 | | 090 | Y | $765.00 |
| **29891** | Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect | 17.22 | $1,437.87 | | 090 | Y | $765.00 |
| **29892** | Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy) | 17.93 | $1,497.16 | | 090 | Y | $765.00 |
| **29893** | Endoscopic plantar fasciotomy | 13.04 | $1,088.84 | | 090 | Y | $1,883.34 |
| **29894** | Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body | 12.97 | $1,083.00 | | 090 | Y | $765.00 |
| **29895** | Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; synovectomy, partial | 12.69 | $1,059.62 | | 090 | Y | $765.00 |
| **29897** | Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, limited | 13.33 | $1,113.06 | | 090 | Y | $765.00 |
| **29898** | Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive | 14.80 | $1,235.80 | | 090 | Y | $765.00 |
| **29899** | Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis | 26.33 | $2,198.56 | | 090 | Y | $765.00 |
| **29900** | Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy | 11.70 | $976.95 | | 090 | Y | $765.00 |
| **29901** | Arthroscopy, metacarpophalangeal joint, surgical; with debridement | 12.95 | $1,081.33 | | 090 | Y | $765.00 |
| **29902** | Arthroscopy, metacarpophalangeal joint, surgical; with reduction of displaced ulnar collateral ligament (eg, Stenar lesion) | 13.26 | $1,107.21 | | 090 | Y | $765.00 |
| **29999** | Unlisted procedure, arthroscopy | 0.00 | BR | | 000 | N | |
| **30000** | Drainage abscess or hematoma, nasal, internal approach | 5.40 | $450.90 | | 010 | N | |
| **30020** | Drainage abscess or hematoma, nasal septum | 4.84 | $404.14 | | 010 | N | |
| **30100** | Biopsy, intranasal | 3.00 | $250.50 | | 000 | N | |
| **30110** | Excision, nasal polyp(s), simple | 4.96 | $414.16 | | 010 | N | |
| **30115** | Excision, nasal polyp(s), extensive | 10.05 | $839.18 | | 090 | N | $669.00 |
| **30117** | Excision or destruction (eg, laser), intranasal lesion; internal approach | 17.23 | $1,438.71 | | 090 | N | $765.00 |
| **30118** | Excision or destruction (eg, laser), intranasal lesion; external approach (lateral rhinotomy) | 18.46 | $1,541.41 | | 090 | Y | $765.00 |
| **30120** | Excision or surgical planing of skin of nose for rhinophyma | 11.90 | $993.65 | | 090 | N | $499.50 |
| **30124** | Excision dermoid cyst, nose; simple, skin, subcutaneous | 6.69 | $558.62 | | 090 | N | |

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|---|---|---|---|---|---|---|---|
| **30125** | Excision dermoid cyst, nose; complex, under bone or cartilage | 15.11 | $1,261.69 | | 090 | Y | $669.00 |
| **30130** | Excision inferior turbinate, partial or complete, any method | 8.90 | $743.15 | | 090 | N | $765.00 |
| **30140** | Submucous resection inferior turbinate, partial or complete, any method | 9.77 | $815.80 | | 090 | N | $669.00 |
| **30150** | Rhinectomy; partial | 19.84 | $1,656.64 | | 090 | N | $765.00 |
| **30160** | Rhinectomy; total | 19.48 | $1,626.58 | | 090 | Y | $945.00 |
| **30200** | Injection into turbinate(s), therapeutic | 2.45 | $204.58 | | 000 | N | |
| **30210** | Displacement therapy (Proetz type) | 3.24 | $270.54 | | 010 | N | |
| **30220** | Insertion, nasal septal prosthesis (button) | 6.05 | $505.18 | | 010 | N | $696.23 |
| **30300** | Removal foreign body, intranasal; office type procedure | 5.54 | $462.59 | | 010 | N | |
| **30310** | Removal foreign body, intranasal; requiring general anesthesia | 4.95 | $413.33 | | 010 | Y | $499.50 |
| **30320** | Removal foreign body, intranasal; by lateral rhinotomy | 11.27 | $941.05 | | 090 | Y | $669.00 |
| **30400** | Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip | 25.63 | $2,140.11 | | 090 | N | $945.00 |
| **30410** | Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip | 31.15 | $2,601.03 | | 090 | Y | $1,075.50 |
| **30420** | Rhinoplasty, primary; including major septal repair | 33.57 | $2,803.10 | | 090 | N | $1,075.50 |
| **30430** | Rhinoplasty, secondary; minor revision (small amount of nasal tip work) | 23.16 | $1,933.86 | | 090 | Y | $765.00 |
| **30435** | Rhinoplasty, secondary; intermediate revision (bony work with osteotomies) | 30.65 | $2,559.28 | | 090 | Y | $1,075.50 |
| **30450** | Rhinoplasty, secondary; major revision (nasal tip work and osteotomies) | 39.91 | $3,332.49 | | 090 | Y | $1,492.50 |
| **30460** | Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only | 19.51 | $1,629.09 | | 090 | Y | $1,492.50 |
| **30462** | Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies | 39.46 | $3,294.91 | | 090 | Y | $2,008.50 |
| **30465** | Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction) | 23.61 | $1,971.44 | | 090 | Y | $2,008.50 |
| **30520** | Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft | 13.47 | $1,124.75 | | 090 | N | $945.00 |
| **30540** | Repair choanal atresia; intranasal | 16.41 | $1,370.24 | | 090 | Y | $1,075.50 |
| **30545** | Repair choanal atresia; transpalatine | 23.51 | $1,963.09 | | 090 | Y | $1,075.50 |
| **30560** | Lysis intranasal synechia | 6.06 | $506.01 | | 010 | N | $226.08 |
| **30580** | Repair fistula; oromaxillary (combine with 31030 if antrotomy is included) | 14.85 | $1,239.98 | | 090 | N | $945.00 |
| **30600** | Repair fistula; oronasal | 13.68 | $1,142.28 | | 090 | Y | $945.00 |
| **30620** | Septal or other intranasal dermatoplasty (does not include obtaining graft) | 14.66 | $1,224.11 | | 090 | N | $1,492.50 |
| **30630** | Repair nasal septal perforations | 14.82 | $1,237.47 | | 090 | N | $1,492.50 |
| **30801** | Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method; superficial | 5.19 | $433.37 | | 010 | N | $499.50 |
| **30802** | Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method; intramural | 6.61 | $551.94 | | 010 | N | $499.50 |
| **30901** | Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method | 2.52 | $210.42 | | 000 | N | |
| **30903** | Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method | 4.32 | $360.72 | | 000 | N | $108.72 |
| **30905** | Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial | 5.51 | $460.09 | | 000 | N | $108.72 |
| **30906** | Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent | 6.31 | $526.89 | | 000 | N | $108.72 |
| **30915** | Ligation arteries; ethmoidal | 13.69 | $1,143.12 | | 090 | N | $669.00 |
| **30920** | Ligation arteries; internal maxillary artery, transantral | 19.51 | $1,629.09 | | 090 | N | $765.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **30930** | Fracture nasal inferior turbinate(s), therapeutic | 2.87 | $239.65 | | 010 | N | $945.00 |
| **30999** | Unlisted procedure, nose | 0.00 | BR | | 000 | N | |
| **31000** | Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium) | 4.02 | $335.67 | | 010 | N | |
| **31002** | Lavage by cannulation; sphenoid sinus | 4.95 | $413.33 | | 010 | Y | |
| **31020** | Sinusotomy, maxillary (antrotomy); intranasal | 11.40 | $951.90 | | 090 | N | $669.00 |
| **31030** | Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyps | 17.02 | $1,421.17 | | 090 | N | $765.00 |
| **31032** | Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) with removal of antrochoanal polyps | 13.60 | $1,135.60 | | 090 | N | $945.00 |
| **31040** | Pterygomaxillary fossa surgery, any approach | 18.75 | $1,565.63 | | 090 | N | |
| **31050** | Sinusotomy, sphenoid, with or without biopsy; | 11.58 | $966.93 | | 090 | N | $669.00 |
| **31051** | Sinusotomy, sphenoid, with or without biopsy; with mucosal stripping or removal of polyp(s) | 15.18 | $1,267.53 | | 090 | N | $945.00 |
| **31070** | Sinusotomy frontal; external, simple (trephine operation) | 10.15 | $847.53 | | 090 | N | $669.00 |
| **31075** | Sinusotomy frontal; transorbital, unilateral (for mucocele or osteoma, Lynch type) | 18.65 | $1,557.28 | | 090 | Y | $945.00 |
| **31080** | Sinusotomy frontal; obliterative without osteoplastic flap, brow incision (includes ablation) | 25.28 | $2,110.88 | | 090 | Y | $945.00 |
| **31081** | Sinusotomy frontal; obliterative, without osteoplastic flap, coronal incision (includes ablation) | 29.25 | $2,442.38 | | 090 | Y | $945.00 |
| **31084** | Sinusotomy frontal; obliterative, with osteoplastic flap, brow incision | 27.58 | $2,302.93 | | 090 | Y | $945.00 |
| **31085** | Sinusotomy frontal; obliterative, with osteoplastic flap, coronal incision | 29.35 | $2,450.73 | | 090 | Y | $945.00 |
| **31086** | Sinusotomy frontal; nonobliterative, with osteoplastic flap, brow incision | 26.73 | $2,231.96 | | 090 | Y | $945.00 |
| **31087** | Sinusotomy frontal; nonobliterative, with osteoplastic flap, coronal incision | 26.49 | $2,211.92 | | 090 | Y | $945.00 |
| **31090** | Sinusotomy, unilateral, three or more paranasal sinuses (frontal, maxillary, ethmoid, sphenoid) | 23.24 | $1,940.54 | | 090 | N | $1,075.50 |
| **31200** | Ethmoidectomy; intranasal, anterior | 13.58 | $1,133.93 | | 090 | N | $669.00 |
| **31201** | Ethmoidectomy; intranasal, total | 17.42 | $1,454.57 | | 090 | N | $1,075.50 |
| **31205** | Ethmoidectomy; extranasal, total | 21.40 | $1,786.90 | | 090 | Y | $765.00 |
| **31225** | Maxillectomy; without orbital exenteration | 42.87 | $3,579.65 | | 090 | Y | |
| **31230** | Maxillectomy; with orbital exenteration (en bloc) | 48.11 | $4,017.19 | | 090 | Y | |
| **31231** | Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure) | 4.45 | $371.58 | | 000 | N | |
| **31233** | Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture) | 6.37 | $531.90 | | 000 | N | $129.59 |
| **31235** | Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium) | 7.39 | $617.07 | | 000 | N | $499.50 |
| **31237** | Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure) | 7.99 | $667.17 | | 000 | N | $669.00 |
| **31238** | Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage | 8.24 | $688.04 | | 000 | N | $499.50 |
| **31239** | Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy | 16.51 | $1,378.59 | | 010 | Y | $945.00 |
| **31240** | Nasal/sinus endoscopy, surgical; with concha bullosa resection | 4.18 | $349.03 | | 000 | N | $669.00 |
| **31254** | Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior) | 7.19 | $600.37 | | 000 | N | $765.00 |
| **31255** | Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior) | 10.67 | $890.95 | | 000 | N | $1,075.50 |
| **31256** | Nasal/sinus endoscopy, surgical, with maxillary antrostomy; | 5.21 | $435.04 | | 000 | N | $765.00 |
| **31267** | Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus | 8.41 | $702.24 | | 000 | N | $765.00 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **31276** | Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus | 13.45 | $1,123.08 | | 000 | N | $765.00 |
| | **31287** | Nasal/sinus endoscopy, surgical, with sphenoidotomy; | 6.13 | $511.86 | | 000 | N | $765.00 |
| | **31288** | Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus | 7.11 | $593.69 | | 000 | N | $765.00 |
| | **31290** | Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region | 29.13 | $2,432.36 | | 010 | Y | |
| | **31291** | Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; sphenoid region | 30.73 | $2,565.96 | | 010 | Y | |
| | **31292** | Nasal/sinus endoscopy, surgical; with medial or inferior orbital wall decompression | 25.21 | $2,105.04 | | 010 | Y | |
| | **31293** | Nasal/sinus endoscopy, surgical; with medial orbital wall and inferior orbital wall decompression | 27.43 | $2,290.41 | | 010 | Y | |
| | **31294** | Nasal/sinus endoscopy, surgical; with optic nerve decompression | 31.58 | $2,636.93 | | 010 | Y | |
| | **31299** | Unlisted procedure, accessory sinuses | 0.00 | BR | | 000 | N | |
| | **31300** | Laryngotomy (thyrotomy, laryngofissure); with removal of tumor or laryngocele, cordectomy | 29.93 | $2,499.16 | | 090 | Y | $1,075.50 |
| | **31320** | Laryngotomy (thyrotomy, laryngofissure); diagnostic | 15.54 | $1,297.59 | | 090 | Y | $669.00 |
| | **31360** | Laryngectomy; total, without radical neck dissection | 45.10 | $3,765.85 | | 090 | Y | |
| | **31365** | Laryngectomy; total, with radical neck dissection | 57.08 | $4,766.18 | | 090 | Y | |
| | **31367** | Laryngectomy; subtotal supraglottic, without radical neck dissection | 50.52 | $4,218.42 | | 090 | Y | |
| | **31368** | Laryngectomy; subtotal supraglottic, with radical neck dissection | 57.38 | $4,791.23 | | 090 | Y | |
| | **31370** | Partial laryngectomy (hemilaryngectomy); horizontal | 48.03 | $4,010.51 | | 090 | Y | |
| | **31375** | Partial laryngectomy (hemilaryngectomy); laterovertical | 44.93 | $3,751.66 | | 090 | Y | |
| | **31380** | Partial laryngectomy (hemilaryngectomy); anterovertical | 44.64 | $3,727.44 | | 090 | Y | |
| | **31382** | Partial laryngectomy (hemilaryngectomy); antero-latero-vertical | 48.45 | $4,045.58 | | 090 | Y | |
| | **31390** | Pharyngolaryngectomy, with radical neck dissection; without reconstruction | 64.37 | $5,374.90 | | 090 | Y | |
| | **31395** | Pharyngolaryngectomy, with radical neck dissection; with reconstruction | 69.30 | $5,786.55 | | 090 | Y | |
| | **31400** | Arytenoidectomy or arytenoidopexy, external approach | 24.37 | $2,034.90 | | 090 | Y | $669.00 |
| | **31420** | Epiglottidectomy | 20.15 | $1,682.53 | | 090 | Y | $669.00 |
| ⊘ | **31500** | Intubation, endotracheal, emergency procedure | 2.79 | $232.97 | | 000 | N | |
| | **31502** | Tracheotomy tube change prior to establishment of fistula tract | 0.89 | $74.32 | | 000 | N | |
| | **31505** | Laryngoscopy, indirect; diagnostic (separate procedure) | 2.02 | $168.67 | | 000 | N | |
| | **31510** | Laryngoscopy, indirect; with biopsy | 5.11 | $426.69 | | 000 | N | $669.00 |
| | **31511** | Laryngoscopy, indirect; with removal of foreign body | 5.16 | $430.86 | | 000 | N | $129.59 |
| | **31512** | Laryngoscopy, indirect; with removal of lesion | 5.12 | $427.52 | | 000 | Y | $669.00 |
| | **31513** | Laryngoscopy, indirect; with vocal cord injection | 3.40 | $283.90 | | 000 | N | $129.59 |
| | **31515** | Laryngoscopy direct, with or without tracheoscopy; for aspiration | 5.18 | $432.53 | | 000 | N | $499.50 |
| | **31520** | Laryngoscopy direct, with or without tracheoscopy; diagnostic, newborn | 3.95 | $329.83 | | 000 | N | |
| | **31525** | Laryngoscopy direct, with or without tracheoscopy; diagnostic, except newborn | 6.12 | $511.02 | | 000 | N | $499.50 |
| | **31526** | Laryngoscopy direct, with or without tracheoscopy; diagnostic, with operating microscope or telescope | 4.09 | $341.52 | | 000 | N | $669.00 |
| | **31527** | Laryngoscopy direct, with or without tracheoscopy; with insertion of obturator | 4.93 | $411.66 | | 000 | Y | $499.50 |
| | **31528** | Laryngoscopy direct, with or without tracheoscopy; with dilation, initial | 3.66 | $305.61 | | 000 | N | $669.00 |
| | **31529** | Laryngoscopy direct, with or without tracheoscopy; with dilation, subsequent | 4.19 | $349.87 | | 000 | Y | $669.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **31530** | Laryngoscopy, direct, operative, with foreign body removal; | 5.12 | $427.52 | | 000 | N | $669.00 |
| **31531** | Laryngoscopy, direct, operative, with foreign body removal; with operating microscope or telescope | 5.57 | $465.10 | | 000 | N | $765.00 |
| **31535** | Laryngoscopy, direct, operative, with biopsy; | 4.92 | $410.82 | | 000 | N | $669.00 |
| **31536** | Laryngoscopy, direct, operative, with biopsy; with operating microscope or telescope | 5.52 | $460.92 | | 000 | N | $765.00 |
| **31540** | Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; | 6.34 | $529.39 | | 000 | N | $765.00 |
| **31541** | Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope or telescope | 6.95 | $580.33 | | 000 | N | $945.00 |
| **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) | 9.21 | $769.04 | | 000 | N | $945.00 |
| **31546** | Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with graft(s) (includes obtaining autograft) | 14.20 | $1,185.70 | | 000 | N | $945.00 |
| **31560** | Laryngoscopy, direct, operative, with arytenoidectomy; | 8.17 | $682.20 | | 000 | Y | $1,075.50 |
| **31561** | Laryngoscopy, direct, operative, with arytenoidectomy; with operating microscope or telescope | 8.93 | $745.66 | | 000 | Y | $1,075.50 |
| **31570** | Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; | 9.02 | $753.17 | | 000 | N | $669.00 |
| **31571** | Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope | 6.54 | $546.09 | | 000 | N | $669.00 |
| **31575** | Laryngoscopy, flexible fiberoptic; diagnostic | 2.90 | $242.15 | | 000 | N | |
| **31576** | Laryngoscopy, flexible fiberoptic; with biopsy | 5.48 | $457.58 | | 000 | N | $669.00 |
| **31577** | Laryngoscopy, flexible fiberoptic; with removal of foreign body | 6.06 | $506.01 | | 000 | N | $354.63 |
| **31578** | Laryngoscopy, flexible fiberoptic; with removal of lesion | 6.91 | $576.99 | | 000 | N | $669.00 |
| **31579** | Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy | 5.71 | $476.79 | | 000 | N | |
| **31580** | Laryngoplasty; for laryngeal web, two stage, with keel insertion and removal | 29.32 | $2,448.22 | | 090 | Y | $1,075.50 |
| **31582** | Laryngoplasty; for laryngeal stenosis, with graft or core mold, including tracheotomy | 46.81 | $3,908.64 | | 090 | Y | $1,075.50 |
| **31584** | Laryngoplasty; with open reduction of fracture | 37.21 | $3,107.04 | | 090 | Y | |
| **31587** | Laryngoplasty, cricoid split | 23.53 | $1,964.76 | | 090 | Y | |
| **31588** | Laryngoplasty, not otherwise specified (eg, for burns, reconstruction after partial laryngectomy) | 27.28 | $2,277.88 | | 090 | Y | $1,075.50 |
| **31590** | Laryngeal reinnervation by neuromuscular pedicle | 22.37 | $1,867.90 | | 090 | Y | $1,075.50 |
| **31595** | Section recurrent laryngeal nerve, therapeutic (separate procedure), unilateral | 18.70 | $1,561.45 | | 090 | Y | $669.00 |
| **31599** | Unlisted procedure, larynx | 0.00 | BR | | 000 | N | |
| **31600** | Tracheostomy, planned (separate procedure); | 10.20 | $851.70 | | 000 | N | |
| **31601** | Tracheostomy, planned (separate procedure); younger than two years | 6.60 | $551.10 | | 000 | Y | |
| **31603** | Tracheostomy, emergency procedure; transtracheal | 5.73 | $478.46 | | 000 | N | $499.50 |
| **31605** | Tracheostomy, emergency procedure; cricothyroid membrane | 4.71 | $393.29 | | 000 | N | |
| **31610** | Tracheostomy, fenestration procedure with skin flaps | 17.14 | $1,431.19 | | 090 | N | |
| **31611** | Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis) | 12.70 | $1,060.45 | | 090 | Y | $765.00 |
| **31612** | Tracheal puncture, percutaneous with transtracheal aspiration and/or injection | 1.99 | $166.17 | | 000 | N | $499.50 |
| **31613** | Tracheostoma revision; simple, without flap rotation | 10.52 | $878.42 | | 090 | N | $669.00 |
| **31614** | Tracheostoma revision; complex, with flap rotation | 16.96 | $1,416.16 | | 090 | N | $669.00 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| ⊙ | 31615 | Tracheobronchoscopy through established tracheostomy incision | 4.54 | $379.09 | | 000 | N | $499.50 |
| +⊙ | 31620 | Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure(s)) | 7.10 | $592.85 | | 000 | N | $499.50 |
| ⊙ | 31622 | Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure) | 8.23 | $687.21 | | 000 | N | $499.50 |
| ⊙ | 31623 | Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with brushing or protected brushings | 9.04 | $754.84 | | 000 | N | $669.00 |
| ⊙ | 31624 | Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with bronchial alveolar lavage | 8.39 | $700.57 | | 000 | N | $669.00 |
| ⊙ | 31625 | Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with bronchial or endobronchial biopsy(s), single or multiple sites | 8.93 | $745.66 | | 000 | N | $669.00 |
| ⊙ | 31628 | Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), single lobe | 10.62 | $886.77 | | 000 | N | $669.00 |
| ⊙ | 31629 | Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i) | 17.54 | $1,464.59 | | 000 | N | $669.00 |
| | 31630 | Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with tracheal/bronchial dilation or closed reduction of fracture | 5.36 | $447.56 | | 000 | N | $669.00 |
| | 31631 | Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required) | 5.93 | $495.16 | | 000 | N | $669.00 |
| + | 31632 | Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure) | 1.94 | $161.99 | | 000 | N | |
| + | 31633 | Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure) | 2.29 | $191.22 | | 000 | N | |
| ⊙ | 31635 | Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with removal of foreign body | 9.42 | $786.57 | | 000 | N | $669.00 |
| | 31636 | Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus | 5.85 | $488.48 | | 000 | N | $669.00 |
| + | 31637 | Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; each additional major bronchus stented (List separately in addition to code for primary procedure) | 2.08 | $173.68 | | 000 | N | $499.50 |
| | 31638 | Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required) | 6.48 | $541.08 | | 000 | N | $669.00 |
| | 31640 | Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with excision of tumor | 6.83 | $570.31 | | 000 | N | $669.00 |
| | 31641 | Bronchoscopy, (rigid or flexible); with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy) | 6.65 | $555.28 | | 000 | N | $669.00 |
| | 31643 | Bronchoscopy, (rigid or flexible); with placement of catheter(s) for intracavitary radioelement application | 4.53 | $378.26 | | 000 | N | $669.00 |
| ⊙ | 31645 | Bronchoscopy, (rigid or flexible); with therapeutic aspiration of tracheobronchial tree, initial (eg, drainage of lung abscess) | 8.05 | $672.18 | | 000 | N | $499.50 |
| ⊙ | 31646 | Bronchoscopy, (rigid or flexible); with therapeutic aspiration of tracheobronchial tree, subsequent | 7.35 | $613.73 | | 000 | N | $499.50 |
| ⊙ | 31656 | Bronchoscopy, (rigid or flexible); with injection of contrast material for segmental bronchography (fiberscope only) | 8.89 | $742.32 | | 000 | N | $499.50 |
| | 31715 | Transtracheal injection for bronchography | 1.40 | $116.90 | | 000 | N | |
| | 31717 | Catheterization with bronchial brush biopsy | 9.70 | $809.95 | | 000 | N | $354.63 |
| | 31720 | Catheter aspiration (separate procedure); nasotracheal | 1.33 | $111.06 | | 000 | N | $70.98 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| ⊙ | **31725** | Catheter aspiration (separate procedure); tracheobronchial with fiberscope, bedside | 2.45 | $204.58 | | 000 | N | |
| | **31730** | Transtracheal (percutaneous) introduction of needle wire dilator/stent or indwelling tube for oxygen therapy | 10.75 | $897.63 | | 000 | N | $354.63 |
| | **31750** | Tracheoplasty; cervical | 31.93 | $2,666.16 | | 090 | Y | $1,075.50 |
| | **31755** | Tracheoplasty; tracheopharyngeal fistulization, each stage | 40.72 | $3,400.12 | | 090 | Y | $669.00 |
| | **31760** | Tracheoplasty; intrathoracic | 34.43 | $2,874.91 | | 090 | Y | |
| | **31766** | Carinal reconstruction | 46.03 | $3,843.51 | | 090 | Y | |
| | **31770** | Bronchoplasty; graft repair | 33.84 | $2,825.64 | | 090 | Y | |
| | **31775** | Bronchoplasty; excision stenosis and anastomosis | 36.13 | $3,016.86 | | 090 | Y | |
| | **31780** | Excision tracheal stenosis and anastomosis; cervical | 29.69 | $2,479.12 | | 090 | Y | |
| | **31781** | Excision tracheal stenosis and anastomosis; cervicothoracic | 35.94 | $3,000.99 | | 090 | Y | |
| | **31785** | Excision of tracheal tumor or carcinoma; cervical | 27.08 | $2,261.18 | | 090 | Y | |
| | **31786** | Excision of tracheal tumor or carcinoma; thoracic | 38.36 | $3,203.06 | | 090 | Y | |
| | **31800** | Suture of tracheal wound or injury; cervical | 17.09 | $1,427.02 | | 090 | Y | |
| | **31805** | Suture of tracheal wound or injury; intrathoracic | 20.82 | $1,738.47 | | 090 | Y | |
| | **31820** | Surgical closure tracheostomy or fistula; without plastic repair | 10.11 | $844.19 | | 090 | Y | $499.50 |
| | **31825** | Surgical closure tracheostomy or fistula; with plastic repair | 14.27 | $1,191.55 | | 090 | Y | $669.00 |
| | **31830** | Revision of tracheostomy scar | 10.25 | $855.88 | | 090 | N | $669.00 |
| | **31899** | Unlisted procedure, trachea, bronchi | 0.00 | BR | | 000 | N | |
| ⊘ | **32000** | Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent | 4.33 | $361.56 | | 000 | N | $334.17 |
| ⊘ | **32002** | Thoracentesis with insertion of tube with or without water seal (eg, for pneumothorax) (separate procedure) | 5.18 | $432.53 | | 000 | N | |
| | **32005** | Chemical pleurodesis (eg, for recurrent or persistent pneumothorax) | 8.30 | $693.05 | | 000 | N | |
| ⊙ | **32019** | Insertion of indwelling tunneled pleural catheter with cuff | 22.93 | $1,914.66 | | 000 | N | |
| ⊘⊙ | **32020** | Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure) | 4.64 | $387.44 | | 000 | N | |
| | **32035** | Thoracostomy; with rib resection for empyema | 17.24 | $1,439.54 | | 090 | Y | |
| | **32036** | Thoracostomy; with open flap drainage for empyema | 18.83 | $1,572.31 | | 090 | Y | |
| | **32095** | Thoracotomy, limited, for biopsy of lung or pleura | 15.59 | $1,301.77 | | 090 | Y | |
| | **32100** | Thoracotomy, major; with exploration and biopsy | 24.33 | $2,031.56 | | 090 | Y | |
| | **32110** | Thoracotomy, major; with control of traumatic hemorrhage and/or repair of lung tear | 36.39 | $3,038.57 | | 090 | Y | |
| | **32120** | Thoracotomy, major; for postoperative complications | 21.48 | $1,793.58 | | 090 | Y | |
| | **32124** | Thoracotomy, major; with open intrapleural pneumonolysis | 22.86 | $1,908.81 | | 090 | Y | |
| | **32140** | Thoracotomy, major; with cyst(s) removal, with or without a pleural procedure | 24.47 | $2,043.25 | | 090 | Y | |
| | **32141** | Thoracotomy, major; with excision-plication of bullae, with or without any pleural procedure | 34.63 | $2,891.61 | | 090 | Y | |
| | **32150** | Thoracotomy, major; with removal of intrapleural foreign body or fibrin deposit | 24.61 | $2,054.94 | | 090 | Y | |
| | **32151** | Thoracotomy, major; with removal of intrapulmonary foreign body | 25.36 | $2,117.56 | | 090 | Y | |
| | **32160** | Thoracotomy, major; with cardiac massage | 18.43 | $1,538.91 | | 090 | Y | |
| | **32200** | Pneumonostomy; with open drainage of abscess or cyst | 27.41 | $2,288.74 | | 090 | Y | |
| ⊙ | **32201** | Pneumonostomy; with percutaneous drainage of abscess or cyst | 24.04 | $2,007.34 | | 000 | Y | |
| | **32215** | Pleural scarification for repeat pneumothorax | 20.09 | $1,677.52 | | 090 | Y | |
| | **32220** | Decortication, pulmonary (separate procedure); total | 40.05 | $3,344.18 | | 090 | Y | |
| | **32225** | Decortication, pulmonary (separate procedure); partial | 24.65 | $2,058.28 | | 090 | Y | |
| | **32310** | Pleurectomy, parietal (separate procedure) | 22.91 | $1,912.99 | | 090 | Y | |
| | **32320** | Decortication and parietal pleurectomy | 39.85 | $3,327.48 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **32400** | Biopsy, pleura; percutaneous needle | 3.77 | $314.80 | | 000 | N | $499.50 |
| | **32402** | Biopsy, pleura; open | 14.10 | $1,177.35 | | 090 | Y | |
| | **32405** | Biopsy, lung or mediastinum, percutaneous needle | 2.49 | $207.92 | | 000 | N | $499.50 |
| | **32420** | Pneumocentesis, puncture of lung for aspiration | 2.74 | $228.79 | | 000 | N | $334.17 |
| | **32440** | Removal of lung, total pneumonectomy; | 40.57 | $3,387.60 | | 090 | Y | |
| | **32442** | Removal of lung, total pneumonectomy; with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy) | 70.26 | $5,866.71 | | 090 | Y | |
| | **32445** | Removal of lung, total pneumonectomy; extrapleural | 77.22 | $6,447.87 | | 090 | Y | |
| | **32480** | Removal of lung, other than total pneumonectomy; single lobe (lobectomy) | 38.25 | $3,193.88 | | 090 | Y | |
| | **32482** | Removal of lung, other than total pneumonectomy; two lobes (bilobectomy) | 40.69 | $3,397.62 | | 090 | Y | |
| | **32484** | Removal of lung, other than total pneumonectomy; single segment (segmentectomy) | 36.74 | $3,067.79 | | 090 | Y | |
| | **32486** | Removal of lung, other than total pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy) | 55.74 | $4,654.29 | | 090 | Y | |
| | **32488** | Removal of lung, other than total pneumonectomy; all remaining lung following previous removal of a portion of lung (completion pneumonectomy) | 56.59 | $4,725.27 | | 090 | Y | |
| | **32491** | Removal of lung, other than total pneumonectomy; 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 | 37.69 | $3,147.12 | | 090 | Y | |
| | **32500** | Removal of lung, other than total pneumonectomy; wedge resection, single or multiple | 37.14 | $3,101.19 | | 090 | Y | |
| + | **32501** | Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure) | 6.36 | $531.06 | | 000 | Y | |
| | **32503** | Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; without chest wall reconstruction(s) | 47.18 | $3,939.53 | | 090 | Y | |
| | **32504** | Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; with chest wall reconstruction | 53.77 | $4,489.80 | | 090 | Y | |
| | **32540** | Extrapleural enucleation of empyema (empyemectomy) | 39.53 | $3,300.76 | | 090 | Y | |
| | **32601** | Thoracoscopy, diagnostic (separate procedure); lungs and pleural space, without biopsy | 7.99 | $667.17 | | 000 | Y | |
| | **32602** | Thoracoscopy, diagnostic (separate procedure); lungs and pleural space, with biopsy | 8.67 | $723.95 | | 000 | Y | |
| | **32603** | Thoracoscopy, diagnostic (separate procedure); pericardial sac, without biopsy | 11.18 | $933.53 | | 000 | Y | |
| | **32604** | Thoracoscopy, diagnostic (separate procedure); pericardial sac, with biopsy | 12.49 | $1,042.92 | | 000 | Y | |
| | **32605** | Thoracoscopy, diagnostic (separate procedure); mediastinal space, without biopsy | 10.03 | $837.51 | | 000 | Y | |
| | **32606** | Thoracoscopy, diagnostic (separate procedure); mediastinal space, with biopsy | 12.02 | $1,003.67 | | 000 | Y | |
| | **32650** | Thoracoscopy, surgical; with pleurodesis (eg, mechanical or chemical) | 17.66 | $1,474.61 | | 090 | Y | |
| | **32651** | Thoracoscopy, surgical; with partial pulmonary decortication | 26.05 | $2,175.18 | | 090 | Y | |
| | **32652** | Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis | 39.22 | $3,274.87 | | 090 | Y | |
| | **32653** | Thoracoscopy, surgical; with removal of intrapleural foreign body or fibrin deposit | 25.26 | $2,109.21 | | 090 | Y | |
| | **32654** | Thoracoscopy, surgical; with control of traumatic hemorrhage | 27.65 | $2,308.78 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **32655** | Thoracoscopy, surgical; with excision-plication of bullae, including any pleural procedure | 23.56 | $1,967.26 | | 090 | Y | |
| | **32656** | Thoracoscopy, surgical; with parietal pleurectomy | 21.21 | $1,771.04 | | 090 | Y | |
| | **32657** | Thoracoscopy, surgical; with wedge resection of lung, single or multiple | 20.84 | $1,740.14 | | 090 | Y | |
| | **32658** | Thoracoscopy, surgical; with removal of clot or foreign body from pericardial sac | 19.10 | $1,594.85 | | 090 | Y | |
| | **32659** | Thoracoscopy, surgical; with creation of pericardial window or partial resection of pericardial sac for drainage | 19.36 | $1,616.56 | | 090 | Y | |
| | **32660** | Thoracoscopy, surgical; with total pericardiectomy | 26.98 | $2,252.83 | | 090 | Y | |
| | **32661** | Thoracoscopy, surgical; with excision of pericardial cyst, tumor, or mass | 21.26 | $1,775.21 | | 090 | Y | |
| | **32662** | Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass | 23.88 | $1,993.98 | | 090 | Y | |
| | **32663** | Thoracoscopy, surgical; with lobectomy, total or segmental | 35.26 | $2,944.21 | | 090 | Y | |
| | **32664** | Thoracoscopy, surgical; with thoracic sympathectomy | 22.44 | $1,873.74 | | 090 | Y | |
| | **32665** | Thoracoscopy, surgical; with esophagomyotomy (Heller type) | 29.71 | $2,480.79 | | 090 | Y | |
| | **32800** | Repair lung hernia through chest wall | 23.34 | $1,948.89 | | 090 | Y | |
| | **32810** | Closure of chest wall following open flap drainage for empyema (Clagett type procedure) | 22.70 | $1,895.45 | | 090 | Y | |
| | **32815** | Open closure of major bronchial fistula | 61.03 | $5,096.01 | | 090 | Y | |
| | **32820** | Major reconstruction, chest wall (posttraumatic) | 34.69 | $2,896.62 | | 090 | Y | |
| | **32850** | Donor pneumonectomy(s) (including cold preservation), from cadaver donor | 0.00 | BR | | 000 | Y | |
| | **32851** | Lung transplant, single; without cardiopulmonary bypass | 68.37 | $5,708.90 | | 090 | Y | |
| | **32852** | Lung transplant, single; with cardiopulmonary bypass | 76.98 | $6,427.83 | | 090 | Y | |
| | **32853** | Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass | 81.78 | $6,828.63 | | 090 | Y | |
| | **32854** | Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass | 88.36 | $7,378.06 | | 090 | Y | |
| | **32855** | Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; unilateral | 0.00 | BR | | 000 | Y | |
| | **32856** | Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; bilateral | 0.00 | BR | | 000 | Y | |
| | **32900** | Resection of ribs, extrapleural, all stages | 34.11 | $2,848.19 | | 090 | Y | |
| | **32905** | Thoracoplasty, Schede type or extrapleural (all stages); | 34.00 | $2,839.00 | | 090 | Y | |
| | **32906** | Thoracoplasty, Schede type or extrapleural (all stages); with closure of bronchopleural fistula | 42.10 | $3,515.35 | | 090 | Y | |
| | **32940** | Pneumonolysis, extraperiosteal, including filling or packing procedures | 31.24 | $2,608.54 | | 090 | Y | |
| | **32960** | Pneumothorax, therapeutic, intrapleural injection of air | 3.49 | $291.42 | | 000 | N | |
| | **32997** | Total lung lavage (unilateral) | 9.02 | $753.17 | | 000 | N | |
| | **32998** | Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral | 74.11 | $6,188.19 | | 000 | Y | |
| | **32999** | Unlisted procedure, lungs and pleura | 0.00 | BR | | 000 | N | |
| ⊙ | **33010** | Pericardiocentesis; initial | 3.00 | $250.50 | | 000 | N | $334.17 |
| ⊙ | **33011** | Pericardiocentesis; subsequent | 3.05 | $254.68 | | 000 | N | $334.17 |
| | **33015** | Tube pericardiostomy | 13.22 | $1,103.87 | | 090 | N | |
| | **33020** | Pericardiotomy for removal of clot or foreign body (primary procedure) | 21.88 | $1,826.98 | | 090 | Y | |
| | **33025** | Creation of pericardial window or partial resection for drainage | 20.34 | $1,698.39 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **33030** | Pericardiectomy, subtotal or complete; without cardiopulmonary bypass | 32.32 | $2,698.72 | | 090 | Y | |
| | **33031** | Pericardiectomy, subtotal or complete; with cardiopulmonary bypass | 35.90 | $2,997.65 | | 090 | Y | |
| | **33050** | Excision of pericardial cyst or tumor | 25.08 | $2,094.18 | | 090 | Y | |
| | **33120** | Excision of intracardiac tumor, resection with cardiopulmonary bypass | 39.65 | $3,310.78 | | 090 | Y | |
| | **33130** | Resection of external cardiac tumor | 34.59 | $2,888.27 | | 090 | Y | |
| | **33140** | Transmyocardial laser revascularization, by thoracotomy; (separate procedure) | 39.10 | $3,264.85 | | 090 | Y | |
| + | **33141** | Transmyocardial laser revascularization, by thoracotomy; performed at the time of other open cardiac procedure(s) (List separately in addition to code for primary procedure) | 4.36 | $364.06 | | 000 | Y | |
| | **33202** | Insertion of epicardial electrode(s); open incision (eg, thoracotomy, median sternotomy, subxiphoid approach) | 19.76 | $1,649.96 | | 090 | Y | |
| | **33203** | Insertion of epicardial electrode(s); endoscopic approach (eg, thoracoscopy, pericardioscopy) | 20.20 | $1,686.70 | | 090 | N | |
| ⊙ | **33206** | Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial | 11.73 | $979.46 | | 090 | N | |
| ⊙ | **33207** | Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular | 13.68 | $1,142.28 | | 090 | N | |
| ⊙ | **33208** | Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular | 12.81 | $1,069.64 | | 090 | N | |
| ⊙ | **33210** | Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter (separate procedure) | 4.52 | $377.42 | | 000 | N | |
| ⊙ | **33211** | Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure) | 4.67 | $389.95 | | 000 | N | |
| ⊙ | **33212** | Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular | 8.85 | $738.98 | | 090 | N | $765.00 |
| ⊙ | **33213** | Insertion or replacement of pacemaker pulse generator only; dual chamber | 10.04 | $838.34 | | 090 | N | $765.00 |
| ⊙ | **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) | 12.61 | $1,052.94 | | 090 | Y | |
| | **33215** | Repositioning of previously implanted transvenous pacemaker or pacing cardioverter-defibrillator (right atrial or right ventricular) electrode | 8.04 | $671.34 | | 090 | N | |
| ⊙ | **33216** | Insertion of a transvenous electrode; single chamber (one electrode) permanent pacemaker or single chamber pacing cardioverter-defibrillator | 9.90 | $826.65 | | 090 | N | |
| ⊙ | **33217** | Insertion of a transvenous electrode; dual chamber (two electrodes) permanent pacemaker or dual chamber pacing cardioverter-defibrillator | 9.90 | $826.65 | | 090 | N | |
| ⊙ | **33218** | Repair of single transvenous electrode for a single chamber, permanent pacemaker or single chamber pacing cardioverter-defibrillator | 10.18 | $850.03 | | 090 | N | |
| ⊙ | **33220** | Repair of two transvenous electrodes for a dual chamber permanent pacemaker or dual chamber pacing cardioverter-defibrillator | 10.25 | $855.88 | | 090 | N | |
| ⊙ | **33222** | Revision or relocation of skin pocket for pacemaker | 9.24 | $771.54 | | 090 | N | $669.00 |
| ⊙ | **33223** | Revision of skin pocket for single or dual chamber pacing cardioverter-defibrillator | 10.99 | $917.67 | | 090 | Y | $669.00 |
| | **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) | 12.95 | $1,081.33 | | 000 | N | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| + | **33225** | Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system) (List separately in addition to code for primary procedure) | 11.51 | $961.09 | | 000 | N | |
| | **33226** | Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of generator) | 12.50 | $1,043.75 | | 000 | N | |
| ⊙ | **33233** | Removal of permanent pacemaker pulse generator | 6.51 | $543.59 | | 090 | N | $669.00 |
| ⊙ | **33234** | Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular | 12.70 | $1,060.45 | | 090 | N | |
| ⊙ | **33235** | Removal of transvenous pacemaker electrode(s); dual lead system | 16.62 | $1,387.77 | | 090 | N | |
| | **33236** | Removal of permanent epicardial pacemaker and electrodes by thoracotomy; single lead system, atrial or ventricular | 20.30 | $1,695.05 | | 090 | Y | |
| | **33237** | Removal of permanent epicardial pacemaker and electrodes by thoracotomy; dual lead system | 21.72 | $1,813.62 | | 090 | Y | |
| | **33238** | Removal of permanent transvenous electrode(s) by thoracotomy | 24.00 | $2,004.00 | | 090 | Y | |
| ⊙ | **33240** | Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator | 12.04 | $1,005.34 | | 090 | N | |
| ⊙ | **33241** | Subcutaneous removal of single or dual chamber pacing cardioverter-defibrillator pulse generator | 6.10 | $509.35 | | 090 | Y | |
| | **33243** | Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by thoracotomy | 34.51 | $2,881.59 | | 090 | Y | |
| ⊙ | **33244** | Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by transvenous extraction | 22.52 | $1,880.42 | | 090 | N | |
| ⊙ | **33249** | Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator | 23.17 | $1,934.70 | | 090 | Y | |
| | **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 | 37.18 | $3,104.53 | | 090 | Y | |
| | **33251** | Operative ablation of supraventricular arrhythmogenic focus or pathway (eg, Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci); with cardiopulmonary bypass | 41.02 | $3,425.17 | | 090 | Y | |
| | **33254** | Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure) | 34.50 | $2,880.75 | | 090 | Y | |
| | **33255** | Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass | 41.51 | $3,466.09 | | 090 | Y | |
| | **33256** | Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass | 49.59 | $4,140.77 | | 090 | Y | |
| | **33261** | Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary bypass | 41.01 | $3,424.34 | | 090 | Y | |
| | **33265** | Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass | 34.50 | $2,880.75 | | 090 | Y | |
| | **33266** | Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass | 47.20 | $3,941.20 | | 090 | Y | |
| | **33282** | Implantation of patient-activated cardiac event recorder | 8.56 | $714.76 | | 090 | N | |
| | **33284** | Removal of an implantable, patient-activated cardiac event recorder | 6.37 | $531.90 | | 090 | N | |
| | **33300** | Repair of cardiac wound; without bypass | 53.86 | $4,497.31 | | 090 | Y | |
| | **33305** | Repair of cardiac wound; with cardiopulmonary bypass | 86.51 | $7,223.59 | | 090 | Y | |
| | **33310** | Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); without bypass | 30.17 | $2,519.20 | | 090 | Y | |
| | **33315** | Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); with cardiopulmonary bypass | 37.48 | $3,129.58 | | 090 | Y | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| 33320 | Suture repair of aorta or great vessels; without shunt or cardiopulmonary bypass | 27.02 | $2,256.17 | | 090 | Y | |
| 33321 | Suture repair of aorta or great vessels; with shunt bypass | 31.45 | $2,626.08 | | 090 | Y | |
| 33322 | Suture repair of aorta or great vessels; with cardiopulmonary bypass | 34.94 | $2,917.49 | | 090 | Y | |
| 33330 | Insertion of graft, aorta or great vessels; without shunt, or cardiopulmonary bypass | 35.59 | $2,971.77 | | 090 | Y | |
| 33332 | Insertion of graft, aorta or great vessels; with shunt bypass | 35.31 | $2,948.39 | | 090 | Y | |
| 33335 | Insertion of graft, aorta or great vessels; with cardiopulmonary bypass | 47.91 | $4,000.49 | | 090 | Y | |
| 33400 | Valvuloplasty, aortic valve; open, with cardiopulmonary bypass | 56.86 | $4,747.81 | | 090 | Y | |
| 33401 | Valvuloplasty, aortic valve; open, with inflow occlusion | 38.09 | $3,180.52 | | 090 | Y | |
| 33403 | Valvuloplasty, aortic valve; using transventricular dilation, with cardiopulmonary bypass | 39.74 | $3,318.29 | | 090 | Y | |
| 33404 | Construction of apical-aortic conduit | 46.40 | $3,874.40 | | 090 | Y | |
| 33405 | Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve | 59.96 | $5,006.66 | | 090 | Y | |
| 33406 | Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand) | 71.74 | $5,990.29 | | 090 | Y | |
| 33410 | Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve | 62.97 | $5,258.00 | | 090 | Y | |
| 33411 | Replacement, aortic valve; with aortic annulus enlargement, noncoronary cusp | 80.63 | $6,732.61 | | 090 | Y | |
| 33412 | Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure) | 65.18 | $5,442.53 | | 090 | Y | |
| 33413 | Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure) | 81.01 | $6,764.34 | | 090 | Y | |
| 33414 | Repair of left ventricular outflow tract obstruction by patch enlargement of the outflow tract | 54.31 | $4,534.89 | | 090 | Y | |
| 33415 | Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis | 49.85 | $4,162.48 | | 090 | Y | |
| 33416 | Ventriculomyotomy (-myectomy) for idiopathic hypertrophic subaortic stenosis (eg, asymmetric septal hypertrophy) | 50.86 | $4,246.81 | | 090 | Y | |
| 33417 | Aortoplasty (gusset) for supravalvular stenosis | 43.57 | $3,638.10 | | 090 | Y | |
| 33420 | Valvotomy, mitral valve; closed heart | 34.33 | $2,866.56 | | 090 | Y | |
| 33422 | Valvotomy, mitral valve; open heart, with cardiopulmonary bypass | 43.92 | $3,667.32 | | 090 | Y | |
| 33425 | Valvuloplasty, mitral valve, with cardiopulmonary bypass; | 63.15 | $5,273.03 | | 090 | Y | |
| 33426 | Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring | 60.70 | $5,068.45 | | 090 | Y | |
| 33427 | Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring | 64.82 | $5,412.47 | | 090 | Y | |
| 33430 | Replacement, mitral valve, with cardiopulmonary bypass | 68.45 | $5,715.58 | | 090 | Y | |
| 33460 | Valvectomy, tricuspid valve, with cardiopulmonary bypass | 55.93 | $4,670.16 | | 090 | Y | |
| 33463 | Valvuloplasty, tricuspid valve; without ring insertion | 69.71 | $5,820.79 | | 090 | Y | |
| 33464 | Valvuloplasty, tricuspid valve; with ring insertion | 58.36 | $4,873.06 | | 090 | Y | |
| 33465 | Replacement, tricuspid valve, with cardiopulmonary bypass | 64.05 | $5,348.18 | | 090 | Y | |
| 33468 | Tricuspid valve repositioning and plication for Ebstein anomaly | 47.67 | $3,980.45 | | 090 | Y | |
| 33470 | Valvotomy, pulmonary valve, closed heart; transventricular | 30.40 | $2,538.40 | | 090 | Y | |
| 33471 | Valvotomy, pulmonary valve, closed heart; via pulmonary artery | 33.16 | $2,768.86 | | 090 | Y | |
| 33472 | Valvotomy, pulmonary valve, open heart; with inflow occlusion | 34.85 | $2,909.98 | | 090 | Y | |
| 33474 | Valvotomy, pulmonary valve, open heart; with cardiopulmonary bypass | 51.01 | $4,259.34 | | 090 | Y | |
| 33475 | Replacement, pulmonary valve | 58.41 | $4,877.24 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **33476** | Right ventricular resection for infundibular stenosis, with or without commissurotomy | 38.00 | $3,173.00 | | 090 | Y | |
| | **33478** | Outflow tract augmentation (gusset), with or without commissurotomy or infundibular resection | 41.05 | $3,427.68 | | 090 | Y | |
| | **33496** | Repair of non-structural prosthetic valve dysfunction with cardiopulmonary bypass (separate procedure) | 43.27 | $3,613.05 | | 090 | Y | |
| | **33500** | Repair of coronary arteriovenous or arteriocardiac chamber fistula; with cardiopulmonary bypass | 40.25 | $3,360.88 | | 090 | Y | |
| | **33501** | Repair of coronary arteriovenous or arteriocardiac chamber fistula; without cardiopulmonary bypass | 27.67 | $2,310.45 | | 090 | Y | |
| | **33502** | Repair of anomalous coronary artery from pulmonary artery origin; by ligation | 33.13 | $2,766.36 | | 090 | Y | |
| | **33503** | Repair of anomalous coronary artery from pulmonary artery origin; by graft, without cardiopulmonary bypass | 31.79 | $2,654.47 | | 090 | Y | |
| | **33504** | Repair of anomalous coronary artery from pulmonary artery origin; by graft, with cardiopulmonary bypass | 37.50 | $3,131.25 | | 090 | Y | |
| | **33505** | Repair of anomalous coronary artery from pulmonary artery origin; with construction of intrapulmonary artery tunnel (Takeuchi procedure) | 49.43 | $4,127.41 | | 090 | Y | |
| | **33506** | Repair of anomalous coronary artery from pulmonary artery origin; by translocation from pulmonary artery to aorta | 53.47 | $4,464.75 | | 090 | Y | |
| | **33507** | Repair of anomalous (eg, intramural) aortic origin of coronary artery by unroofing or translocation | 45.43 | $3,793.41 | | 090 | Y | |
| + | **33508** | Endoscopy, surgical, including video-assisted harvest of vein(s) for coronary artery bypass procedure (List separately in addition to code for primary procedure) | 0.42 | $35.07 | | 000 | Y | |
| | **33510** | Coronary artery bypass, vein only; single coronary venous graft | 51.32 | $4,285.22 | | 090 | Y | |
| | **33511** | Coronary artery bypass, vein only; two coronary venous grafts | 55.46 | $4,630.91 | | 090 | Y | |
| | **33512** | Coronary artery bypass, vein only; three coronary venous grafts | 61.39 | $5,126.07 | | 090 | Y | |
| | **33513** | Coronary artery bypass, vein only; four coronary venous grafts | 63.13 | $5,271.36 | | 090 | Y | |
| | **33514** | Coronary artery bypass, vein only; five coronary venous grafts | 65.86 | $5,499.31 | | 090 | Y | |
| | **33516** | Coronary artery bypass, vein only; six or more coronary venous grafts | 68.53 | $5,722.26 | | 090 | Y | |
| ⊘ | **33517** | Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (List separately in addition to code for arterial graft) | 4.55 | $379.93 | | 000 | Y | |
| ⊘ | **33518** | Coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (List separately in addition to code for arterial graft) | 9.65 | $805.78 | | 000 | Y | |
| ⊘ | **33519** | Coronary artery bypass, using venous graft(s) and arterial graft(s); three venous grafts (List separately in addition to code for arterial graft) | 13.01 | $1,086.34 | | 000 | Y | |
| ⊘ | **33521** | Coronary artery bypass, using venous graft(s) and arterial graft(s); four venous grafts (List separately in addition to code for arterial graft) | 15.96 | $1,332.66 | | 000 | Y | |
| ⊘ | **33522** | Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (List separately in addition to code for arterial graft) | 18.44 | $1,539.74 | | 000 | Y | |
| ⊘ | **33523** | Coronary artery bypass, using venous graft(s) and arterial graft(s); six or more venous grafts (List separately in addition to code for arterial graft) | 21.23 | $1,772.71 | | 000 | Y | |
| + | **33530** | Reoperation, coronary artery bypass procedure or valve procedure, more than one month after original operation (List separately in addition to code for primary procedure) | 12.20 | $1,018.70 | | 000 | Y | |
| | **33533** | Coronary artery bypass, using arterial graft(s); single arterial graft | 50.37 | $4,205.90 | | 090 | Y | |
| | **33534** | Coronary artery bypass, using arterial graft(s); two coronary arterial grafts | 57.50 | $4,801.25 | | 090 | Y | |
| | **33535** | Coronary artery bypass, using arterial graft(s); three coronary arterial grafts | 62.93 | $5,254.66 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **33536** | Coronary artery bypass, using arterial graft(s); four or more coronary arterial grafts | 67.01 | $5,595.34 | | 090 | Y | |
| | **33542** | Myocardial resection (eg, ventricular aneurysmectomy) | 61.74 | $5,155.29 | | 090 | Y | |
| | **33545** | Repair of postinfarction ventricular septal defect, with or without myocardial resection | 73.26 | $6,117.21 | | 090 | Y | |
| | **33548** | Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures) | 73.54 | $6,140.59 | | 090 | Y | |
| + | **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) | 6.06 | $506.01 | | 000 | Y | |
| | **33600** | Closure of atrioventricular valve (mitral or tricuspid) by suture or patch | 44.04 | $3,677.34 | | 090 | Y | |
| | **33602** | Closure of semilunar valve (aortic or pulmonary) by suture or patch | 42.79 | $3,572.97 | | 090 | Y | |
| | **33606** | Anastomosis of pulmonary artery to aorta (Damus-Kaye-Stansel procedure) | 45.90 | $3,832.65 | | 090 | Y | |
| | **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 | 47.20 | $3,941.20 | | 090 | Y | |
| | **33610** | Repair of complex cardiac anomalies (eg, single ventricle with subaortic obstruction) by surgical enlargement of ventricular septal defect | 45.68 | $3,814.28 | | 090 | Y | |
| | **33611** | Repair of double outlet right ventricle with intraventricular tunnel repair; | 50.03 | $4,177.51 | | 090 | Y | |
| | **33612** | Repair of double outlet right ventricle with intraventricular tunnel repair; with repair of right ventricular outflow tract obstruction | 52.71 | $4,401.29 | | 090 | Y | |
| | **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) | 49.47 | $4,130.75 | | 090 | Y | |
| | **33617** | Repair of complex cardiac anomalies (eg, single ventricle) by modified Fontan procedure | 56.80 | $4,742.80 | | 090 | Y | |
| | **33619** | Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure) | 70.33 | $5,872.56 | | 090 | Y | |
| | **33641** | Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch | 39.69 | $3,314.12 | | 090 | Y | |
| | **33645** | Direct or patch closure, sinus venosus, with or without anomalous pulmonary venous drainage | 40.53 | $3,384.26 | | 090 | Y | |
| | **33647** | Repair of atrial septal defect and ventricular septal defect, with direct or patch closure | 43.14 | $3,602.19 | | 090 | Y | |
| | **33660** | Repair of incomplete or partial atrioventricular canal (ostium primum atrial septal defect), with or without atrioventricular valve repair | 46.02 | $3,842.67 | | 090 | Y | |
| | **33665** | Repair of intermediate or transitional atrioventricular canal, with or without atrioventricular valve repair | 48.75 | $4,070.63 | | 090 | Y | |
| | **33670** | Repair of complete atrioventricular canal, with or without prosthetic valve | 50.49 | $4,215.92 | | 090 | Y | |
| | **33675** | Closure of multiple ventricular septal defects; | 55.03 | $4,595.01 | | 090 | Y | |
| | **33676** | Closure of multiple ventricular septal defects; with pulmonary valvotomy or infundibular resection (acyanotic) | 56.77 | $4,740.30 | | 090 | Y | |
| | **33677** | Closure of multiple ventricular septal defects; with removal of pulmonary artery band, with or without gusset | 59.01 | $4,927.34 | | 090 | Y | |
| | **33681** | Closure of single ventricular septal defect, with or without patch; | 47.69 | $3,982.12 | | 090 | Y | |
| | **33684** | Closure of single ventricular septal defect, with or without patch; with pulmonary valvotomy or infundibular resection (acyanotic) | 49.36 | $4,121.56 | | 090 | Y | |
| | **33688** | Closure of single ventricular septal defect, with or without patch; with removal of pulmonary artery band, with or without gusset | 46.12 | $3,851.02 | | 090 | Y | |
| | **33690** | Banding of pulmonary artery | 29.91 | $2,497.49 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **33692** | Complete repair tetralogy of Fallot without pulmonary atresia; | 45.54 | $3,802.59 | | 090 | Y | |
| | **33694** | Complete repair tetralogy of Fallot without pulmonary atresia; with transannular patch | 50.38 | $4,206.73 | | 090 | Y | |
| | **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 | 54.45 | $4,546.58 | | 090 | Y | |
| | **33702** | Repair sinus of Valsalva fistula, with cardiopulmonary bypass; | 40.35 | $3,369.23 | | 090 | Y | |
| | **33710** | Repair sinus of Valsalva fistula, with cardiopulmonary bypass; with repair of ventricular septal defect | 45.04 | $3,760.84 | | 090 | Y | |
| | **33720** | Repair sinus of Valsalva aneurysm, with cardiopulmonary bypass | 40.23 | $3,359.21 | | 090 | Y | |
| | **33722** | Closure of aortico-left ventricular tunnel | 39.98 | $3,338.33 | | 090 | Y | |
| | **33724** | Repair of isolated partial anomalous pulmonary venous return (eg, Scimitar Syndrome) | 39.34 | $3,284.89 | | 090 | Y | |
| | **33726** | Repair of pulmonary venous stenosis | 51.80 | $4,325.30 | | 090 | Y | |
| | **33730** | Complete repair of anomalous pulmonary venous return (supracardiac, intracardiac, or infracardiac types) | 51.33 | $4,286.06 | | 090 | Y | |
| | **33732** | Repair of cor triatriatum or supravalvular mitral ring by resection of left atrial membrane | 43.32 | $3,617.22 | | 090 | Y | |
| | **33735** | Atrial septectomy or septostomy; closed heart (Blalock-Hanlon type operation) | 30.82 | $2,573.47 | | 090 | Y | |
| | **33736** | Atrial septectomy or septostomy; open heart with cardiopulmonary bypass | 36.39 | $3,038.57 | | 090 | Y | |
| | **33737** | Atrial septectomy or septostomy; open heart, with inflow occlusion | 33.42 | $2,790.57 | | 090 | Y | |
| | **33750** | Shunt; subclavian to pulmonary artery (Blalock-Taussig type operation) | 31.51 | $2,631.09 | | 090 | Y | |
| | **33755** | Shunt; ascending aorta to pulmonary artery (Waterston type operation) | 31.99 | $2,671.17 | | 090 | Y | |
| | **33762** | Shunt; descending aorta to pulmonary artery (Potts-Smith type operation) | 32.72 | $2,732.12 | | 090 | Y | |
| | **33764** | Shunt; central, with prosthetic graft | 33.16 | $2,768.86 | | 090 | Y | |
| | **33766** | Shunt; superior vena cava to pulmonary artery for flow to one lung (classical Glenn procedure) | 35.64 | $2,975.94 | | 090 | Y | |
| | **33767** | Shunt; superior vena cava to pulmonary artery for flow to both lungs (bidirectional Glenn procedure) | 37.58 | $3,137.93 | | 090 | Y | |
| + | **33768** | Anastomosis, cavopulmonary, second superior vena cava (List separately in addition to primary procedure) | 10.94 | $913.49 | | 000 | Y | |
| | **33770** | Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; without surgical enlargement of ventricular septal defect | 54.48 | $4,549.08 | | 090 | Y | |
| | **33771** | Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; with surgical enlargement of ventricular septal defect | 54.10 | $4,517.35 | | 090 | Y | |
| | **33774** | Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; | 47.27 | $3,947.05 | | 090 | Y | |
| | **33775** | Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with removal of pulmonary band | 48.29 | $4,032.22 | | 090 | Y | |
| | **33776** | Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with closure of ventricular septal defect | 51.33 | $4,286.06 | | 090 | Y | |
| | **33777** | Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with repair of subpulmonic obstruction | 50.21 | $4,192.54 | | 090 | Y | |
| | **33778** | Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); | 61.00 | $5,093.50 | | 090 | Y | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **33779** | Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with removal of pulmonary band | 56.10 | $4,684.35 | | 090 | Y | |
| **33780** | Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with closure of ventricular septal defect | 60.35 | $5,039.23 | | 090 | Y | |
| **33781** | Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with repair of subpulmonic obstruction | 58.33 | $4,870.56 | | 090 | Y | |
| **33786** | Total repair, truncus arteriosus (Rastelli type operation) | 58.64 | $4,896.44 | | 090 | Y | |
| **33788** | Reimplantation of an anomalous pulmonary artery | 39.94 | $3,334.99 | | 090 | Y | |
| **33800** | Aortic suspension (aortopexy) for tracheal decompression (eg, for tracheomalacia) (separate procedure) | 25.87 | $2,160.15 | | 090 | Y | |
| **33802** | Division of aberrant vessel (vascular ring); | 27.48 | $2,294.58 | | 090 | Y | |
| **33803** | Division of aberrant vessel (vascular ring); with reanastomosis | 30.65 | $2,559.28 | | 090 | Y | |
| **33813** | Obliteration of aortopulmonary septal defect; without cardiopulmonary bypass | 32.64 | $2,725.44 | | 090 | Y | |
| **33814** | Obliteration of aortopulmonary septal defect; with cardiopulmonary bypass | 39.69 | $3,314.12 | | 090 | Y | |
| **33820** | Repair of patent ductus arteriosus; by ligation | 25.66 | $2,142.61 | | 090 | Y | |
| **33822** | Repair of patent ductus arteriosus; by division, younger than 18 years | 26.74 | $2,232.79 | | 090 | Y | |
| **33824** | Repair of patent ductus arteriosus; by division, 18 years and older | 30.60 | $2,555.10 | | 090 | Y | |
| **33840** | Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with direct anastomosis | 31.20 | $2,605.20 | | 090 | Y | |
| **33845** | Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with graft | 34.61 | $2,889.94 | | 090 | Y | |
| **33851** | Excision of coarctation of aorta, with or without associated patent ductus arteriosus; repair using either left subclavian artery or prosthetic material as gusset for enlargement | 33.12 | $2,765.52 | | 090 | Y | |
| **33852** | Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; without cardiopulmonary bypass | 34.98 | $2,920.83 | | 090 | Y | |
| **33853** | Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; with cardiopulmonary bypass | 47.95 | $4,003.83 | | 090 | Y | |
| **33860** | Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; | 76.60 | $6,396.10 | | 090 | Y | |
| **33861** | Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with coronary reconstruction | 63.19 | $5,276.37 | | 090 | Y | |
| **33863** | Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction | 78.40 | $6,546.40 | | 090 | Y | |
| **33870** | Transverse arch graft, with cardiopulmonary bypass | 65.88 | $5,500.98 | | 090 | Y | |
| **33875** | Descending thoracic aorta graft, with or without bypass | 50.83 | $4,244.31 | | 090 | Y | |
| **33877** | Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass | 85.53 | $7,141.76 | | 090 | Y | |
| **33880** | Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin | 46.49 | $3,881.92 | | 090 | Y | |
| **33881** | Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin | 40.13 | $3,350.86 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | 33883 | Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension | 29.61 | $2,472.44 | | 090 | Y | |
| + | 33884 | Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (List separately in addition to code for primary procedure) | 10.67 | $890.95 | | 000 | Y | |
| | 33886 | Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta | 25.70 | $2,145.95 | | 090 | Y | |
| | 33889 | Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral | 21.42 | $1,788.57 | | 000 | Y | |
| | 33891 | Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision | 27.52 | $2,297.92 | | 000 | Y | |
| | 33910 | Pulmonary artery embolectomy; with cardiopulmonary bypass | 41.70 | $3,481.95 | | 090 | Y | |
| | 33915 | Pulmonary artery embolectomy; without cardiopulmonary bypass | 33.35 | $2,784.73 | | 090 | Y | |
| | 33916 | Pulmonary endarterectomy, with or without embolectomy, with cardiopulmonary bypass | 40.34 | $3,368.39 | | 090 | Y | |
| | 33917 | Repair of pulmonary artery stenosis by reconstruction with patch or graft | 38.04 | $3,176.34 | | 090 | Y | |
| | 33920 | Repair of pulmonary atresia with ventricular septal defect, by construction or replacement of conduit from right or left ventricle to pulmonary artery | 46.88 | $3,914.48 | | 090 | Y | |
| | 33922 | Transection of pulmonary artery with cardiopulmonary bypass | 35.81 | $2,990.14 | | 090 | Y | |
| + | 33924 | Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to code for primary procedure) | 7.68 | $641.28 | | 000 | Y | |
| | 33925 | Repair of pulmonary artery arborization anomalies by unifocalization; without cardiopulmonary bypass | 46.26 | $3,862.71 | | 090 | Y | |
| | 33926 | Repair of pulmonary artery arborization anomalies by unifocalization; with cardiopulmonary bypass | 63.25 | $5,281.38 | | 090 | Y | |
| | 33930 | Donor cardiectomy-pneumonectomy (including cold preservation) | 0.00 | BR | | 000 | Y | |
| | 33933 | Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, and trachea for implantation | 0.00 | BR | | 000 | Y | |
| | 33935 | Heart-lung transplant with recipient cardiectomy-pneumonectomy | 91.92 | $7,675.32 | | 090 | Y | |
| | 33940 | Donor cardiectomy (including cold preservation) | 0.00 | BR | | 000 | Y | |
| | 33944 | Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation | 0.00 | BR | | 000 | Y | |
| | 33945 | Heart transplant, with or without recipient cardiectomy | 110.12 | $9,195.02 | | 090 | Y | |
| | 33960 | Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial 24 hours | 25.15 | $2,100.03 | | 000 | Y | |
| + | 33961 | Prolonged extracorporeal circulation for cardiopulmonary insufficiency; each additional 24 hours (List separately in addition to code for primary procedure) | 14.14 | $1,180.69 | | 000 | Y | |
| | 33967 | Insertion of intra-aortic balloon assist device, percutaneous | 6.70 | $559.45 | | 000 | Y | |
| | 33968 | Removal of intra-aortic balloon assist device, percutaneous | 0.89 | $74.32 | | 000 | N | |
| | 33970 | Insertion of intra-aortic balloon assist device through the femoral artery, open approach | 9.23 | $770.71 | | 000 | Y | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| 33971 | Removal of intra-aortic balloon assist device including repair of femoral artery, with or without graft | 17.98 | $1,501.33 | | 090 | Y | |
| 33973 | Insertion of intra-aortic balloon assist device through the ascending aorta | 13.49 | $1,126.42 | | 000 | Y | |
| 33974 | Removal of intra-aortic balloon assist device from the ascending aorta, including repair of the ascending aorta, with or without graft | 23.03 | $1,923.01 | | 090 | Y | |
| 33975 | Insertion of ventricular assist device; extracorporeal, single ventricle | 28.30 | $2,363.05 | | 000 | Y | |
| 33976 | Insertion of ventricular assist device; extracorporeal, biventricular | 31.56 | $2,635.26 | | 000 | Y | |
| 33977 | Removal of ventricular assist device; extracorporeal, single ventricle | 31.50 | $2,630.25 | | 090 | Y | |
| 33978 | Removal of ventricular assist device; extracorporeal, biventricular | 34.99 | $2,921.67 | | 090 | Y | |
| 33979 | Insertion of ventricular assist device, implantable intracorporeal, single ventricle | 63.07 | $5,266.35 | | 000 | Y | |
| 33980 | Removal of ventricular assist device, implantable intracorporeal, single ventricle | 92.10 | $7,690.35 | | 090 | Y | |
| 33999 | Unlisted procedure, cardiac surgery | 0.00 | BR | | 000 | N | |
| 34001 | Embolectomy or thrombectomy, with or without catheter; carotid, subclavian or innominate artery, by neck incision | 24.53 | $2,048.26 | | 090 | Y | |
| 34051 | Embolectomy or thrombectomy, with or without catheter; innominate, subclavian artery, by thoracic incision | 24.98 | $2,085.83 | | 090 | Y | |
| 34101 | Embolectomy or thrombectomy, with or without catheter; axillary, brachial, innominate, subclavian artery, by arm incision | 16.28 | $1,359.38 | | 090 | Y | |
| 34111 | Embolectomy or thrombectomy, with or without catheter; radial or ulnar artery, by arm incision | 16.29 | $1,360.22 | | 090 | Y | |
| 34151 | Embolectomy or thrombectomy, with or without catheter; renal, celiac, mesentery, aortoiliac artery, by abdominal incision | 37.31 | $3,115.39 | | 090 | Y | |
| 34201 | Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision | 24.63 | $2,056.61 | | 090 | Y | |
| 34203 | Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision | 25.99 | $2,170.17 | | 090 | Y | |
| 34401 | Thrombectomy, direct or with catheter; vena cava, iliac vein, by abdominal incision | 37.24 | $3,109.54 | | 090 | Y | |
| 34421 | Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by leg incision | 19.52 | $1,629.92 | | 090 | Y | |
| 34451 | Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by abdominal and leg incision | 40.39 | $3,372.57 | | 090 | Y | |
| 34471 | Thrombectomy, direct or with catheter; subclavian vein, by neck incision | 25.96 | $2,167.66 | | 090 | Y | |
| 34490 | Thrombectomy, direct or with catheter; axillary and subclavian vein, by arm incision | 16.33 | $1,363.56 | | 090 | N | |
| 34501 | Valvuloplasty, femoral vein | 25.51 | $2,130.09 | | 090 | Y | |
| 34502 | Reconstruction of vena cava, any method | 40.60 | $3,390.10 | | 090 | Y | |
| 34510 | Venous valve transposition, any vein donor | 29.01 | $2,422.34 | | 090 | Y | |
| 34520 | Cross-over vein graft to venous system | 28.07 | $2,343.85 | | 090 | Y | |
| 34530 | Saphenopopliteal vein anastomosis | 26.15 | $2,183.53 | | 090 | Y | |
| 34800 | Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis | 30.48 | $2,545.08 | | 090 | Y | |
| 34802 | Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb) | 33.03 | $2,758.01 | | 090 | Y | |
| 34803 | Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (two docking limbs) | 33.94 | $2,833.99 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **34804** | Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis | 32.99 | $2,754.67 | | 090 | Y | |
| | **34805** | Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-uniiliac or aorto-unifemoral prosthesis | 31.37 | $2,619.40 | | 090 | Y | |
| + | **34808** | Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure) | 5.60 | $467.60 | | 000 | Y | |
| | **34812** | Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral | 9.34 | $779.89 | | 000 | Y | |
| + | **34813** | Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to code for primary procedure) | 6.46 | $539.41 | | 000 | Y | |
| | **34820** | Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral | 13.30 | $1,110.55 | | 000 | Y | |
| | **34825** | Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel | 18.61 | $1,553.94 | | 090 | Y | |
| + | **34826** | Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code for primary procedure) | 5.46 | $455.91 | | 000 | Y | |
| | **34830** | Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis | 49.08 | $4,098.18 | | 090 | Y | |
| | **34831** | Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bi-iliac prosthesis | 50.75 | $4,237.63 | | 090 | Y | |
| | **34832** | Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bifemoral prosthesis | 52.76 | $4,405.46 | | 090 | Y | |
| | **34833** | Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral | 16.62 | $1,387.77 | | 000 | Y | |
| | **34834** | Open brachial artery exposure to assist in the deployment of aortic or iliac endovascular prosthesis by arm incision, unilateral | 7.60 | $634.60 | | 000 | Y | |
| | **34900** | Endovascular graft placement for repair of iliac artery (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) | 24.32 | $2,030.72 | | 090 | Y | |
| | **35001** | Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, carotid, subclavian artery, by neck incision | 30.50 | $2,546.75 | | 090 | Y | |
| | **35002** | Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, carotid, subclavian artery, by neck incision | 32.11 | $2,681.19 | | 090 | Y | |
| | **35005** | 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, vertebral artery | 27.54 | $2,299.59 | | 090 | Y | |
| | **35011** | Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision | 26.78 | $2,236.13 | | 090 | Y | |
| | **35013** | Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, axillary-brachial artery, by arm incision | 33.12 | $2,765.52 | | 090 | Y | |
| | **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 | 31.97 | $2,669.50 | | 090 | Y | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **35022** | Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, innominate, subclavian artery, by thoracic incision | 35.96 | $3,002.66 | | 090 | Y | |
| **35045** | 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, radial or ulnar artery | 25.85 | $2,158.48 | | 090 | Y | |
| **35081** | 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, abdominal aorta | 45.38 | $3,789.23 | | 090 | Y | |
| **35082** | Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta | 57.90 | $4,834.65 | | 090 | Y | |
| **35091** | 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, abdominal aorta involving visceral vessels (mesenteric, celiac, renal) | 49.70 | $4,149.95 | | 090 | Y | |
| **35092** | Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving visceral vessels (mesenteric, celiac, renal) | 69.08 | $5,768.18 | | 090 | Y | |
| **35102** | 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, abdominal aorta involving iliac vessels (common, hypogastric, external) | 49.36 | $4,121.56 | | 090 | Y | |
| **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) | 60.06 | $5,015.01 | | 090 | Y | |
| **35111** | 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, splenic artery | 37.00 | $3,089.50 | | 090 | Y | |
| **35112** | Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, splenic artery | 44.85 | $3,744.98 | | 090 | Y | |
| **35121** | 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, hepatic, celiac, renal, or mesenteric artery | 44.44 | $3,710.74 | | 090 | Y | |
| **35122** | Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, hepatic, celiac, renal, or mesenteric artery | 52.08 | $4,348.68 | | 090 | Y | |
| **35131** | 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, iliac artery (common, hypogastric, external) | 37.73 | $3,150.46 | | 090 | Y | |
| **35132** | Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, iliac artery (common, hypogastric, external) | 45.33 | $3,785.06 | | 090 | Y | |
| **35141** | 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, common femoral artery (profunda femoris, superficial femoral) | 30.09 | $2,512.52 | | 090 | Y | |
| **35142** | Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, common femoral artery (profunda femoris, superficial femoral) | 35.74 | $2,984.29 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **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 | 33.93 | $2,833.16 | | 090 | Y | |
| | **35152** | Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, popliteal artery | 39.16 | $3,269.86 | | 090 | Y | |
| | **35180** | Repair, congenital arteriovenous fistula; head and neck | 21.14 | $1,765.19 | | 090 | Y | |
| | **35182** | Repair, congenital arteriovenous fistula; thorax and abdomen | 45.29 | $3,781.72 | | 090 | Y | |
| | **35184** | Repair, congenital arteriovenous fistula; extremities | 27.32 | $2,281.22 | | 090 | Y | |
| | **35188** | Repair, acquired or traumatic arteriovenous fistula; head and neck | 22.98 | $1,918.83 | | 090 | Y | $945.00 |
| | **35189** | Repair, acquired or traumatic arteriovenous fistula; thorax and abdomen | 42.35 | $3,536.23 | | 090 | Y | |
| | **35190** | Repair, acquired or traumatic arteriovenous fistula; extremities | 19.97 | $1,667.50 | | 090 | Y | |
| | **35201** | Repair blood vessel, direct; neck | 25.09 | $2,095.02 | | 090 | Y | |
| | **35206** | Repair blood vessel, direct; upper extremity | 20.51 | $1,712.59 | | 090 | Y | |
| | **35207** | Repair blood vessel, direct; hand, finger | 18.43 | $1,538.91 | | 090 | Y | $945.00 |
| | **35211** | Repair blood vessel, direct; intrathoracic, with bypass | 35.72 | $2,982.62 | | 090 | Y | |
| | **35216** | Repair blood vessel, direct; intrathoracic, without bypass | 45.65 | $3,811.78 | | 090 | Y | |
| | **35221** | Repair blood vessel, direct; intra-abdominal | 36.82 | $3,074.47 | | 090 | Y | |
| | **35226** | Repair blood vessel, direct; lower extremity | 22.76 | $1,900.46 | | 090 | Y | |
| | **35231** | Repair blood vessel with vein graft; neck | 31.10 | $2,596.85 | | 090 | Y | |
| | **35236** | Repair blood vessel with vein graft; upper extremity | 26.11 | $2,180.19 | | 090 | Y | |
| | **35241** | Repair blood vessel with vein graft; intrathoracic, with bypass | 37.28 | $3,112.88 | | 090 | Y | |
| | **35246** | Repair blood vessel with vein graft; intrathoracic, without bypass | 40.75 | $3,402.63 | | 090 | Y | |
| | **35251** | Repair blood vessel with vein graft; intra-abdominal | 44.05 | $3,678.18 | | 090 | Y | |
| | **35256** | Repair blood vessel with vein graft; lower extremity | 27.62 | $2,306.27 | | 090 | Y | |
| | **35261** | Repair blood vessel with graft other than vein; neck | 27.40 | $2,287.90 | | 090 | Y | |
| | **35266** | Repair blood vessel with graft other than vein; upper extremity | 22.95 | $1,916.33 | | 090 | Y | |
| | **35271** | Repair blood vessel with graft other than vein; intrathoracic, with bypass | 35.50 | $2,964.25 | | 090 | Y | |
| | **35276** | Repair blood vessel with graft other than vein; intrathoracic, without bypass | 37.42 | $3,124.57 | | 090 | Y | |
| | **35281** | Repair blood vessel with graft other than vein; intra-abdominal | 42.11 | $3,516.19 | | 090 | Y | |
| | **35286** | Repair blood vessel with graft other than vein; lower extremity | 25.34 | $2,115.89 | | 090 | Y | |
| | **35301** | Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision | 28.29 | $2,362.22 | | 090 | Y | |
| | **35302** | Thromboendarterectomy, including patch graft, if performed; superficial femoral artery | 29.25 | $2,442.38 | | 090 | Y | |
| | **35303** | Thromboendarterectomy, including patch graft, if performed; popliteal artery | 32.13 | $2,682.86 | | 090 | Y | |
| | **35304** | Thromboendarterectomy, including patch graft, if performed; tibioperoneal trunk artery | 33.43 | $2,791.41 | | 090 | Y | |
| | **35305** | Thromboendarterectomy, including patch graft, if performed; tibial or peroneal artery, initial vessel | 32.13 | $2,682.86 | | 090 | Y | |
| + | **35306** | Thromboendarterectomy, including patch graft, if performed; each additional tibial or peroneal artery (List separately in addition to code for primary procedure) | 12.04 | $1,005.34 | | 000 | Y | |
| | **35311** | Thromboendarterectomy, including patch graft, if performed; subclavian, innominate, by thoracic incision | 40.29 | $3,364.22 | | 090 | Y | |
| | **35321** | Thromboendarterectomy, including patch graft, if performed; axillary-brachial | 24.13 | $2,014.86 | | 090 | Y | |
| | **35331** | Thromboendarterectomy, including patch graft, if performed; abdominal aorta | 39.33 | $3,284.06 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | 35341 | Thromboendarterectomy, including patch graft, if performed; mesenteric, celiac, or renal | 37.53 | $3,133.76 | | 090 | Y | |
| | 35351 | Thromboendarterectomy, including patch graft, if performed; iliac | 34.59 | $2,888.27 | | 090 | Y | |
| | 35355 | Thromboendarterectomy, including patch graft, if performed; iliofemoral | 28.15 | $2,350.53 | | 090 | Y | |
| | 35361 | Thromboendarterectomy, including patch graft, if performed; combined aortoiliac | 42.43 | $3,542.91 | | 090 | Y | |
| | 35363 | Thromboendarterectomy, including patch graft, if performed; combined aortoiliofemoral | 45.38 | $3,789.23 | | 090 | Y | |
| | 35371 | Thromboendarterectomy, including patch graft, if performed; common femoral | 22.42 | $1,872.07 | | 090 | Y | |
| | 35372 | Thromboendarterectomy, including patch graft, if performed; deep (profunda) femoral | 26.88 | $2,244.48 | | 090 | Y | |
| + | 35390 | Reoperation, carotid, thromboendarterectomy, more than one month after original operation (List separately in addition to code for primary procedure) | 4.34 | $362.39 | | 000 | Y | |
| + | 35400 | Angioscopy (non-coronary vessels or grafts) during therapeutic intervention (List separately in addition to code for primary procedure) | 4.15 | $346.53 | | 000 | N | |
| | 35450 | Transluminal balloon angioplasty, open; renal or other visceral artery | 13.76 | $1,148.96 | | 000 | Y | |
| | 35452 | Transluminal balloon angioplasty, open; aortic | 9.63 | $804.11 | | 000 | Y | |
| | 35454 | Transluminal balloon angioplasty, open; iliac | 8.48 | $708.08 | | 000 | Y | |
| | 35456 | Transluminal balloon angioplasty, open; femoral-popliteal | 10.28 | $858.38 | | 000 | Y | |
| | 35458 | Transluminal balloon angioplasty, open; brachiocephalic trunk or branches, each vessel | 13.12 | $1,095.52 | | 000 | Y | |
| | 35459 | Transluminal balloon angioplasty, open; tibioperoneal trunk and branches | 11.97 | $999.50 | | 000 | Y | |
| | 35460 | Transluminal balloon angioplasty, open; venous | 8.40 | $701.40 | | 000 | Y | |
| ⊙ | 35470 | Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel | 90.22 | $7,533.37 | | 000 | N | |
| ⊙ | 35471 | Transluminal balloon angioplasty, percutaneous; renal or visceral artery | 101.31 | $8,459.39 | | 000 | N | |
| ⊙ | 35472 | Transluminal balloon angioplasty, percutaneous; aortic | 66.84 | $5,581.14 | | 000 | Y | |
| ⊙ | 35473 | Transluminal balloon angioplasty, percutaneous; iliac | 62.33 | $5,204.56 | | 000 | N | |
| ⊙ | 35474 | Transluminal balloon angioplasty, percutaneous; femoral-popliteal | 87.88 | $7,337.98 | | 000 | N | |
| ⊙ | 35475 | Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel | 63.10 | $5,268.85 | | 000 | N | |
| ⊙ | 35476 | Transluminal balloon angioplasty, percutaneous; venous | 48.21 | $4,025.54 | | 000 | N | |
| | 35480 | Transluminal peripheral atherectomy, open; renal or other visceral artery | 15.26 | $1,274.21 | | 000 | Y | |
| | 35481 | Transluminal peripheral atherectomy, open; aortic | 10.75 | $897.63 | | 000 | Y | |
| | 35482 | Transluminal peripheral atherectomy, open; iliac | 9.31 | $777.39 | | 000 | Y | |
| | 35483 | Transluminal peripheral atherectomy, open; femoral-popliteal | 11.39 | $951.07 | | 000 | Y | |
| | 35484 | Transluminal peripheral atherectomy, open; brachiocephalic trunk or branches, each vessel | 14.23 | $1,188.21 | | 000 | Y | |
| | 35485 | Transluminal peripheral atherectomy, open; tibioperoneal trunk and branches | 13.28 | $1,108.88 | | 000 | Y | |
| | 35490 | Transluminal peripheral atherectomy, percutaneous; renal or other visceral artery | 15.77 | $1,316.80 | | 000 | Y | |
| | 35491 | Transluminal peripheral atherectomy, percutaneous; aortic | 11.04 | $921.84 | | 000 | Y | |
| | 35492 | Transluminal peripheral atherectomy, percutaneous; iliac | 9.70 | $809.95 | | 000 | Y | |
| | 35493 | Transluminal peripheral atherectomy, percutaneous; femoral-popliteal | 11.73 | $979.46 | | 000 | N | |
| | 35494 | Transluminal peripheral atherectomy, percutaneous; brachiocephalic trunk or branches, each vessel | 14.60 | $1,219.10 | | 000 | N | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **35495** | Transluminal peripheral atherectomy, percutaneous; tibioperoneal trunk and branches | 13.67 | $1,141.45 | | 000 | Y | |
| + | **35500** | Harvest of upper extremity vein, one segment, for lower extremity or coronary artery bypass procedure (List separately in addition to code for primary procedure) | 8.66 | $723.11 | | 000 | Y | |
| | **35501** | Bypass graft, with vein; common carotid-ipsilateral internal carotid | 39.39 | $3,289.07 | | 090 | Y | |
| | **35506** | Bypass graft, with vein; carotid-subclavian or subclavian-carotid | 34.77 | $2,903.30 | | 090 | Y | |
| | **35508** | Bypass graft, with vein; carotid-vertebral | 35.51 | $2,965.09 | | 090 | Y | |
| | **35509** | Bypass graft, with vein; carotid-contralateral carotid | 38.33 | $3,200.56 | | 090 | Y | |
| | **35510** | Bypass graft, with vein; carotid-brachial | 33.54 | $2,800.59 | | 090 | Y | |
| | **35511** | Bypass graft, with vein; subclavian-subclavian | 31.63 | $2,641.11 | | 090 | Y | |
| | **35512** | Bypass graft, with vein; subclavian-brachial | 32.89 | $2,746.32 | | 090 | Y | |
| | **35515** | Bypass graft, with vein; subclavian-vertebral | 35.22 | $2,940.87 | | 090 | Y | |
| | **35516** | Bypass graft, with vein; subclavian-axillary | 31.06 | $2,593.51 | | 090 | Y | |
| | **35518** | Bypass graft, with vein; axillary-axillary | 31.93 | $2,666.16 | | 090 | Y | |
| | **35521** | Bypass graft, with vein; axillary-femoral | 34.12 | $2,849.02 | | 090 | Y | |
| | **35522** | Bypass graft, with vein; axillary-brachial | 32.03 | $2,674.51 | | 090 | Y | |
| | **35525** | Bypass graft, with vein; brachial-brachial | 30.35 | $2,534.23 | | 090 | Y | |
| | **35526** | Bypass graft, with vein; aortosubclavian or carotid | 45.90 | $3,832.65 | | 090 | Y | |
| | **35531** | Bypass graft, with vein; aortoceliac or aortomesenteric | 54.07 | $4,514.85 | | 090 | Y | |
| | **35533** | Bypass graft, with vein; axillary-femoral-femoral | 41.92 | $3,500.32 | | 090 | Y | |
| | **35536** | Bypass graft, with vein; splenorenal | 47.18 | $3,939.53 | | 090 | Y | |
| | **35537** | Bypass graft, with vein; aortoiliac | 56.49 | $4,716.92 | | 090 | Y | |
| | **35538** | Bypass graft, with vein; aortobi-iliac | 63.10 | $5,268.85 | | 090 | Y | |
| | **35539** | Bypass graft, with vein; aortofemoral | 59.31 | $4,952.39 | | 090 | Y | |
| | **35540** | Bypass graft, with vein; aortobifemoral | 66.11 | $5,520.19 | | 090 | Y | |
| | **35548** | Bypass graft, with vein; aortoiliofemoral, unilateral | 32.31 | $2,697.89 | | 090 | Y | |
| | **35549** | Bypass graft, with vein; aortoiliofemoral, bilateral | 35.26 | $2,944.21 | | 090 | Y | |
| | **35551** | Bypass graft, with vein; aortofemoral-popliteal | 39.76 | $3,319.96 | | 090 | Y | |
| | **35556** | Bypass graft, with vein; femoral-popliteal | 36.55 | $3,051.93 | | 090 | Y | |
| | **35558** | Bypass graft, with vein; femoral-femoral | 32.86 | $2,743.81 | | 090 | Y | |
| | **35560** | Bypass graft, with vein; aortorenal | 47.91 | $4,000.49 | | 090 | Y | |
| | **35563** | Bypass graft, with vein; ilioiliac | 36.93 | $3,083.66 | | 090 | Y | |
| | **35565** | Bypass graft, with vein; iliofemoral | 35.50 | $2,964.25 | | 090 | Y | |
| | **35566** | Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels | 43.88 | $3,663.98 | | 090 | Y | |
| | **35571** | Bypass graft, with vein; popliteal-tibial, -peroneal artery or other distal vessels | 36.50 | $3,047.75 | | 090 | Y | |
| + | **35572** | Harvest of femoropopliteal vein, one segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery) (List separately in addition to code for primary procedure) | 9.26 | $773.21 | | 000 | Y | |
| | **35583** | In-situ vein bypass; femoral-popliteal | 37.86 | $3,161.31 | | 090 | Y | |
| | **35585** | In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery | 44.74 | $3,735.79 | | 090 | Y | |
| | **35587** | In-situ vein bypass; popliteal-tibial, peroneal | 37.73 | $3,150.46 | | 090 | Y | |
| ⊘ | **35600** | Harvest of upper extremity artery, one segment, for coronary artery bypass procedure | 6.77 | $565.30 | | 000 | Y | |
| | **35601** | Bypass graft, with other than vein; common carotid-ipsilateral internal carotid | 37.08 | $3,096.18 | | 090 | Y | |
| | **35606** | Bypass graft, with other than vein; carotid-subclavian | 31.48 | $2,628.58 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **35612** | Bypass graft, with other than vein; subclavian-subclavian | 24.62 | $2,055.77 | | 090 | Y | |
| | **35616** | Bypass graft, with other than vein; subclavian-axillary | 29.60 | $2,471.60 | | 090 | Y | |
| | **35621** | Bypass graft, with other than vein; axillary-femoral | 30.01 | $2,505.84 | | 090 | Y | |
| | **35623** | Bypass graft, with other than vein; axillary-popliteal or -tibial | 36.68 | $3,062.78 | | 090 | Y | |
| | **35626** | Bypass graft, with other than vein; aortosubclavian or carotid | 41.75 | $3,486.13 | | 090 | Y | |
| | **35631** | Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal | 50.37 | $4,205.90 | | 090 | Y | |
| | **35636** | Bypass graft, with other than vein; splenorenal (splenic to renal arterial anastomosis) | 44.23 | $3,693.21 | | 090 | Y | |
| | **35637** | Bypass graft, with other than vein; aortoiliac | 44.97 | $3,755.00 | | 090 | Y | |
| | **35638** | Bypass graft, with other than vein; aortobi-iliac | 45.68 | $3,814.28 | | 090 | Y | |
| | **35642** | Bypass graft, with other than vein; carotid-vertebral | 27.66 | $2,309.61 | | 090 | Y | |
| | **35645** | Bypass graft, with other than vein; subclavian-vertebral | 27.02 | $2,256.17 | | 090 | Y | |
| | **35646** | Bypass graft, with other than vein; aortobifemoral | 46.49 | $3,881.92 | | 090 | Y | |
| | **35647** | Bypass graft, with other than vein; aortofemoral | 41.90 | $3,498.65 | | 090 | Y | |
| | **35650** | Bypass graft, with other than vein; axillary-axillary | 28.74 | $2,399.79 | | 090 | Y | |
| | **35651** | Bypass graft, with other than vein; aortofemoral-popliteal | 36.96 | $3,086.16 | | 090 | Y | |
| | **35654** | Bypass graft, with other than vein; axillary-femoral-femoral | 37.19 | $3,105.37 | | 090 | Y | |
| | **35656** | Bypass graft, with other than vein; femoral-popliteal | 29.35 | $2,450.73 | | 090 | Y | |
| | **35661** | Bypass graft, with other than vein; femoral-femoral | 29.42 | $2,456.57 | | 090 | Y | |
| | **35663** | Bypass graft, with other than vein; ilioiliac | 34.02 | $2,840.67 | | 090 | Y | |
| | **35665** | Bypass graft, with other than vein; iliofemoral | 31.97 | $2,669.50 | | 090 | Y | |
| | **35666** | Bypass graft, with other than vein; femoral-anterior tibial, posterior tibial, or peroneal artery | 34.48 | $2,879.08 | | 090 | Y | |
| | **35671** | Bypass graft, with other than vein; popliteal-tibial or -peroneal artery | 30.35 | $2,534.23 | | 090 | Y | |
| + | **35681** | Bypass graft; composite, prosthetic and vein (List separately in addition to code for primary procedure) | 2.17 | $181.20 | | 000 | Y | |
| + | **35682** | Bypass graft; autogenous composite, two segments of veins from two locations (List separately in addition to code for primary procedure) | 9.73 | $812.46 | | 000 | Y | |
| + | **35683** | Bypass graft; autogenous composite, three or more segments of vein from two or more locations (List separately in addition to code for primary procedure) | 11.48 | $958.58 | | 000 | Y | |
| + | **35685** | Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (List separately in addition to code for primary procedure) | 5.47 | $456.75 | | 000 | Y | |
| + | **35686** | Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis) (List separately in addition to code for primary procedure) | 4.53 | $378.26 | | 000 | Y | |
| | **35691** | Transposition and/or reimplantation; vertebral to carotid artery | 26.94 | $2,249.49 | | 090 | Y | |
| | **35693** | Transposition and/or reimplantation; vertebral to subclavian artery | 23.59 | $1,969.77 | | 090 | Y | |
| | **35694** | Transposition and/or reimplantation; subclavian to carotid artery | 28.05 | $2,342.18 | | 090 | Y | |
| | **35695** | Transposition and/or reimplantation; carotid to subclavian artery | 28.76 | $2,401.46 | | 090 | Y | |
| + | **35697** | Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery (List separately in addition to code for primary procedure) | 4.07 | $339.85 | | 000 | Y | |
| + | **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 code for primary procedure) | 4.18 | $349.03 | | 000 | Y | |
| | **35701** | Exploration (not followed by surgical repair), with or without lysis of artery; carotid artery | 14.24 | $1,189.04 | | 090 | Y | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **35721** | Exploration (not followed by surgical repair), with or without lysis of artery; femoral artery | 12.18 | $1,017.03 | | 090 | Y | |
| **35741** | Exploration (not followed by surgical repair), with or without lysis of artery; popliteal artery | 13.35 | $1,114.73 | | 090 | Y | |
| **35761** | Exploration (not followed by surgical repair), with or without lysis of artery; other vessels | 9.88 | $824.98 | | 090 | Y | |
| **35800** | Exploration for postoperative hemorrhage, thrombosis or infection; neck | 12.62 | $1,053.77 | | 090 | Y | |
| **35820** | Exploration for postoperative hemorrhage, thrombosis or infection; chest | 43.76 | $3,653.96 | | 090 | Y | |
| **35840** | Exploration for postoperative hemorrhage, thrombosis or infection; abdomen | 16.30 | $1,361.05 | | 090 | Y | |
| **35860** | Exploration for postoperative hemorrhage, thrombosis or infection; extremity | 10.71 | $894.29 | | 090 | Y | |
| **35870** | Repair of graft-enteric fistula | 34.32 | $2,865.72 | | 090 | Y | |
| **35875** | Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula); | 15.96 | $1,332.66 | | 090 | Y | $2,008.50 |
| **35876** | Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula); with revision of arterial or venous graft | 25.52 | $2,130.92 | | 090 | Y | $2,008.50 |
| **35879** | Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplasty | 25.12 | $2,097.52 | | 090 | Y | |
| **35881** | Revision, lower extremity arterial bypass, without thrombectomy, open; with segmental vein interposition | 28.02 | $2,339.67 | | 090 | Y | |
| **35883** | Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous patch graft (eg, Dacron, ePTFE, bovine pericardium) | 32.90 | $2,747.15 | | 090 | Y | |
| **35884** | Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with autogenous vein patch graft | 34.94 | $2,917.49 | | 090 | Y | |
| **35901** | Excision of infected graft; neck | 13.63 | $1,138.11 | | 090 | Y | |
| **35903** | Excision of infected graft; extremity | 15.58 | $1,300.93 | | 090 | Y | |
| **35905** | Excision of infected graft; thorax | 47.04 | $3,927.84 | | 090 | Y | |
| **35907** | Excision of infected graft; abdomen | 51.76 | $4,321.96 | | 090 | Y | |
| **36000** | Introduction of needle or intracatheter, vein | 0.71 | $59.29 | | 000 | N | |
| **36002** | Injection procedures (eg, thrombin) for percutaneous treatment of extremity pseudoaneurysm | 4.61 | $384.94 | | 000 | N | |
| **36005** | Injection procedure for extremity venography (including introduction of needle or intracatheter) | 8.70 | $726.45 | | 000 | Y | |
| **36010** | Introduction of catheter, superior or inferior vena cava | 19.56 | $1,633.26 | | 000 | N | |
| **36011** | Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein) | 28.71 | $2,397.29 | | 000 | N | |
| **36012** | Selective catheter placement, venous system; second order, or more selective, branch (eg, left adrenal vein, petrosal sinus) | 22.48 | $1,877.08 | | 000 | N | |
| **36013** | Introduction of catheter, right heart or main pulmonary artery | 23.30 | $1,945.55 | | 000 | N | |
| **36014** | Selective catheter placement, left or right pulmonary artery | 22.53 | $1,881.26 | | 000 | N | |
| **36015** | Selective catheter placement, segmental or subsegmental pulmonary artery | 25.51 | $2,130.09 | | 000 | N | |
| **36100** | Introduction of needle or intracatheter, carotid or vertebral artery | 14.82 | $1,237.47 | | 000 | N | |
| **36120** | Introduction of needle or intracatheter; retrograde brachial artery | 12.24 | $1,022.04 | | 000 | N | |
| **36140** | Introduction of needle or intracatheter; extremity artery | 14.12 | $1,179.02 | | 000 | N | |
| **36145** | Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft) | 13.79 | $1,151.47 | | 000 | N | |
| **36160** | Introduction of needle or intracatheter, aortic, translumbar | 15.52 | $1,295.92 | | 000 | N | |
| **36200** | Introduction of catheter, aorta | 18.66 | $1,558.11 | | 000 | N | |
| **36215** | Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family | 31.06 | $2,593.51 | | 000 | N | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **36216** | Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family | 33.62 | $2,807.27 | | 000 | N | |
| | **36217** | Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family | 58.75 | $4,905.63 | | 000 | N | |
| + | **36218** | Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate) | 5.70 | $475.95 | | 000 | N | |
| | **36245** | Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family | 35.68 | $2,979.28 | | 000 | N | |
| | **36246** | Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family | 34.30 | $2,864.05 | | 000 | N | |
| | **36247** | Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family | 54.35 | $4,538.23 | | 000 | N | |
| + | **36248** | Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate) | 4.79 | $399.97 | | 000 | N | |
| | **36260** | Insertion of implantable intra-arterial infusion pump (eg, for chemotherapy of liver) | 14.99 | $1,251.67 | | 090 | N | $765.00 |
| | **36261** | Revision of implanted intra-arterial infusion pump | 9.23 | $770.71 | | 090 | Y | $669.00 |
| | **36262** | Removal of implanted intra-arterial infusion pump | 6.91 | $576.99 | | 090 | N | $499.50 |
| | **36299** | Unlisted procedure, vascular injection | 0.00 | BR | | 000 | N | |
| | **36400** | Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; femoral or jugular vein | 0.66 | $55.11 | | 000 | N | |
| | **36405** | Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein | 0.58 | $48.43 | | 000 | N | |
| | **36406** | Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; other vein | 0.46 | $38.41 | | 000 | N | |
| | **36410** | Venipuncture, age 3 years or older, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture) | 0.47 | $39.25 | | 000 | N | |
| | **36415** | Collection of venous blood by venipuncture | 0.12 | $9.60 | | 000 | N | |
| | **36416** | Collection of capillary blood specimen (eg, finger, heel, ear stick) | 0.12 | $9.60 | | 000 | N | |
| | **36420** | Venipuncture, cutdown; younger than age 1 year | 1.24 | $103.54 | | 000 | N | |
| | **36425** | Venipuncture, cutdown; age 1 or over | 0.96 | $80.16 | | 000 | N | |
| | **36430** | Transfusion, blood or blood components | 1.05 | $87.68 | | 000 | N | |
| | **36440** | Push transfusion, blood, 2 years or younger | 1.36 | $113.56 | | 000 | N | |
| | **36450** | Exchange transfusion, blood; newborn | 2.95 | $246.33 | | 000 | N | |
| | **36455** | Exchange transfusion, blood; other than newborn | 3.29 | $274.72 | | 000 | N | |
| | **36460** | Transfusion, intrauterine, fetal | 8.81 | $735.64 | | 000 | Y | |
| | **36468** | Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk | 0.00 | BR | | 000 | N | |
| | **36469** | Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face | 0.00 | BR | | 000 | N | |
| | **36470** | Injection of sclerosing solution; single vein | 3.72 | $310.62 | | 010 | N | |
| | **36471** | Injection of sclerosing solution; multiple veins, same leg | 4.57 | $381.60 | | 010 | N | |
| | **36475** | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated | 53.98 | $4,507.33 | | 000 | N | $2,008.50 |

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|---|---|---|---|---|---|---|---|---|
| + | **36476** | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) | 10.61 | $885.94 | | 000 | N | $2,008.50 |
| | **36478** | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated | 49.26 | $4,113.21 | | 000 | N | $2,008.50 |
| + | **36479** | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) | 10.81 | $902.64 | | 000 | N | $2,008.50 |
| | **36481** | Percutaneous portal vein catheterization by any method | 9.29 | $775.72 | | 000 | N | |
| | **36500** | Venous catheterization for selective organ blood sampling | 4.68 | $390.78 | | 000 | N | |
| | **36510** | Catheterization of umbilical vein for diagnosis or therapy, newborn | 4.27 | $356.55 | | 000 | N | |
| | **36511** | Therapeutic apheresis; for white blood cells | 2.33 | $194.56 | | 000 | N | |
| | **36512** | Therapeutic apheresis; for red blood cells | 2.35 | $196.23 | | 000 | N | |
| | **36513** | Therapeutic apheresis; for platelets | 2.41 | $201.24 | | 000 | N | |
| | **36514** | Therapeutic apheresis; for plasma pheresis | 16.97 | $1,417.00 | | 000 | N | |
| | **36515** | Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion | 62.56 | $5,223.76 | | 000 | N | |
| | **36516** | Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion | 76.55 | $6,391.93 | | 000 | N | |
| | **36522** | Photopheresis, extracorporeal | 34.65 | $2,893.28 | | 000 | N | |
| | **36540** | Collection of blood specimen from a completely implantable venous access device | 0.56 | $46.84 | | 000 | N | |
| | **36550** | Declotting by thrombolytic agent of implanted vascular access device or catheter | 0.74 | $61.79 | | 000 | N | |
| ⊙ | **36555** | Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age | 7.86 | $656.31 | | 000 | N | $499.50 |
| | **36556** | Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older | 7.37 | $615.40 | | 000 | N | $499.50 |
| ⊙ | **36557** | Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; younger than 5 years of age | 24.60 | $2,054.10 | | 010 | N | $669.00 |
| ⊙ | **36558** | Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older | 24.27 | $2,026.55 | | 010 | N | $669.00 |
| ⊙ | **36560** | Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age | 33.64 | $2,808.94 | | 010 | N | $765.00 |
| ⊙ | **36561** | Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older | 33.61 | $2,806.44 | | 010 | N | $765.00 |
| ⊙ | **36563** | Insertion of tunneled centrally inserted central venous access device with subcutaneous pump | 32.19 | $2,687.87 | | 010 | N | $765.00 |
| ⊙ | **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) | 28.87 | $2,410.65 | | 010 | N | $765.00 |
| ⊙ | **36566** | Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; with subcutaneous port(s) | 53.60 | $4,475.60 | | 010 | N | $765.00 |
| ⊙ | **36568** | Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; younger than 5 years of age | 8.87 | $740.65 | | 000 | N | $499.50 |
| | **36569** | Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older | 8.38 | $699.73 | | 000 | N | $499.50 |
| ⊙ | **36570** | Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age | 35.83 | $2,991.81 | | 010 | N | $765.00 |
| ⊙ | **36571** | Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older | 36.35 | $3,035.23 | | 010 | N | $765.00 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **36575** | Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site | 4.64 | $387.44 | | 000 | N | $669.00 |
| ⊙ | **36576** | Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site | 9.71 | $810.79 | | 010 | N | $669.00 |
| ⊙ | **36578** | Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site | 13.87 | $1,158.15 | | 010 | N | $669.00 |
| | **36580** | Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access | 7.53 | $628.76 | | 000 | N | $499.50 |
| ⊙ | **36581** | Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access | 21.62 | $1,805.27 | | 010 | N | $669.00 |
| ⊙ | **36582** | Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access | 29.39 | $2,454.07 | | 010 | N | $765.00 |
| ⊙ | **36583** | Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access | 29.45 | $2,459.08 | | 010 | N | $765.00 |
| | **36584** | Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access | 7.43 | $620.41 | | 000 | N | $499.50 |
| ⊙ | **36585** | Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access | 30.81 | $2,572.64 | | 010 | N | $765.00 |
| | **36589** | Removal of tunneled central venous catheter, without subcutaneous port or pump | 4.41 | $368.24 | | 010 | N | $499.50 |
| ⊙ | **36590** | Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion | 6.85 | $571.98 | | 010 | N | $499.50 |
| | **36595** | Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access | 18.94 | $1,581.49 | | 000 | N | |
| | **36596** | Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen | 4.10 | $342.35 | | 000 | N | |
| | **36597** | Repositioning of previously placed central venous catheter under fluoroscopic guidance | 3.44 | $287.24 | | 000 | N | |
| | **36598** | Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report | 3.24 | $270.54 | | 000 | N | |
| | **36600** | Arterial puncture, withdrawal of blood for diagnosis | 0.80 | $66.80 | | 000 | N | |
| ⊘ | **36620** | Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous | 1.32 | $110.22 | | 000 | N | |
| | **36625** | Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); cutdown | 2.68 | $223.78 | | 000 | N | |
| | **36640** | Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown | 3.11 | $259.69 | | 000 | N | $499.50 |
| ⊘ | **36660** | Catheterization, umbilical artery, newborn, for diagnosis or therapy | 1.78 | $148.63 | | 000 | N | |
| | **36680** | Placement of needle for intraosseous infusion | 1.64 | $136.94 | | 000 | N | |
| | **36800** | Insertion of cannula for hemodialysis, other purpose (separate procedure); vein to vein | 4.18 | $349.03 | | 000 | N | $765.00 |
| | **36810** | Insertion of cannula for hemodialysis, other purpose (separate procedure); arteriovenous, external (Scribner type) | 5.61 | $468.44 | | 000 | N | $765.00 |
| | **36815** | Insertion of cannula for hemodialysis, other purpose (separate procedure); arteriovenous, external revision, or closure | 3.85 | $321.48 | | 000 | N | $765.00 |
| | **36818** | Arteriovenous anastomosis, open; by upper arm cephalic vein transposition | 18.25 | $1,523.88 | | 090 | Y | $765.00 |
| | **36819** | Arteriovenous anastomosis, open; by upper arm basilic vein transposition | 20.98 | $1,751.83 | | 090 | Y | $765.00 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **36820** | Arteriovenous anastomosis, open; by forearm vein transposition | 21.00 | $1,753.50 | | 090 | Y | $765.00 |
| | **36821** | Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure) | 13.95 | $1,164.83 | | 090 | Y | $765.00 |
| | **36822** | Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure) | 9.98 | $833.33 | | 090 | N | |
| | **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 | 32.64 | $2,725.44 | | 090 | N | |
| | **36825** | Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft | 15.21 | $1,270.04 | | 090 | Y | $945.00 |
| | **36830** | Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft) | 17.43 | $1,455.41 | | 090 | Y | $945.00 |
| | **36831** | Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure) | 12.06 | $1,007.01 | | 090 | Y | $2,008.50 |
| | **36832** | Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure) | 15.38 | $1,284.23 | | 090 | Y | $945.00 |
| | **36833** | Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure) | 17.36 | $1,449.56 | | 090 | Y | $945.00 |
| | **36834** | Plastic repair of arteriovenous aneurysm (separate procedure) | 16.04 | $1,339.34 | | 090 | Y | $765.00 |
| | **36835** | Insertion of Thomas shunt (separate procedure) | 11.87 | $991.15 | | 090 | Y | $945.00 |
| | **36838** | Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome) | 31.25 | $2,609.38 | | 090 | Y | |
| | **36860** | External cannula declotting (separate procedure); without balloon catheter | 4.08 | $340.68 | | 000 | N | $191.10 |
| | **36861** | External cannula declotting (separate procedure); with balloon catheter | 3.96 | $330.66 | | 000 | N | $765.00 |
| ⊙ | **36870** | Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis) | 54.48 | $4,549.08 | | 090 | N | $2,008.50 |
| | **37140** | Venous anastomosis, open; portocaval | 34.68 | $2,895.78 | | 090 | Y | |
| | **37145** | Venous anastomosis, open; renoportal | 37.17 | $3,103.70 | | 090 | Y | |
| | **37160** | Venous anastomosis, open; caval-mesenteric | 32.59 | $2,721.27 | | 090 | Y | |
| | **37180** | Venous anastomosis, open; splenorenal, proximal | 36.81 | $3,073.64 | | 090 | Y | |
| | **37181** | Venous anastomosis, open; splenorenal, distal (selective decompression of esophagogastric varices, any technique) | 39.41 | $3,290.74 | | 090 | Y | |
| | **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) | 22.08 | $1,843.68 | | 000 | N | |
| | **37183** | Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation) | 10.55 | $880.93 | | 000 | N | |
| ⊙ | **37184** | Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel | 73.96 | $6,175.66 | | 000 | N | |

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|---|---|---|---|---|---|---|---|---|
| +⊙ | 37185 | Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure) | 24.17 | $2,018.20 | | 000 | N | |
| +⊙ | 37186 | Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure) | 49.93 | $4,169.16 | | 000 | N | |
| ⊙ | 37187 | Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance | 71.94 | $6,006.99 | | 000 | N | |
| ⊙ | 37188 | Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy | 62.10 | $5,185.35 | | 000 | N | |
| | 37195 | Thrombolysis, cerebral, by intravenous infusion | 8.41 | $702.40 | | 000 | N | |
| | 37200 | Transcatheter biopsy | 5.82 | $485.97 | | 000 | N | |
| | 37201 | Transcatheter therapy, infusion for thrombolysis other than coronary | 7.25 | $605.38 | | 000 | N | |
| | 37202 | Transcatheter therapy, infusion other than for thrombolysis, any type (eg, spasmolytic, vasoconstrictive) | 8.66 | $723.11 | | 000 | N | |
| ⊙ | 37203 | Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter) | 36.67 | $3,061.95 | | 000 | N | |
| | 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 | 23.52 | $1,963.92 | | 000 | N | |
| | 37205 | Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel | 11.81 | $986.14 | | 000 | N | |
| + | 37206 | Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; each additional vessel (List separately in addition to code for primary procedure) | 5.48 | $457.58 | | 000 | N | |
| | 37207 | Transcatheter placement of an intravascular stent(s), (non-coronary vessel), open; initial vessel | 11.59 | $967.77 | | 000 | Y | |
| + | 37208 | Transcatheter placement of an intravascular stent(s), (non-coronary vessel), open; each additional vessel (List separately in addition to code for primary procedure) | 5.60 | $467.60 | | 000 | Y | |
| | 37209 | Exchange of a previously placed intravascular catheter during thrombolytic therapy | 2.91 | $242.99 | | 000 | N | |
| ⊙ | 37210 | Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure | 56.16 | $4,689.36 | | 000 | N | |
| ⊙ | 37215 | Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection | 28.04 | $2,341.34 | | 090 | N | |
| ⊙ | 37216 | Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection | 26.04 | $2,174.34 | | 090 | N | |
| + | 37250 | Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure) | 2.87 | $239.65 | | 000 | N | |
| + | 37251 | Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel (List separately in addition to code for primary procedure) | 2.17 | $181.20 | | 000 | N | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **37500** | Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS) | 18.41 | $1,537.24 | | 090 | N | $765.00 |
| | **37501** | Unlisted vascular endoscopy procedure | 0.00 | BR | | 000 | N | |
| | **37565** | Ligation, internal jugular vein | 17.59 | $1,468.77 | | 090 | Y | |
| | **37600** | Ligation; external carotid artery | 18.69 | $1,560.62 | | 090 | Y | |
| | **37605** | Ligation; internal or common carotid artery | 21.33 | $1,781.06 | | 090 | Y | |
| | **37606** | Ligation; internal or common carotid artery, with gradual occlusion, as with Selverstone or Crutchfield clamp | 13.71 | $1,144.79 | | 090 | Y | |
| | **37607** | Ligation or banding of angioaccess arteriovenous fistula | 9.86 | $823.31 | | 090 | N | $765.00 |
| | **37609** | Ligation or biopsy, temporal artery | 7.51 | $627.09 | | 010 | N | $669.00 |
| | **37615** | Ligation, major artery (eg, post-traumatic, rupture); neck | 11.71 | $977.79 | | 090 | Y | |
| | **37616** | Ligation, major artery (eg, post-traumatic, rupture); chest | 27.36 | $2,284.56 | | 090 | Y | |
| | **37617** | Ligation, major artery (eg, post-traumatic, rupture); abdomen | 33.15 | $2,768.03 | | 090 | Y | |
| | **37618** | Ligation, major artery (eg, post-traumatic, rupture); extremity | 9.57 | $799.10 | | 090 | Y | |
| | **37620** | Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device) | 16.76 | $1,399.46 | | 090 | Y | |
| | **37650** | Ligation of femoral vein | 13.13 | $1,096.36 | | 090 | Y | $669.00 |
| | **37660** | Ligation of common iliac vein | 31.25 | $2,609.38 | | 090 | Y | |
| | **37700** | Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions | 6.61 | $551.94 | | 090 | N | 669.00 |
| | **37718** | Ligation, division, and stripping, short saphenous vein | 10.40 | $868.40 | | 090 | N | $765.00 |
| | **37722** | Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below | 12.38 | $1,033.73 | | 090 | N | $765.00 |
| | **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 | 16.49 | $1,376.92 | | 090 | Y | $765.00 |
| | **37760** | Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open | 16.19 | $1,351.87 | | 090 | Y | $765.00 |
| | **37765** | Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions | 11.70 | $976.95 | | 090 | N | |
| | **37766** | Stab phlebectomy of varicose veins, one extremity; more than 20 incisions | 14.11 | $1,178.19 | | 090 | N | |
| | **37780** | Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure) | 6.77 | $565.30 | | 090 | N | $765.00 |
| | **37785** | Ligation, division, and/or excision of varicose vein cluster(s), one leg | 9.14 | $763.19 | | 090 | N | $765.00 |
| | **37788** | Penile revascularization, artery, with or without vein graft | 32.99 | $2,754.67 | | 090 | Y | |
| | **37790** | Penile venous occlusive procedure | 12.68 | $1,058.78 | | 090 | Y | $765.00 |
| | **37799** | Unlisted procedure, vascular surgery | 0.00 | BR | | 000 | N | |
| | **38100** | Splenectomy; total (separate procedure) | 25.78 | $2,152.63 | | 090 | Y | |
| | **38101** | Splenectomy; partial (separate procedure) | 26.28 | $2,194.38 | | 090 | Y | |
| + | **38102** | Splenectomy; total, en bloc for extensive disease, in conjunction with other procedure (List in addition to code for primary procedure) | 6.49 | $541.92 | | 000 | Y | |
| | **38115** | Repair of ruptured spleen (splenorrhaphy) with or without partial splenectomy | 28.57 | $2,385.60 | | 090 | Y | |
| | **38120** | Laparoscopy, surgical, splenectomy | 24.78 | $2,069.13 | | 090 | Y | |
| | **38129** | Unlisted laparoscopy procedure, spleen | 0.00 | BR | | 000 | N | |
| | **38200** | Injection procedure for splenoportography | 3.42 | $285.57 | | 000 | N | |
| | **38204** | Management of recipient hematopoietic progenitor cell donor search and cell acquisition | 1.86 | $155.31 | | 000 | N | |
| | **38205** | Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic | 2.06 | $172.01 | | 000 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **38206** | Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous | 2.06 | $172.01 | | 000 | N | |
| **38207** | Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage | 0.43 | $35.91 | | 000 | N | |
| **38208** | Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing | 0.52 | $43.42 | | 000 | N | |
| **38209** | Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing | 0.23 | $19.21 | | 000 | N | |
| **38210** | Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion | 0.88 | $73.48 | | 000 | N | |
| **38211** | Transplant preparation of hematopoietic progenitor cells; tumor cell depletion | 0.66 | $55.11 | | 000 | N | |
| **38212** | Transplant preparation of hematopoietic progenitor cells; red blood cell removal | 0.44 | $36.74 | | 000 | N | |
| **38213** | Transplant preparation of hematopoietic progenitor cells; platelet depletion | 0.23 | $19.21 | | 000 | N | |
| **38214** | Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion | 0.23 | $19.21 | | 000 | N | |
| **38215** | Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer | 0.51 | $42.59 | | 000 | N | |
| **38220** | Bone marrow; aspiration only | 4.48 | $374.08 | | 000 | N | |
| **38221** | Bone marrow; biopsy, needle or trocar | 4.94 | $412.49 | | 000 | N | |
| **38230** | Bone marrow harvesting for transplantation | 7.92 | $661.32 | | 010 | N | |
| **38240** | Bone marrow or blood-derived peripheral stem cell transplantation; allogenic | 3.13 | $261.36 | | 000 | N | |
| **38241** | Bone marrow or blood-derived peripheral stem cell transplantation; autologous | 3.14 | $262.19 | | 000 | N | |
| **38242** | Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions | 2.38 | $198.73 | | 000 | N | |
| **38300** | Drainage of lymph node abscess or lymphadenitis; simple | 6.42 | $536.07 | | 010 | N | $499.50 |
| **38305** | Drainage of lymph node abscess or lymphadenitis; extensive | 10.95 | $914.33 | | 090 | N | $669.00 |
| **38308** | Lymphangiotomy or other operations on lymphatic channels | 10.59 | $884.27 | | 090 | Y | $669.00 |
| **38380** | Suture and/or ligation of thoracic duct; cervical approach | 13.68 | $1,142.28 | | 090 | Y | |
| **38381** | Suture and/or ligation of thoracic duct; thoracic approach | 20.51 | $1,712.59 | | 090 | Y | |
| **38382** | Suture and/or ligation of thoracic duct; abdominal approach | 16.50 | $1,377.75 | | 090 | Y | |
| **38500** | Biopsy or excision of lymph node(s); open, superficial | 7.57 | $632.10 | | 010 | N | $669.00 |
| **38505** | Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary) | 3.16 | $263.86 | | 000 | N | $360.00 |
| **38510** | Biopsy or excision of lymph node(s); open, deep cervical node(s) | 12.20 | $1,018.70 | | 010 | N | $669.00 |
| **38520** | Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad | 11.05 | $922.68 | | 090 | N | $669.00 |
| **38525** | Biopsy or excision of lymph node(s); open, deep axillary node(s) | 9.84 | $821.64 | | 090 | N | $669.00 |
| **38530** | Biopsy or excision of lymph node(s); open, internal mammary node(s) | 12.87 | $1,074.65 | | 090 | Y | $669.00 |
| **38542** | Dissection, deep jugular node(s) | 10.37 | $865.90 | | 090 | Y | $669.00 |
| **38550** | Excision of cystic hygroma, axillary or cervical; without deep neurovascular dissection | 11.16 | $931.86 | | 090 | Y | $765.00 |
| **38555** | Excision of cystic hygroma, axillary or cervical; with deep neurovascular dissection | 23.85 | $1,991.48 | | 090 | Y | $945.00 |
| **38562** | Limited lymphadenectomy for staging (separate procedure); pelvic and para-aortic | 16.79 | $1,401.97 | | 090 | Y | |
| **38564** | Limited lymphadenectomy for staging (separate procedure); retroperitoneal (aortic and/or splenic) | 16.71 | $1,395.29 | | 090 | Y | |
| **38570** | Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple | 13.46 | $1,123.91 | | 010 | Y | $2,008.50 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **38571** | Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy | 20.34 | $1,698.39 | | 010 | Y | $2,008.50 |
| | **38572** | Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple | 23.93 | $1,998.16 | | 010 | Y | $2,008.50 |
| | **38589** | Unlisted laparoscopy procedure, lymphatic system | 0.00 | BR | | 000 | N | |
| | **38700** | Suprahyoid lymphadenectomy | 18.30 | $1,528.05 | | 090 | Y | |
| | **38720** | Cervical lymphadenectomy (complete) | 30.09 | $2,512.52 | | 090 | Y | |
| | **38724** | Cervical lymphadenectomy (modified radical neck dissection) | 32.48 | $2,712.08 | | 090 | Y | |
| | **38740** | Axillary lymphadenectomy; superficial | 15.79 | $1,318.47 | | 090 | Y | $669.00 |
| | **38745** | Axillary lymphadenectomy; complete | 20.14 | $1,681.69 | | 090 | Y | $945.00 |
| + | **38746** | Thoracic lymphadenectomy, regional, including mediastinal and peritracheal nodes (List separately in addition to code for primary procedure) | 6.68 | $557.78 | | 000 | Y | |
| + | **38747** | Abdominal lymphadenectomy, regional, including celiac, gastric, portal, peripancreatic, with or without para-aortic and vena caval nodes (List separately in addition to code for primary procedure) | 6.60 | $551.10 | | 000 | Y | |
| | **38760** | Inguinofemoral lymphadenectomy, superficial, including Cloquets node (separate procedure) | 19.94 | $1,664.99 | | 090 | Y | $669.00 |
| | **38765** | Inguinofemoral lymphadenectomy, superficial, in continuity with pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure) | 30.84 | $2,575.14 | | 090 | Y | |
| | **38770** | Pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure) | 20.02 | $1,671.67 | | 090 | Y | |
| | **38780** | Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure) | 25.84 | $2,157.64 | | 090 | Y | |
| | **38790** | Injection procedure; lymphangiography | 2.04 | $170.34 | | 000 | N | |
| ⊘ | **38792** | Injection procedure; for identification of sentinel node | 0.98 | $81.83 | | 000 | N | |
| | **38794** | Cannulation, thoracic duct | 7.68 | $641.28 | | 090 | Y | |
| | **38999** | Unlisted procedure, hemic or lymphatic system | 0.00 | BR | | 000 | N | |
| | **39000** | Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; cervical approach | 12.20 | $1,018.70 | | 090 | Y | |
| | **39010** | Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; transthoracic approach, including either transthoracic or median sternotomy | 20.74 | $1,731.79 | | 090 | Y | |
| | **39200** | Excision of mediastinal cyst | 22.77 | $1,901.30 | | 090 | Y | |
| | **39220** | Excision of mediastinal tumor | 29.01 | $2,422.34 | | 090 | Y | |
| | **39400** | Mediastinoscopy, with or without biopsy | 12.70 | $1,060.45 | | 010 | N | |
| | **39499** | Unlisted procedure, mediastinum | 0.00 | BR | | 000 | N | |
| | **39501** | Repair, laceration of diaphragm, any approach | 20.59 | $1,719.27 | | 090 | Y | |
| | **39502** | Repair, paraesophageal hiatus hernia, transabdominal, with or without fundoplasty, vagotomy, and/or pyloroplasty, except neonatal | 24.55 | $2,049.93 | | 090 | Y | |
| | **39503** | Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia | 141.45 | $11,811.08 | | 090 | Y | |
| | **39520** | Repair, diaphragmatic hernia (esophageal hiatal); transthoracic | 24.96 | $2,084.16 | | 090 | Y | |
| | **39530** | Repair, diaphragmatic hernia (esophageal hiatal); combined, thoracoabdominal | 23.65 | $1,974.78 | | 090 | Y | |
| | **39531** | Repair, diaphragmatic hernia (esophageal hiatal); combined, thoracoabdominal, with dilation of stricture (with or without gastroplasty) | 24.90 | $2,079.15 | | 090 | Y | |
| | **39540** | Repair, diaphragmatic hernia (other than neonatal), traumatic; acute | 20.92 | $1,746.82 | | 090 | Y | |
| | **39541** | Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic | 22.50 | $1,878.75 | | 090 | Y | |
| | **39545** | Imbrication of diaphragm for eventration, transthoracic or transabdominal, paralytic or nonparalytic | 22.41 | $1,871.24 | | 090 | Y | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **39560** | Resection, diaphragm; with simple repair (eg, primary suture) | 19.36 | $1,616.56 | | 090 | Y | |
| **39561** | Resection, diaphragm; with complex repair (eg, prosthetic material, local muscle flap) | 29.55 | $2,467.43 | | 090 | Y | |
| **39599** | Unlisted procedure, diaphragm | 0.00 | BR | | 000 | N | |
| **40490** | Biopsy of lip | 2.90 | $242.15 | | 000 | N | |
| **40500** | Vermilionectomy (lip shave), with mucosal advancement | 11.41 | $952.74 | | 090 | N | $669.00 |
| **40510** | Excision of lip; transverse wedge excision with primary closure | 11.35 | $947.73 | | 090 | N | $669.00 |
| **40520** | Excision of lip; V-excision with primary direct linear closure | 12.14 | $1,013.69 | | 090 | N | $669.00 |
| **40525** | Excision of lip; full thickness, reconstruction with local flap (eg, Estlander or fan) | 13.75 | $1,148.13 | | 090 | N | $669.00 |
| **40527** | Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander) | 16.25 | $1,356.88 | | 090 | N | $669.00 |
| **40530** | Resection of lip, more than one-fourth, without reconstruction | 13.15 | $1,098.03 | | 090 | N | $669.00 |
| **40650** | Repair lip, full thickness; vermilion only | 10.28 | $858.38 | | 090 | N | $696.23 |
| **40652** | Repair lip, full thickness; up to half vertical height | 11.98 | $1,000.33 | | 090 | N | $696.23 |
| **40654** | Repair lip, full thickness; over one-half vertical height, or complex | 13.91 | $1,161.49 | | 090 | N | $696.23 |
| **40700** | Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral | 22.64 | $1,890.44 | | 090 | N | $1,492.50 |
| **40701** | Plastic repair of cleft lip/nasal deformity; primary bilateral, one stage procedure | 28.33 | $2,365.56 | | 090 | Y | $1,492.50 |
| **40702** | Plastic repair of cleft lip/nasal deformity; primary bilateral, one of two stages | 21.92 | $1,830.32 | | 090 | Y | |
| **40720** | Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure | 24.60 | $2,054.10 | | 090 | Y | $1,492.50 |
| **40761** | Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle | 26.02 | $2,172.67 | | 090 | N | $765.00 |
| **40799** | Unlisted procedure, lips | 0.00 | BR | | 000 | N | |
| **40800** | Drainage of abscess, cyst, hematoma, vestibule of mouth; simple | 4.38 | $365.73 | | 010 | N | |
| **40801** | Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated | 6.85 | $571.98 | | 010 | N | $669.00 |
| **40804** | Removal of embedded foreign body, vestibule of mouth; simple | 4.69 | $391.62 | | 010 | N | |
| **40805** | Removal of embedded foreign body, vestibule of mouth; complicated | 7.41 | $618.74 | | 010 | Y | |
| **40806** | Incision of labial frenum (frenotomy) | 2.29 | $191.22 | | 000 | Y | |
| **40808** | Biopsy, vestibule of mouth | 3.85 | $321.48 | | 010 | N | |
| **40810** | Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair | 4.38 | $365.73 | | 010 | N | |
| **40812** | Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair | 6.30 | $526.05 | | 010 | N | |
| **40814** | Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair | 8.62 | $719.77 | | 090 | N | $669.00 |
| **40816** | Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle | 9.06 | $756.51 | | 090 | N | $669.00 |
| **40818** | Excision of mucosa of vestibule of mouth as donor graft | 7.98 | $666.33 | | 090 | N | $226.08 |
| **40819** | Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy) | 6.77 | $565.30 | | 090 | N | $499.50 |
| **40820** | Destruction of lesion or scar of vestibule of mouth by physical methods (eg, laser, thermal, cryo, chemical) | 5.51 | $460.09 | | 010 | N | |
| **40830** | Closure of laceration, vestibule of mouth; 2.5 cm or less | 5.60 | $467.60 | | 010 | N | |
| **40831** | Closure of laceration, vestibule of mouth; over 2.5 cm or complex | 7.38 | $616.23 | | 010 | Y | $499.50 |
| **40840** | Vestibuloplasty; anterior | 19.05 | $1,590.68 | | 090 | Y | $669.00 |
| **40842** | Vestibuloplasty; posterior, unilateral | 19.19 | $1,602.37 | | 090 | Y | $765.00 |
| **40843** | Vestibuloplasty; posterior, bilateral | 24.66 | $2,059.11 | | 090 | Y | $765.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **40844** | Vestibuloplasty; entire arch | 32.44 | $2,708.74 | | 090 | Y | $1,075.50 |
| **40845** | Vestibuloplasty; complex (including ridge extension, muscle repositioning) | 35.86 | $2,994.31 | | 090 | Y | $1,075.50 |
| **40899** | Unlisted procedure, vestibule of mouth | 0.00 | BR | | 000 | N | |
| **41000** | Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual | 3.67 | $306.45 | | 010 | N | |
| **41005** | Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, superficial | 4.82 | $402.47 | | 010 | Y | $226.08 |
| **41006** | Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, deep, supramylohyoid | 8.22 | $686.37 | | 090 | Y | $499.50 |
| **41007** | Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submental space | 8.32 | $694.72 | | 090 | Y | $499.50 |
| **41008** | Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space | 8.35 | $697.23 | | 090 | Y | $499.50 |
| **41009** | Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; masticator space | 8.91 | $743.99 | | 090 | Y | $226.08 |
| **41010** | Incision of lingual frenum (frenotomy) | 4.45 | $371.58 | | 010 | N | $499.50 |
| **41015** | Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual | 9.67 | $807.45 | | 090 | Y | $226.08 |
| **41016** | Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submental | 9.98 | $833.33 | | 090 | Y | $499.50 |
| **41017** | Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submandibular | 10.04 | $838.34 | | 090 | Y | $499.50 |
| **41018** | Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space | 11.54 | $963.59 | | 090 | Y | $499.50 |
| **41100** | Biopsy of tongue; anterior two-thirds | 3.86 | $322.31 | | 010 | N | |
| **41105** | Biopsy of tongue; posterior one-third | 3.80 | $317.30 | | 010 | N | |
| **41108** | Biopsy of floor of mouth | 3.21 | $268.04 | | 010 | N | |
| **41110** | Excision of lesion of tongue without closure | 4.61 | $384.94 | | 010 | N | |
| **41112** | Excision of lesion of tongue with closure; anterior two-thirds | 7.40 | $617.90 | | 090 | N | $669.00 |
| **41113** | Excision of lesion of tongue with closure; posterior one-third | 8.16 | $681.36 | | 090 | N | $669.00 |
| **41114** | Excision of lesion of tongue with closure; with local tongue flap | 15.56 | $1,299.26 | | 090 | Y | $669.00 |
| **41115** | Excision of lingual frenum (frenectomy) | 5.29 | $441.72 | | 010 | N | |
| **41116** | Excision, lesion of floor of mouth | 7.04 | $587.84 | | 090 | N | $499.50 |
| **41120** | Glossectomy; less than one-half tongue | 25.41 | $2,121.74 | | 090 | Y | $1,075.50 |
| **41130** | Glossectomy; hemiglossectomy | 30.69 | $2,562.62 | | 090 | Y | |
| **41135** | Glossectomy; partial, with unilateral radical neck dissection | 51.17 | $4,272.70 | | 090 | Y | |
| **41140** | Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection | 53.57 | $4,473.10 | | 090 | Y | |
| **41145** | Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection | 65.92 | $5,504.32 | | 090 | Y | |
| **41150** | Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection | 52.37 | $4,372.90 | | 090 | Y | |
| **41153** | Glossectomy; composite procedure with resection floor of mouth, with suprahyoid neck dissection | 56.24 | $4,696.04 | | 090 | Y | |
| **41155** | Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type) | 68.36 | $5,708.06 | | 090 | Y | |
| **41250** | Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue | 4.92 | $410.82 | | 010 | N | $226.08 |
| **41251** | Repair of laceration 2.5 cm or less; posterior one-third of tongue | 5.52 | $460.92 | | 010 | Y | $226.08 |
| **41252** | Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex | 6.99 | $583.67 | | 010 | Y | $669.00 |
| **41500** | Fixation of tongue, mechanical, other than suture (eg, K-wire) | 10.88 | $908.48 | | 090 | N | $499.50 |
| **41510** | Suture of tongue to lip for micrognathia (Douglas type procedure) | 11.01 | $919.34 | | 090 | Y | $499.50 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| 41520 | Frenoplasty (surgical revision of frenum, eg, with Z-plasty) | 7.66 | $639.61 | | 090 | Y | $669.00 |
| 41599 | Unlisted procedure, tongue, floor of mouth | 0.00 | BR | | 000 | N | |
| 41800 | Drainage of abscess, cyst, hematoma from dentoalveolar structures | 4.34 | $362.39 | | 010 | N | $132.69 |
| 41805 | Removal of embedded foreign body from dentoalveolar structures; soft tissues | 4.46 | $372.41 | | 010 | Y | |
| 41806 | Removal of embedded foreign body from dentoalveolar structures; bone | 6.99 | $583.67 | | 010 | Y | |
| 41820 | Gingivectomy, excision gingiva, each quadrant | 5.61 | $468.27 | | 000 | N | |
| 41821 | Operculectomy, excision pericoronal tissues | 1.26 | $105.38 | | 000 | N | |
| 41822 | Excision of fibrous tuberosities, dentoalveolar structures | 6.50 | $542.75 | | 010 | N | |
| 41823 | Excision of osseous tuberosities, dentoalveolar structures | 9.53 | $795.76 | | 090 | N | |
| 41825 | Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair | 4.56 | $380.76 | | 010 | N | |
| 41826 | Excision of lesion or tumor (except listed above), dentoalveolar structures; with simple repair | 5.51 | $460.09 | | 010 | N | |
| 41827 | Excision of lesion or tumor (except listed above), dentoalveolar structures; with complex repair | 9.49 | $792.42 | | 090 | N | $669.00 |
| 41828 | Excision of hyperplastic alveolar mucosa, each quadrant (specify) | 7.12 | $594.52 | | 010 | Y | |
| 41830 | Alveolectomy, including curettage of osteitis or sequestrectomy | 8.71 | $727.29 | | 010 | Y | |
| 41850 | Destruction of lesion (except excision), dentoalveolar structures | 2.80 | $234.13 | | 000 | Y | |
| 41870 | Periodontal mucosal grafting | 7.01 | $585.34 | | 000 | Y | |
| 41872 | Gingivoplasty, each quadrant (specify) | 8.15 | $680.53 | | 090 | Y | |
| 41874 | Alveoloplasty, each quadrant (specify) | 8.34 | $696.39 | | 090 | N | |
| 41899 | Unlisted procedure, dentoalveolar structures | 0.00 | BR | | 000 | N | |
| 42000 | Drainage of abscess of palate, uvula | 3.75 | $313.13 | | 010 | N | $226.08 |
| 42100 | Biopsy of palate, uvula | 3.44 | $287.24 | | 010 | N | |
| 42104 | Excision, lesion of palate, uvula; without closure | 4.41 | $368.24 | | 010 | N | |
| 42106 | Excision, lesion of palate, uvula; with simple primary closure | 5.68 | $474.28 | | 010 | N | |
| 42107 | Excision, lesion of palate, uvula; with local flap closure | 10.34 | $863.39 | | 090 | N | $669.00 |
| 42120 | Resection of palate or extensive resection of lesion | 22.75 | $1,899.63 | | 090 | Y | $945.00 |
| 42140 | Uvulectomy, excision of uvula | 5.46 | $455.91 | | 090 | N | $669.00 |
| 42145 | Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty) | 16.64 | $1,389.44 | | 090 | N | $1,075.50 |
| 42160 | Destruction of lesion, palate or uvula (thermal, cryo or chemical) | 5.91 | $493.49 | | 010 | N | |
| 42180 | Repair, laceration of palate; up to 2 cm | 5.59 | $466.77 | | 010 | Y | $226.08 |
| 42182 | Repair, laceration of palate; over 2 cm or complex | 7.77 | $648.80 | | 010 | Y | $669.00 |
| 42200 | Palatoplasty for cleft palate, soft and/or hard palate only | 22.15 | $1,849.53 | | 090 | Y | $1,075.50 |
| 42205 | Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only | 23.23 | $1,939.71 | | 090 | Y | $1,075.50 |
| 42210 | Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft) | 26.64 | $2,224.44 | | 090 | Y | $1,075.50 |
| 42215 | Palatoplasty for cleft palate; major revision | 17.94 | $1,497.99 | | 090 | Y | $1,492.50 |
| 42220 | Palatoplasty for cleft palate; secondary lengthening procedure | 13.88 | $1,158.98 | | 090 | Y | $1,075.50 |
| 42225 | Palatoplasty for cleft palate; attachment pharyngeal flap | 25.38 | $2,119.23 | | 090 | Y | |
| 42226 | Lengthening of palate, and pharyngeal flap | 24.11 | $2,013.19 | | 090 | Y | $1,075.50 |
| 42227 | Lengthening of palate, with island flap | 23.90 | $1,995.65 | | 090 | Y | |
| 42235 | Repair of anterior palate, including vomer flap | 19.32 | $1,613.22 | | 090 | Y | $1,075.50 |
| 42260 | Repair of nasolabial fistula | 20.40 | $1,703.40 | | 090 | Y | $945.00 |
| 42280 | Maxillary impression for palatal prosthesis | 3.62 | $302.27 | | 010 | Y | |
| 42281 | Insertion of pin-retained palatal prosthesis | 4.60 | $384.10 | | 010 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **42299** | Unlisted procedure, palate, uvula | 0.00 | BR | | 000 | N | |
| **42300** | Drainage of abscess; parotid, simple | 4.76 | $397.46 | | 010 | N | $499.50 |
| **42305** | Drainage of abscess; parotid, complicated | 10.58 | $883.43 | | 090 | Y | $669.00 |
| **42310** | Drainage of abscess; submaxillary or sublingual, intraoral | 3.79 | $316.47 | | 010 | Y | $226.08 |
| **42320** | Drainage of abscess; submaxillary, external | 5.68 | $474.28 | | 010 | Y | $226.08 |
| **42330** | Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral | 5.36 | $447.56 | | 010 | N | |
| **42335** | Sialolithotomy; submandibular (submaxillary), complicated, intraoral | 8.34 | $696.39 | | 090 | N | |
| **42340** | Sialolithotomy; parotid, extraoral or complicated intraoral | 10.70 | $893.45 | | 090 | Y | $669.00 |
| **42400** | Biopsy of salivary gland; needle | 2.47 | $206.25 | | 000 | N | |
| **42405** | Biopsy of salivary gland; incisional | 7.20 | $601.20 | | 010 | N | $669.00 |
| **42408** | Excision of sublingual salivary cyst (ranula) | 10.53 | $879.26 | | 090 | Y | $765.00 |
| **42409** | Marsupialization of sublingual salivary cyst (ranula) | 7.49 | $625.42 | | 090 | Y | $765.00 |
| **42410** | Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection | 15.33 | $1,280.06 | | 090 | Y | $765.00 |
| **42415** | Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve | 27.72 | $2,314.62 | | 090 | Y | $1,492.50 |
| **42420** | Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve | 31.88 | $2,661.98 | | 090 | Y | $1,492.50 |
| **42425** | Excision of parotid tumor or parotid gland; total, en bloc removal with sacrifice of facial nerve | 21.02 | $1,755.17 | | 090 | Y | $1,492.50 |
| **42426** | Excision of parotid tumor or parotid gland; total, with unilateral radical neck dissection | 34.08 | $2,845.68 | | 090 | Y | |
| **42440** | Excision of submandibular (submaxillary) gland | 11.41 | $952.74 | | 090 | Y | $765.00 |
| **42450** | Excision of sublingual gland | 10.51 | $877.59 | | 090 | Y | $669.00 |
| **42500** | Plastic repair of salivary duct, sialodochoplasty; primary or simple | 10.03 | $837.51 | | 090 | N | $765.00 |
| **42505** | Plastic repair of salivary duct, sialodochoplasty; secondary or complicated | 13.19 | $1,101.37 | | 090 | N | $945.00 |
| **42507** | Parotid duct diversion, bilateral (Wilke type procedure); | 12.42 | $1,037.07 | | 090 | Y | $765.00 |
| **42508** | Parotid duct diversion, bilateral (Wilke type procedure); with excision of one submandibular gland | 17.48 | $1,459.58 | | 090 | Y | $945.00 |
| **42509** | Parotid duct diversion, bilateral (Wilke type procedure); with excision of both submandibular glands | 21.24 | $1,773.54 | | 090 | Y | $945.00 |
| **42510** | Parotid duct diversion, bilateral (Wilke type procedure); with ligation of both submandibular (Wharton's) ducts | 15.54 | $1,297.59 | | 090 | Y | $945.00 |
| **42550** | Injection procedure for sialography | 4.12 | $344.02 | | 000 | N | |
| **42600** | Closure salivary fistula | 11.36 | $948.56 | | 090 | Y | $499.50 |
| **42650** | Dilation salivary duct | 1.89 | $157.82 | | 000 | N | |
| **42660** | Dilation and catheterization of salivary duct, with or without injection | 2.48 | $207.08 | | 000 | N | |
| **42665** | Ligation salivary duct, intraoral | 6.85 | $571.98 | | 090 | Y | $1,492.50 |
| **42699** | Unlisted procedure, salivary glands or ducts | 0.00 | BR | | 000 | N | $ |
| **42700** | Incision and drainage abscess; peritonsillar | 4.29 | $358.22 | | 010 | N | $226.08 |
| **42720** | Incision and drainage abscess; retropharyngeal or parapharyngeal, intraoral approach | 10.83 | $904.31 | | 010 | N | $499.50 |
| **42725** | Incision and drainage abscess; retropharyngeal or parapharyngeal, external approach | 19.79 | $1,652.47 | | 090 | Y | $669.00 |
| **42800** | Biopsy; oropharynx | 3.59 | $299.77 | | 010 | N | |
| **42802** | Biopsy; hypopharynx | 6.05 | $505.18 | | 010 | N | $499.50 |
| **42804** | Biopsy; nasopharynx, visible lesion, simple | 4.87 | $406.65 | | 010 | N | $499.50 |
| **42806** | Biopsy; nasopharynx, survey for unknown primary lesion | 5.51 | $460.09 | | 010 | N | $669.00 |
| **42808** | Excision or destruction of lesion of pharynx, any method | 5.35 | $446.73 | | 010 | N | $669.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **42809** | Removal of foreign body from pharynx | 4.09 | $341.52 | | 010 | N | |
| **42810** | Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues | 8.98 | $749.83 | | 090 | Y | $765.00 |
| **42815** | Excision branchial cleft cyst, vestige, or fistula, extending beneath subcutaneous tissues and/or into pharynx | 13.36 | $1,115.56 | | 090 | Y | $1,075.50 |
| **42820** | Tonsillectomy and adenoidectomy; younger than age 12 | 7.17 | $598.70 | | 090 | Y | $765.00 |
| **42821** | Tonsillectomy and adenoidectomy; age 12 or over | 7.54 | $629.59 | | 090 | N | $1,075.50 |
| **42825** | Tonsillectomy, primary or secondary; younger than age 12 | 6.34 | $529.39 | | 090 | Y | $945.00 |
| **42826** | Tonsillectomy, primary or secondary; age 12 or over | 6.22 | $519.37 | | 090 | N | $945.00 |
| **42830** | Adenoidectomy, primary; younger than age 12 | 5.02 | $419.17 | | 090 | Y | $945.00 |
| **42831** | Adenoidectomy, primary; age 12 or over | 5.43 | $453.41 | | 090 | Y | $945.00 |
| **42835** | Adenoidectomy, secondary; younger than age 12 | 4.60 | $384.10 | | 090 | Y | $945.00 |
| **42836** | Adenoidectomy, secondary; age 12 or over | 5.98 | $499.33 | | 090 | Y | $945.00 |
| **42842** | Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure | 22.53 | $1,881.26 | | 090 | Y | |
| **42844** | Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with local flap (eg, tongue, buccal) | 32.68 | $2,728.78 | | 090 | Y | |
| **42845** | Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap | 53.30 | $4,450.55 | | 090 | Y | |
| **42860** | Excision of tonsil tags | 4.53 | $378.26 | | 090 | N | $765.00 |
| **42870** | Excision or destruction lingual tonsil, any method (separate procedure) | 13.76 | $1,148.96 | | 090 | N | $765.00 |
| **42890** | Limited pharyngectomy | 32.18 | $2,687.03 | | 090 | Y | $1,492.50 |
| **42892** | Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and posterior pharyngeal walls | 41.74 | $3,485.29 | | 090 | Y | $1,492.50 |
| **42894** | Resection of pharyngeal wall requiring closure with myocutaneous flap | 53.96 | $4,505.66 | | 090 | Y | |
| **42900** | Suture pharynx for wound or injury | 8.66 | $723.11 | | 010 | Y | $499.50 |
| **42950** | Pharyngoplasty (plastic or reconstructive operation on pharynx) | 19.54 | $1,631.59 | | 090 | Y | $669.00 |
| **42953** | Pharyngoesophageal repair | 25.51 | $2,130.09 | | 090 | Y | $ |
| **42955** | Pharyngostomy (fistulization of pharynx, external for feeding) | 18.26 | $1,524.71 | | 090 | Y | $669.00 |
| **42960** | Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy); simple | 4.17 | $348.20 | | 010 | Y | $108.72 |
| **42961** | Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy); complicated, requiring hospitalization | 10.33 | $862.56 | | 090 | Y | |
| **42962** | Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy); with secondary surgical intervention | 12.78 | $1,067.13 | | 090 | Y | $669.00 |
| **42970** | Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); simple, with posterior nasal packs, with or without anterior packs and/or cautery | 9.59 | $800.77 | | 090 | N | |
| **42971** | Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); complicated, requiring hospitalization | 11.27 | $941.05 | | 090 | Y | |
| **42972** | Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); with secondary surgical intervention | 12.79 | $1,067.97 | | 090 | Y | $765.00 |
| **42999** | Unlisted procedure, pharynx, adenoids, or tonsils | 0.00 | BR | | 000 | N | |
| **43020** | Esophagotomy, cervical approach, with removal of foreign body | 13.34 | $1,113.89 | | 090 | Y | |
| **43030** | Cricopharyngeal myotomy | 12.98 | $1,083.83 | | 090 | Y | |
| **43045** | Esophagotomy, thoracic approach, with removal of foreign body | 32.65 | $2,726.28 | | 090 | Y | |
| **43100** | Excision of lesion, esophagus, with primary repair; cervical approach | 15.46 | $1,290.91 | | 090 | Y | |
| **43101** | Excision of lesion, esophagus, with primary repair; thoracic or abdominal approach | 25.32 | $2,114.22 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **43107** | Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal) | 62.63 | $5,229.61 | | 090 | Y | |
| | **43108** | Total or near total esophagectomy, without thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es) | 95.51 | $7,975.09 | | 090 | Y | |
| | **43112** | Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty | 67.11 | $5,603.69 | | 090 | Y | |
| | **43113** | Total or near total esophagectomy, with thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es) | 94.54 | $7,894.09 | | 090 | Y | |
| | **43116** | Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction | 106.26 | $8,872.71 | | 090 | Y | |
| | **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) | 61.11 | $5,102.69 | | 090 | Y | |
| | **43118** | Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es) | 79.92 | $6,673.32 | | 090 | Y | |
| | **43121** | Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty | 64.80 | $5,410.80 | | 090 | Y | |
| | **43122** | Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty | 61.95 | $5,172.83 | | 090 | Y | |
| | **43123** | Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es) | 95.78 | $7,997.63 | | 090 | Y | |
| | **43124** | Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy | 81.45 | $6,801.08 | | 090 | Y | |
| | **43130** | Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach | 19.49 | $1,627.42 | | 090 | Y | |
| | **43135** | Diverticulectomy of hypopharynx or esophagus, with or without myotomy; thoracic approach | 34.38 | $2,870.73 | | 090 | Y | |
| ⊙ | **43200** | Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) | 5.54 | $462.59 | | 000 | N | $499.50 |
| ⊙ | **43201** | Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance | 6.89 | $575.32 | | 000 | N | $499.50 |
| ⊙ | **43202** | Esophagoscopy, rigid or flexible; with biopsy, single or multiple | 7.29 | $608.72 | | 000 | N | $499.50 |
| ⊙ | **43204** | Esophagoscopy, rigid or flexible; with injection sclerosis of esophageal varices | 5.31 | $443.39 | | 000 | N | $499.50 |
| ⊙ | **43205** | Esophagoscopy, rigid or flexible; with band ligation of esophageal varices | 5.34 | $445.89 | | 000 | N | $499.50 |
| ⊙ | **43215** | Esophagoscopy, rigid or flexible; with removal of foreign body | 3.78 | $315.63 | | 000 | N | $499.50 |
| ⊙ | **43216** | Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery | 3.91 | $326.49 | | 000 | N | $499.50 |
| ⊙ | **43217** | Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique | 9.72 | $811.62 | | 000 | N | $499.50 |
| ⊙ | **43219** | Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent | 4.16 | $347.36 | | 000 | N | $499.50 |
| ⊙ | **43220** | Esophagoscopy, rigid or flexible; with balloon dilation (less than 30 mm diameter) | 3.07 | $256.35 | | 000 | N | $499.50 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| ⊙ | **43226** | Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire | 3.39 | $283.07 | | 000 | N | $499.50 |
| ⊙ | **43227** | Esophagoscopy, rigid or flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator) | 5.06 | $422.51 | | 000 | N | $669.00 |
| ⊙ | **43228** | Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique | 5.35 | $446.73 | | 000 | N | $669.00 |
| ⊙ | **43231** | Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination | 4.52 | $377.42 | | 000 | N | $669.00 |
| ⊙ | **43232** | Esophagoscopy, rigid or flexible; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) | 6.32 | $527.72 | | 000 | N | $669.00 |
| ⊙ | **43234** | Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure) | 7.21 | $602.04 | | 000 | N | $499.50 |
| ⊙ | **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) | 7.53 | $628.76 | | 000 | N | $499.50 |
| ⊙ | **43236** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance | 9.31 | $777.39 | | 000 | N | $669.00 |
| ⊙ | **43237** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus | 5.75 | $480.13 | | 000 | N | $669.00 |
| ⊙ | **43238** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus) | 7.05 | $588.68 | | 000 | N | $669.00 |
| ⊙ | **43239** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple | 8.59 | $717.27 | | 000 | N | $669.00 |
| ⊙ | **43240** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transmural drainage of pseudocyst | 9.54 | $796.59 | | 000 | N | $669.00 |
| ⊙ | **43241** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic intraluminal tube or catheter placement | 3.72 | $310.62 | | 000 | N | $669.00 |
| ⊙ | **43242** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; 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) | 10.08 | $841.68 | | 000 | N | $669.00 |
| ⊙ | **43243** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with injection sclerosis of esophageal and/or gastric varices | 6.37 | $531.90 | | 000 | N | $669.00 |
| ⊙ | **43244** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of esophageal and/or gastric varices | 7.04 | $587.84 | | 000 | N | $669.00 |
| ⊙ | **43245** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation of gastric outlet for obstruction (eg, balloon, guide wire, bougie) | 4.51 | $376.59 | | 000 | N | $669.00 |

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|---|---|---|---|---|---|---|---|---|
| ⊙ | **43246** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube | 6.03 | $503.51 | | 000 | Y | $669.00 |
| ⊙ | **43247** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body | 4.79 | $399.97 | | 000 | N | $669.00 |
| ⊙ | **43248** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire | 4.49 | $374.92 | | 000 | N | $669.00 |
| ⊙ | **43249** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter) | 4.15 | $346.53 | | 000 | N | $669.00 |
| ⊙ | **43250** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery | 4.54 | $379.09 | | 000 | N | $669.00 |
| ⊙ | **43251** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique | 5.21 | $435.04 | | 000 | N | $669.00 |
| ⊙ | **43255** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method | 6.73 | $561.96 | | 000 | N | $669.00 |
| ⊙ | **43256** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation) | 6.07 | $506.85 | | 000 | N | $765.00 |
| ⊙ | **43257** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease | 7.47 | $623.75 | | 000 | N | $765.00 |
| ⊙ | **43258** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique | 6.35 | $530.23 | | 000 | N | $765.00 |
| ⊙ | **43259** | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate | 7.19 | $600.37 | | 000 | N | $765.00 |
| ⊙ | **43260** | Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) | 8.27 | $690.55 | | 000 | N | $669.00 |
| ⊙ | **43261** | Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple | 8.70 | $726.45 | | 000 | N | $669.00 |
| ⊙ | **43262** | Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy | 10.21 | $852.54 | | 000 | N | $669.00 |
| ⊙ | **43263** | Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct) | 10.11 | $844.19 | | 000 | N | $669.00 |
| ⊙ | **43264** | Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts | 12.26 | $1,023.71 | | 000 | N | $669.00 |
| ⊙ | **43265** | Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method | 13.75 | $1,148.13 | | 000 | N | $669.00 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| ⊙ | **43267** | Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube | 10.19 | $850.87 | | 000 | N | $669.00 |
| ⊙ | **43268** | Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct | 10.33 | $862.56 | | 000 | N | $669.00 |
| ⊙ | **43269** | Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent | 11.33 | $946.06 | | 000 | N | $669.00 |
| ⊙ | **43271** | Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s) | 10.21 | $852.54 | | 000 | N | $669.00 |
| ⊙ | **43272** | Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique | 10.23 | $854.21 | | 000 | Y | $669.00 |
| | **43280** | Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures) | 25.60 | $2,137.60 | | 090 | Y | |
| | **43289** | Unlisted laparoscopy procedure, esophagus | 0.00 | BR | | 000 | N | |
| | **43300** | Esophagoplasty (plastic repair or reconstruction), cervical approach; without repair of tracheoesophageal fistula | 15.48 | $1,292.58 | | 090 | Y | |
| | **43305** | Esophagoplasty (plastic repair or reconstruction), cervical approach; with repair of tracheoesophageal fistula | 27.64 | $2,307.94 | | 090 | Y | |
| | **43310** | Esophagoplasty (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula | 37.98 | $3,171.33 | | 090 | Y | |
| | **43312** | Esophagoplasty (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula | 41.71 | $3,482.79 | | 090 | Y | |
| | **43313** | Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula | 67.22 | $5,612.87 | | 090 | Y | |
| | **43314** | Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; with repair of congenital tracheoesophageal fistula | 73.43 | $6,131.41 | | 090 | Y | |
| | **43320** | Esophagogastrostomy (cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach | 32.70 | $2,730.45 | | 090 | Y | |
| | **43324** | Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures) | 31.99 | $2,671.17 | | 090 | Y | |
| | **43325** | Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure) | 31.49 | $2,629.42 | | 090 | Y | |
| | **43326** | Esophagogastric fundoplasty; with gastroplasty (eg, Collis) | 32.07 | $2,677.85 | | 090 | Y | |
| | **43330** | Esophagomyotomy (Heller type); abdominal approach | 30.93 | $2,582.66 | | 090 | Y | |
| | **43331** | Esophagomyotomy (Heller type); thoracic approach | 33.28 | $2,778.88 | | 090 | Y | |
| | **43340** | Esophagojejunostomy (without total gastrectomy); abdominal approach | 32.01 | $2,672.84 | | 090 | Y | |
| | **43341** | Esophagojejunostomy (without total gastrectomy); thoracic approach | 34.63 | $2,891.61 | | 090 | Y | |
| | **43350** | Esophagostomy, fistulization of esophagus, external; abdominal approach | 27.13 | $2,265.36 | | 090 | Y | |
| | **43351** | Esophagostomy, fistulization of esophagus, external; thoracic approach | 31.88 | $2,661.98 | | 090 | Y | |
| | **43352** | Esophagostomy, fistulization of esophagus, external; cervical approach | 26.29 | $2,195.22 | | 090 | Y | |
| | **43360** | Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty | 56.12 | $4,686.02 | | 090 | Y | |
| | **43361** | Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es) | 62.30 | $5,202.05 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **43400** | Ligation, direct, esophageal varices | 35.38 | $2,954.23 | | 090 | Y | |
| | **43401** | Transection of esophagus with repair, for esophageal varices | 36.23 | $3,025.21 | | 090 | Y | |
| | **43405** | Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation | 34.70 | $2,897.45 | | 090 | Y | |
| | **43410** | Suture of esophageal wound or injury; cervical approach | 23.97 | $2,001.50 | | 090 | Y | |
| | **43415** | Suture of esophageal wound or injury; transthoracic or transabdominal approach | 41.13 | $3,434.36 | | 090 | Y | |
| | **43420** | Closure of esophagostomy or fistula; cervical approach | 23.70 | $1,978.95 | | 090 | Y | |
| | **43425** | Closure of esophagostomy or fistula; transthoracic or transabdominal approach | 35.50 | $2,964.25 | | 090 | Y | |
| | **43450** | Dilation of esophagus, by unguided sound or bougie, single or multiple passes | 3.99 | $333.17 | | 000 | N | $499.50 |
| ⊙ | **43453** | Dilation of esophagus, over guide wire | 7.59 | $633.77 | | 000 | N | $499.50 |
| ⊙ | **43456** | Dilation of esophagus, by balloon or dilator, retrograde | 16.06 | $1,341.01 | | 000 | N | $503.12 |
| ⊙ | **43458** | Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia | 9.71 | $810.79 | | 000 | N | $503.12 |
| | **43460** | Esophagogastric tamponade, with balloon (Sengstaaken type) | 5.27 | $440.05 | | 000 | N | |
| | **43496** | Free jejunum transfer with microvascular anastomosis | 0.00 | BR | | 090 | Y | |
| | **43499** | Unlisted procedure, esophagus | 0.00 | BR | | 000 | N | |
| | **43500** | Gastrotomy; with exploration or foreign body removal | 17.92 | $1,496.32 | | 090 | Y | |
| | **43501** | Gastrotomy; with suture repair of bleeding ulcer | 31.12 | $2,598.52 | | 090 | Y | |
| | **43502** | Gastrotomy; with suture repair of pre-existing esophagogastric laceration (eg, Mallory-Weiss) | 35.43 | $2,958.41 | | 090 | Y | |
| | **43510** | Gastrotomy; with esophageal dilation and insertion of permanent intraluminal tube (eg, Celestin or Mousseaux-Barbin) | 21.63 | $1,806.11 | | 090 | Y | |
| | **43520** | Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation) | 16.59 | $1,385.27 | | 090 | Y | |
| | **43600** | Biopsy of stomach; by capsule, tube, peroral (one or more specimens) | 2.56 | $213.76 | | 000 | Y | $499.50 |
| | **43605** | Biopsy of stomach; by laparotomy | 19.17 | $1,600.70 | | 090 | Y | |
| | **43610** | Excision, local; ulcer or benign tumor of stomach | 22.69 | $1,894.62 | | 090 | Y | |
| | **43611** | Excision, local; malignant tumor of stomach | 28.13 | $2,348.86 | | 090 | Y | |
| | **43620** | Gastrectomy, total; with esophagoenterostomy | 46.08 | $3,847.68 | | 090 | Y | |
| | **43621** | Gastrectomy, total; with Roux-en-Y reconstruction | 51.58 | $4,306.93 | | 090 | Y | |
| | **43622** | Gastrectomy, total; with formation of intestinal pouch, any type | 52.78 | $4,407.13 | | 090 | Y | |
| | **43631** | Gastrectomy, partial, distal; with gastroduodenostomy | 33.94 | $2,833.99 | | 090 | Y | |
| | **43632** | Gastrectomy, partial, distal; with gastrojejunostomy | 44.18 | $3,689.03 | | 090 | Y | |
| | **43633** | Gastrectomy, partial, distal; with Roux-en-Y reconstruction | 42.46 | $3,545.41 | | 090 | Y | |
| | **43634** | Gastrectomy, partial, distal; with formation of intestinal pouch | 46.70 | $3,899.45 | | 090 | Y | |
| + | **43635** | Vagotomy when performed with partial distal gastrectomy (List separately in addition to code(s) for primary procedure) | 2.78 | $232.13 | | 000 | Y | |
| | **43640** | Vagotomy including pyloroplasty, with or without gastrostomy; truncal or selective | 27.02 | $2,256.17 | | 090 | Y | |
| | **43641** | Vagotomy including pyloroplasty, with or without gastrostomy; parietal cell (highly selective) | 27.40 | $2,287.90 | | 090 | Y | |
| | **43644** | Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less) | 40.43 | $3,375.91 | | 090 | Y | |
| | **43645** | Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption | 43.54 | $3,635.59 | | 090 | Y | |
| | **43647** | Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum | 0.00 | BR | | 000 | Y | |
| | **43648** | Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum | 0.00 | BR | | 000 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **43651** | Laparoscopy, surgical; transection of vagus nerves, truncal | 15.17 | $1,266.70 | | 090 | Y | |
| | **43652** | Laparoscopy, surgical; transection of vagus nerves, selective or highly selective | 18.07 | $1,508.85 | | 090 | Y | |
| | **43653** | Laparoscopy, surgical; gastrostomy, without construction of gastric tube (eg, Stamm procedure) (separate procedure) | 12.78 | $1,067.13 | | 090 | Y | $2,008.50 |
| | **43659** | Unlisted laparoscopy procedure, stomach | 0.00 | BR | | 000 | N | |
| ⊙ | **43750** | Percutaneous placement of gastrostomy tube | 6.71 | $560.29 | | 010 | N | $669.00 |
| | **43752** | Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report) | 1.00 | $83.50 | | 000 | N | |
| | **43760** | Change of gastrostomy tube | 5.85 | $488.48 | | 000 | N | $217.47 |
| | **43761** | Repositioning of the gastric feeding tube, any method, through the duodenum for enteric nutrition | 3.05 | $254.68 | | 000 | N | $499.50 |
| | **43770** | Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port components) | 25.89 | $2,161.82 | | 090 | Y | |
| | **43771** | Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric band component only | 29.59 | $2,470.77 | | 090 | Y | |
| | **43772** | Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band component only | 22.29 | $1,861.22 | | 090 | Y | |
| | **43773** | Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric band component only | 29.60 | $2,471.60 | | 090 | Y | |
| | **43774** | Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band and subcutaneous port components | 22.39 | $1,869.57 | | 090 | Y | |
| | **43800** | Pyloroplasty | 21.52 | $1,796.92 | | 090 | Y | |
| | **43810** | Gastroduodenostomy | 23.25 | $1,941.38 | | 090 | Y | |
| | **43820** | Gastrojejunostomy; without vagotomy | 29.03 | $2,424.01 | | 090 | Y | |
| | **43825** | Gastrojejunostomy; with vagotomy, any type | 29.98 | $2,503.33 | | 090 | Y | |
| | **43830** | Gastrostomy, open; without construction of gastric tube (eg, Stamm procedure) (separate procedure) | 15.85 | $1,323.48 | | 090 | Y | |
| | **43831** | Gastrostomy, open; neonatal, for feeding | 13.24 | $1,105.54 | | 090 | Y | |
| | **43832** | Gastrostomy, open; with construction of gastric tube (eg, Janeway procedure) | 24.42 | $2,039.07 | | 090 | Y | |
| | **43840** | Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury | 29.61 | $2,472.44 | | 090 | Y | |
| | **43842** | Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty | 28.78 | $2,403.13 | | 090 | N | |
| | **43843** | Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty | 29.19 | $2,437.37 | | 090 | Y | |
| | **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) | 45.04 | $3,760.84 | | 090 | Y | |
| | **43846** | Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy | 37.71 | $3,148.79 | | 090 | Y | |
| | **43847** | Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption | 41.47 | $3,462.75 | | 090 | Y | |
| | **43848** | Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric band (separate procedure) | 44.87 | $3,746.65 | | 090 | Y | |
| | **43850** | Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy | 37.69 | $3,147.12 | | 090 | Y | |
| | **43855** | Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; with vagotomy | 39.35 | $3,285.73 | | 090 | Y | |
| | **43860** | Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy | 38.13 | $3,183.86 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **43865** | Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy | 39.93 | $3,334.16 | | 090 | Y | |
| | **43870** | Closure of gastrostomy, surgical | 16.13 | $1,346.86 | | 090 | Y | $499.50 |
| | **43880** | Closure of gastrocolic fistula | 37.36 | $3,119.56 | | 090 | Y | |
| | **43881** | Implantation or replacement of gastric neurostimulator electrodes, antrum, open | 0.00 | BR | | 000 | Y | |
| | **43882** | Revision or removal of gastric neurostimulator electrodes, antrum, open | 0.00 | BR | | 000 | Y | |
| | **43886** | Gastric restrictive procedure, open; revision of subcutaneous port component only | 7.52 | $627.92 | | 090 | Y | |
| | **43887** | Gastric restrictive procedure, open; removal of subcutaneous port component only | 7.13 | $595.36 | | 090 | Y | |
| | **43888** | Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only | 10.19 | $850.87 | | 090 | Y | |
| | **43999** | Unlisted procedure, stomach | 0.00 | BR | | 000 | N | |
| | **44005** | Enterolysis (freeing of intestinal adhesion) (separate procedure) | 25.37 | $2,118.40 | | 090 | Y | |
| | **44010** | Duodenotomy, for exploration, biopsy(s), or foreign body removal | 19.86 | $1,658.31 | | 090 | Y | |
| + | **44015** | Tube or needle catheter jejunostomy for enteral alimentation, intraoperative, any method (List separately in addition to primary procedure) | 3.54 | $295.59 | | 000 | Y | |
| | **44020** | Enterotomy, small intestine, other than duodenum; for exploration, biopsy(s), or foreign body removal | 22.34 | $1,865.39 | | 090 | Y | |
| | **44021** | Enterotomy, small intestine, other than duodenum; for decompression (eg, Baker tube) | 22.52 | $1,880.42 | | 090 | Y | |
| | **44025** | Colotomy, for exploration, biopsy(s), or foreign body removal | 22.74 | $1,898.79 | | 090 | Y | |
| | **44050** | Reduction of volvulus, intussusception, internal hernia, by laparotomy | 21.68 | $1,810.28 | | 090 | Y | |
| | **44055** | Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (eg, Ladd procedure) | 34.55 | $2,884.93 | | 090 | Y | |
| | **44100** | Biopsy of intestine by capsule, tube, peroral (one or more specimens) | 2.74 | $228.79 | | 000 | N | $499.50 |
| | **44110** | Excision of one or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; single enterotomy | 19.42 | $1,621.57 | | 090 | Y | |
| | **44111** | Excision of one or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; multiple enterotomies | 22.78 | $1,902.13 | | 090 | Y | |
| | **44120** | Enterectomy, resection of small intestine; single resection and anastomosis | 28.01 | $2,338.84 | | 090 | Y | |
| + | **44121** | Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure) | 6.00 | $501.00 | | 000 | Y | |
| | **44125** | Enterectomy, resection of small intestine; with enterostomy | 27.41 | $2,288.74 | | 090 | Y | |
| | **44126** | Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; without tapering | 56.54 | $4,721.09 | | 090 | Y | |
| | **44127** | Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; with tapering | 65.40 | $5,460.90 | | 090 | Y | |
| + | **44128** | Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure) | 6.01 | $501.84 | | 000 | Y | |
| | **44130** | Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure) | 28.31 | $2,363.89 | | 090 | Y | |
| | **44132** | Donor enterectomy (including cold preservation), open; from cadaver donor | 0.00 | BR | | 000 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | 44133 | Donor enterectomy (including cold preservation), open; partial, from living donor | 0.00 | BR | | 000 | Y | |
| | 44135 | Intestinal allotransplantation; from cadaver donor | 0.00 | BR | | 000 | Y | |
| | 44136 | Intestinal allotransplantation; from living donor | 0.00 | BR | | 000 | Y | |
| | 44137 | Removal of transplanted intestinal allograft, complete | 0.00 | BR | | 000 | Y | |
| + | 44139 | Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure) | 3.00 | $250.50 | | 000 | Y | |
| | 44140 | Colectomy, partial; with anastomosis | 31.43 | $2,624.41 | | 090 | Y | |
| | 44141 | Colectomy, partial; with skin level cecostomy or colostomy | 39.80 | $3,323.30 | | 090 | Y | |
| | 44143 | Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure) | 38.50 | $3,214.75 | | 090 | Y | |
| | 44144 | Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula | 39.50 | $3,298.25 | | 090 | Y | |
| | 44145 | Colectomy, partial; with coloproctostomy (low pelvic anastomosis) | 39.38 | $3,288.23 | | 090 | Y | |
| | 44146 | Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy | 48.00 | $4,008.00 | | 090 | Y | |
| | 44147 | Colectomy, partial; abdominal and transanal approach | 42.01 | $3,507.84 | | 090 | Y | |
| | 44150 | Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy | 42.20 | $3,523.70 | | 090 | Y | |
| | 44151 | Colectomy, total, abdominal, without proctectomy; with continent ileostomy | 48.30 | $4,033.05 | | 090 | Y | |
| | 44155 | Colectomy, total, abdominal, with proctectomy; with ileostomy | 47.44 | $3,961.24 | | 090 | Y | |
| | 44156 | Colectomy, total, abdominal, with proctectomy; with continent ileostomy | 52.40 | $4,375.40 | | 090 | Y | |
| | 44157 | Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy, when performed | 51.52 | $4,301.92 | | 090 | Y | |
| | 44158 | Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, creation of ileal reservoir (S or J), includes loop ileostomy, and rectal mucosectomy, when performed | 52.85 | $4,412.98 | | 090 | Y | |
| | 44160 | Colectomy, partial, with removal of terminal ileum with ileocolostomy | 28.76 | $2,401.46 | | 090 | Y | |
| | 44180 | Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure) | 7.76 | $647.96 | | 090 | Y | |
| | 44186 | Laparoscopy, surgical; jejunostomy (eg, for decompression or feeding) | 5.88 | $490.98 | | 090 | Y | |
| | 44187 | Laparoscopy, surgical; ileostomy or jejunostomy, non-tube | 25.74 | $2,149.29 | | 090 | Y | |
| | 44188 | Laparoscopy, surgical, colostomy or skin level cecostomy | 28.33 | $2,365.56 | | 090 | Y | |
| | 44202 | Laparoscopy, surgical; enterectomy, resection of small intestine, single resection and anastomosis | 32.55 | $2,717.93 | | 090 | Y | |
| + | 44203 | Laparoscopy, surgical; each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure) | 5.97 | $498.50 | | 000 | Y | |
| | 44204 | Laparoscopy, surgical; colectomy, partial, with anastomosis | 36.47 | $3,045.25 | | 090 | Y | |
| | 44205 | Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy | 31.91 | $2,664.49 | | 090 | Y | |
| | 44206 | Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure) | 41.19 | $3,439.37 | | 090 | Y | |
| | 44207 | Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) | 43.43 | $3,626.41 | | 090 | Y | |
| | 44208 | Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy | 47.22 | $3,942.87 | | 090 | Y | |
| | 44210 | Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy | 42.01 | $3,507.84 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **44211** | Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, includes rectal mucosectomy, when performed | 51.80 | $4,325.30 | | 090 | Y | |
| | **44212** | Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy | 48.27 | $4,030.55 | | 090 | Y | |
| + | **44213** | Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure) | 4.73 | $394.96 | | 000 | Y | |
| | **44227** | Laparoscopy, surgical, closure of enterostomy, large or small intestine, with resection and anastomosis | 39.36 | $3,286.56 | | 090 | Y | |
| | **44238** | Unlisted laparoscopy procedure, intestine (except rectum) | 0.00 | BR | | 000 | N | |
| | **44300** | Enterostomy or cecostomy, tube (eg, for decompression or feeding) (separate procedure) | 19.39 | $1,619.07 | | 090 | Y | |
| | **44310** | Ileostomy or jejunostomy, non-tube | 24.35 | $2,033.23 | | 090 | Y | |
| | **44312** | Revision of ileostomy; simple (release of superficial scar) (separate procedure) | 13.47 | $1,124.75 | | 090 | N | $499.50 |
| | **44314** | Revision of ileostomy; complicated (reconstruction in-depth) (separate procedure) | 23.32 | $1,947.22 | | 090 | Y | |
| | **44316** | Continent ileostomy (Kock procedure) (separate procedure) | 32.22 | $2,690.37 | | 090 | Y | |
| | **44320** | Colostomy or skin level cecostomy; | 27.67 | $2,310.45 | | 090 | Y | |
| | **44322** | Colostomy or skin level cecostomy; with multiple biopsies (eg, for congenital megacolon) (separate procedure) | 22.15 | $1,849.53 | | 090 | Y | |
| | **44340** | Revision of colostomy; simple (release of superficial scar) (separate procedure) | 13.63 | $1,138.11 | | 090 | N | $765.00 |
| | **44345** | Revision of colostomy; complicated (reconstruction in-depth) (separate procedure) | 24.21 | $2,021.54 | | 090 | Y | |
| | **44346** | Revision of colostomy; with repair of paracolostomy hernia (separate procedure) | 27.07 | $2,260.35 | | 090 | Y | |
| ⊙ | **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) | 3.73 | $311.46 | | 000 | N | $669.00 |
| ⊙ | **44361** | Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple | 4.11 | $343.19 | | 000 | N | $669.00 |
| ⊙ | **44363** | Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body | 4.94 | $412.49 | | 000 | N | $669.00 |
| ⊙ | **44364** | Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique | 5.25 | $438.38 | | 000 | N | $669.00 |
| ⊙ | **44365** | Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery | 4.69 | $391.62 | | 000 | N | $669.00 |
| ⊙ | **44366** | Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator) | 6.18 | $516.03 | | 000 | N | $669.00 |
| ⊙ | **44369** | Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique | 6.30 | $526.05 | | 000 | N | $669.00 |
| ⊙ | **44370** | Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with transendoscopic stent placement (includes predilation) | 6.80 | $567.80 | | 000 | N | $2,008.50 |
| ⊙ | **44372** | Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with placement of percutaneous jejunostomy tube | 6.15 | $513.53 | | 000 | N | $669.00 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| ⊙ | **44373** | Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube | 4.91 | $409.99 | | 000 | N | $669.00 |
| ⊙ | **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) | 7.28 | $607.88 | | 000 | N | $669.00 |
| ⊙ | **44377** | Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with biopsy, single or multiple | 7.67 | $640.45 | | 000 | N | $669.00 |
| ⊙ | **44378** | Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator) | 9.84 | $821.64 | | 000 | N | $669.00 |
| ⊙ | **44379** | Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with transendoscopic stent placement (includes predilation) | 10.35 | $864.23 | | 000 | N | $2,008.50 |
| ⊙ | **44380** | Ileoscopy, through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) | 1.62 | $135.27 | | 000 | N | $499.50 |
| ⊙ | **44382** | Ileoscopy, through stoma; with biopsy, single or multiple | 1.93 | $161.16 | | 000 | N | $499.50 |
| ⊙ | **44383** | Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation) | 4.21 | $351.54 | | 000 | N | $2,008.50 |
| ⊙ | **44385** | Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) | 5.52 | $460.92 | | 000 | N | $499.50 |
| ⊙ | **44386** | Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; with biopsy, single or multiple | 8.77 | $732.30 | | 000 | N | $499.50 |
| ⊙ | **44388** | Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) | 8.14 | $679.69 | | 000 | N | $499.50 |
| ⊙ | **44389** | Colonoscopy through stoma; with biopsy, single or multiple | 9.82 | $819.97 | | 000 | N | $499.50 |
| ⊙ | **44390** | Colonoscopy through stoma; with removal of foreign body | 11.08 | $925.18 | | 000 | N | $499.50 |
| ⊙ | **44391** | Colonoscopy through stoma; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator) | 13.00 | $1,085.50 | | 000 | N | $499.50 |
| ⊙ | **44392** | Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery | 10.55 | $880.93 | | 000 | N | $499.50 |
| ⊙ | **44393** | Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique | 11.90 | $993.65 | | 000 | N | $499.50 |
| ⊙ | **44394** | Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique | 12.33 | $1,029.56 | | 000 | N | $499.50 |
| ⊙ | **44397** | Colonoscopy through stoma; with transendoscopic stent placement (includes predilation) | 6.55 | $546.93 | | 000 | N | $499.50 |
| ⊘⊙ | **44500** | Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure) | 0.63 | $52.61 | | 000 | Y | |
| | **44602** | Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; single perforation | 31.00 | $2,588.50 | | 090 | Y | |
| | **44603** | Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; multiple perforations | 35.35 | $2,951.73 | | 090 | Y | |
| | **44604** | Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); without colostomy | 24.73 | $2,064.96 | | 090 | Y | |
| | **44605** | Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); with colostomy | 30.59 | $2,554.27 | | 090 | Y | |
| | **44615** | Intestinal stricturoplasty (enterotomy and enterorrhaphy) with or without dilation, for intestinal obstruction | 24.99 | $2,086.67 | | 090 | Y | |
| | **44620** | Closure of enterostomy, large or small intestine; | 19.80 | $1,653.30 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **44625** | Closure of enterostomy, large or small intestine; with resection and anastomosis other than colorectal | 23.61 | $1,971.44 | | 090 | Y | |
| | **44626** | Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure) | 37.90 | $3,164.65 | | 090 | Y | |
| | **44640** | Closure of intestinal cutaneous fistula | 32.93 | $2,749.66 | | 090 | Y | |
| | **44650** | Closure of enteroenteric or enterocolic fistula | 34.21 | $2,856.54 | | 090 | Y | |
| | **44660** | Closure of enterovesical fistula; without intestinal or bladder resection | 32.27 | $2,694.55 | | 090 | Y | |
| | **44661** | Closure of enterovesical fistula; with intestine and/or bladder resection | 36.87 | $3,078.65 | | 090 | Y | |
| | **44680** | Intestinal plication (separate procedure) | 24.56 | $2,050.76 | | 090 | Y | |
| | **44700** | Exclusion of small intestine from pelvis by mesh or other prosthesis, or native tissue (eg, bladder or omentum) | 24.06 | $2,009.01 | | 090 | Y | |
| + | **44701** | Intraoperative colonic lavage (List separately in addition to code for primary procedure) | 4.15 | $346.53 | | 000 | Y | |
| | **44715** | Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, including mobilization and fashioning of the superior mesenteric artery and vein | 0.00 | BR | | 000 | Y | |
| ⊘ | **44720** | Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; venous anastomosis, each | 6.47 | $540.25 | | 000 | Y | |
| ⊘ | **44721** | Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; arterial anastomosis, each | 9.52 | $794.92 | | 000 | Y | |
| | **44799** | Unlisted procedure, intestine | 0.00 | BR | | 000 | N | |
| | **44800** | Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct | 17.63 | $1,472.11 | | 090 | Y | |
| | **44820** | Excision of lesion of mesentery (separate procedure) | 19.37 | $1,617.40 | | 090 | Y | |
| | **44850** | Suture of mesentery (separate procedure) | 17.22 | $1,437.87 | | 090 | Y | |
| | **44899** | Unlisted procedure, Meckel's diverticulum and the mesentery | 0.00 | BR | | 000 | N | |
| | **44900** | Incision and drainage of appendiceal abscess; open | 17.30 | $1,444.55 | | 090 | Y | |
| ⊙ | **44901** | Incision and drainage of appendiceal abscess; percutaneous | 28.86 | $2,409.81 | | 000 | Y | |
| | **44950** | Appendectomy; | 15.02 | $1,254.17 | | 090 | Y | |
| + | **44955** | Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure) | 2.09 | $174.52 | | 000 | Y | |
| | **44960** | Appendectomy; for ruptured appendix with abscess or generalized peritonitis | 19.93 | $1,664.16 | | 090 | Y | |
| | **44970** | Laparoscopy, surgical, appendectomy | 13.66 | $1,140.61 | | 090 | Y | |
| | **44979** | Unlisted laparoscopy procedure, appendix | 0.00 | BR | | 000 | N | |
| | **45000** | Transrectal drainage of pelvic abscess | 9.20 | $768.20 | | 090 | N | $468.11 |
| | **45005** | Incision and drainage of submucosal abscess, rectum | 6.07 | $506.85 | | 010 | N | $669.00 |
| | **45020** | Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess | 11.71 | $977.79 | | 090 | N | $669.00 |
| | **45100** | Biopsy of anorectal wall, anal approach (eg, congenital megacolon) | 6.48 | $541.08 | | 090 | N | $499.50 |
| | **45108** | Anorectal myomectomy | 7.96 | $664.66 | | 090 | N | $669.00 |
| | **45110** | Proctectomy; complete, combined abdominoperineal, with colostomy | 43.14 | $3,602.19 | | 090 | Y | |
| | **45111** | Proctectomy; partial resection of rectum, transabdominal approach | 25.29 | $2,111.72 | | 090 | Y | |
| | **45112** | Proctectomy, combined abdominoperineal, pull-through procedure (eg, colo-anal anastomosis) | 44.59 | $3,723.27 | | 090 | Y | |
| | **45113** | Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy | 45.61 | $3,808.44 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **45114** | Proctectomy, partial, with anastomosis; abdominal and transsacral approach | 41.67 | $3,479.45 | | 090 | Y | |
| | **45116** | Proctectomy, partial, with anastomosis; transsacral approach only (Kraske type) | 37.55 | $3,135.43 | | 090 | Y | |
| | **45119** | Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy when performed | 45.64 | $3,810.94 | | 090 | Y | |
| | **45120** | Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull-through procedure and anastomosis (eg, Swenson, Duhamel, or Soave type operation) | 36.47 | $3,045.25 | | 090 | Y | |
| | **45121** | Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with subtotal or total colectomy, with multiple biopsies | 40.18 | $3,355.03 | | 090 | Y | |
| | **45123** | Proctectomy, partial, without anastomosis, perineal approach | 25.60 | $2,137.60 | | 090 | Y | |
| | **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 | 67.05 | $5,598.68 | | 090 | Y | |
| | **45130** | Excision of rectal procidentia, with anastomosis; perineal approach | 25.09 | $2,095.02 | | 090 | Y | |
| | **45135** | Excision of rectal procidentia, with anastomosis; abdominal and perineal approach | 30.93 | $2,582.66 | | 090 | Y | |
| | **45136** | Excision of ileoanal reservoir with ileostomy | 42.74 | $3,568.79 | | 090 | Y | |
| | **45150** | Division of stricture of rectum | 8.88 | $741.48 | | 090 | Y | $669.00 |
| | **45160** | Excision of rectal tumor by proctotomy, transsacral or transcoccygeal approach | 22.85 | $1,907.98 | | 090 | Y | $669.00 |
| | **45170** | Excision of rectal tumor, transanal approach | 17.85 | $1,490.48 | | 090 | Y | $669.00 |
| | **45190** | Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach | 15.25 | $1,273.38 | | 090 | Y | $2,008.50 |
| | **45300** | Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) | 2.01 | $167.84 | | 000 | N | |
| ⊙ | **45303** | Proctosigmoidoscopy, rigid; with dilation (eg, balloon, guide wire, bougie) | 19.31 | $1,612.39 | | 000 | N | |
| ⊙ | **45305** | Proctosigmoidoscopy, rigid; with biopsy, single or multiple | 3.80 | $317.30 | | 000 | N | $499.50 |
| ⊙ | **45307** | Proctosigmoidoscopy, rigid; with removal of foreign body | 4.06 | $339.01 | | 000 | N | $499.50 |
| ⊙ | **45308** | Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery | 3.15 | $263.03 | | 000 | N | $499.50 |
| ⊙ | **45309** | Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique | 5.08 | $424.18 | | 000 | N | $499.50 |
| ⊙ | **45315** | Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique | 4.45 | $371.58 | | 000 | N | $499.50 |
| ⊙ | **45317** | Proctosigmoidoscopy, rigid; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator) | 4.19 | $349.87 | | 000 | N | $499.50 |
| ⊙ | **45320** | Proctosigmoidoscopy, rigid; 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) | 4.75 | $396.63 | | 000 | N | $499.50 |
| ⊙ | **45321** | Proctosigmoidoscopy, rigid; with decompression of volvulus | 1.76 | $146.96 | | 000 | N | $499.50 |
| ⊙ | **45327** | Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation) | 2.36 | $197.06 | | 000 | N | $499.50 |
| | **45330** | Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) | 3.27 | $273.05 | | 000 | N | |
| | **45331** | Sigmoidoscopy, flexible; with biopsy, single or multiple | 4.23 | $353.21 | | 000 | N | $448.86 |
| ⊙ | **45332** | Sigmoidoscopy, flexible; with removal of foreign body | 6.92 | $577.82 | | 000 | N | $448.86 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| ⊙ | **45333** | Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery | 6.82 | $569.47 | | 000 | N | $499.50 |
| ⊙ | **45334** | Sigmoidoscopy, flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator) | 3.90 | $325.65 | | 000 | N | $499.50 |
| ⊙ | **45335** | Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance | 5.16 | $430.86 | | 000 | N | $448.86 |
| ⊙ | **45337** | Sigmoidoscopy, flexible; with decompression of volvulus, any method | 3.39 | $283.07 | | 000 | N | $448.86 |
| ⊙ | **45338** | Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique | 7.66 | $639.61 | | 000 | N | $499.50 |
| ⊙ | **45339** | Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique | 7.11 | $593.69 | | 000 | N | $499.50 |
| ⊙ | **45340** | Sigmoidoscopy, flexible; with dilation by balloon, 1 or more strictures | 9.03 | $754.01 | | 000 | N | $499.50 |
| ⊙ | **45341** | Sigmoidoscopy, flexible; with endoscopic ultrasound examination | 3.70 | $308.95 | | 000 | N | $499.50 |
| ⊙ | **45342** | Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s) | 5.65 | $471.78 | | 000 | N | $499.50 |
| ⊙ | **45345** | Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation) | 4.12 | $344.02 | | 000 | N | $499.50 |
| ⊙ | **45355** | Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple | 4.95 | $413.33 | | 000 | N | $499.50 |
| ⊙ | **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) | 9.82 | $819.97 | | 000 | N | $669.00 |
| ⊙ | **45379** | Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body | 12.38 | $1,033.73 | | 000 | N | $669.00 |
| ⊙ | **45380** | Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple | 11.66 | $973.61 | | 000 | N | $669.00 |
| ⊙ | **45381** | Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance | 11.33 | $946.06 | | 000 | N | $669.00 |
| ⊙ | **45382** | Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator) | 15.56 | $1,299.26 | | 000 | N | $669.00 |
| ⊙ | **45383** | Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique | 13.83 | $1,154.81 | | 000 | N | $669.00 |
| ⊙ | **45384** | Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery | 11.50 | $960.25 | | 000 | N | $669.00 |
| ⊙ | **45385** | Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique | 13.13 | $1,096.36 | | 000 | N | $669.00 |
| ⊙ | **45386** | Colonoscopy, flexible, proximal to splenic flexure; with dilation by balloon, 1 or more strictures | 16.87 | $1,408.65 | | 000 | N | $669.00 |
| ⊙ | **45387** | Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation) | 8.28 | $691.38 | | 000 | N | $499.50 |
| ⊙ | **45391** | Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examination | 7.13 | $595.36 | | 000 | N | $669.00 |
| ⊙ | **45392** | Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s) | 8.95 | $747.33 | | 000 | N | $669.00 |
| | **45395** | Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy | 46.63 | $3,893.61 | | 090 | Y | |
| | **45397** | Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy, when performed | 50.42 | $4,210.07 | | 090 | Y | |
| | **45400** | Laparoscopy, surgical; proctopexy (for prolapse) | 27.08 | $2,261.18 | | 090 | Y | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| 45402 | Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resection | 36.26 | $3,027.71 | | 090 | Y | |
| 45499 | Unlisted laparoscopy procedure, rectum | 0.00 | BR | | 000 | N | |
| 45500 | Proctoplasty; for stenosis | 11.37 | $949.40 | | 090 | Y | $669.00 |
| 45505 | Proctoplasty; for prolapse of mucous membrane | 12.41 | $1,036.24 | | 090 | N | $669.00 |
| 45520 | Perirectal injection of sclerosing solution for prolapse | 2.53 | $211.26 | | 000 | N | |
| 45540 | Proctopexy (eg, for prolapse); abdominal approach | 24.61 | $2,054.94 | | 090 | Y | |
| 45541 | Proctopexy (eg, for prolapse); perineal approach | 20.90 | $1,745.15 | | 090 | Y | |
| 45550 | Proctopexy (eg, for prolapse); with sigmoid resection, abdominal approach | 33.98 | $2,837.33 | | 090 | Y | |
| 45560 | Repair of rectocele (separate procedure) | 16.58 | $1,384.43 | | 090 | Y | $669.00 |
| 45562 | Exploration, repair, and presacral drainage for rectal injury; | 25.15 | $2,100.03 | | 090 | Y | |
| 45563 | Exploration, repair, and presacral drainage for rectal injury; with colostomy | 37.31 | $3,115.39 | | 090 | Y | |
| 45800 | Closure of rectovesical fistula; | 27.90 | $2,329.65 | | 090 | Y | |
| 45805 | Closure of rectovesical fistula; with colostomy | 32.33 | $2,699.56 | | 090 | Y | |
| 45820 | Closure of rectourethral fistula; | 27.84 | $2,324.64 | | 090 | Y | |
| 45825 | Closure of rectourethral fistula; with colostomy | 34.03 | $2,841.51 | | 090 | Y | |
| 45900 | Reduction of procidentia (separate procedure) under anesthesia | 4.51 | $376.59 | | 010 | N | $468.11 |
| 45905 | Dilation of anal sphincter (separate procedure) under anesthesia other than local | 3.85 | $321.48 | | 010 | N | $499.50 |
| 45910 | Dilation of rectal stricture (separate procedure) under anesthesia other than local | 4.54 | $379.09 | | 010 | N | $499.50 |
| 45915 | Removal of fecal impaction or foreign body (separate procedure) under anesthesia | 7.44 | $621.24 | | 010 | N | $468.11 |
| 45990 | Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic | 2.58 | $215.43 | | 000 | N | $468.11 |
| 45999 | Unlisted procedure, rectum | 0.00 | BR | | 000 | N | |
| 46020 | Placement of seton | 5.51 | $460.09 | | 010 | N | $765.00 |
| 46030 | Removal of anal seton, other marker | 2.74 | $228.79 | | 010 | N | $468.11 |
| 46040 | Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure) | 11.10 | $926.85 | | 090 | N | $765.00 |
| 46045 | Incision and drainage of intramural, intramuscular, or submucosal abscess, transanal, under anesthesia | 8.90 | $743.15 | | 090 | N | $669.00 |
| 46050 | Incision and drainage, perianal abscess, superficial | 3.93 | $328.16 | | 010 | N | $468.11 |
| 46060 | Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton | 9.82 | $819.97 | | 090 | N | $669.00 |
| 46070 | Incision, anal septum (infant) | 4.78 | $399.13 | | 090 | Y | |
| 46080 | Sphincterotomy, anal, division of sphincter (separate procedure) | 5.08 | $424.18 | | 010 | N | $765.00 |
| 46083 | Incision of thrombosed hemorrhoid, external | 3.91 | $326.49 | | 010 | N | |
| 46200 | Fissurectomy, with or without sphincterotomy | 7.98 | $666.33 | | 090 | N | $669.00 |
| 46210 | Cryptectomy; single | 8.09 | $675.52 | | 090 | N | $669.00 |
| 46211 | Cryptectomy; multiple (separate procedure) | 10.19 | $850.87 | | 090 | N | $669.00 |
| 46220 | Papillectomy or excision of single tag, anus (separate procedure) | 4.05 | $338.18 | | 010 | N | $499.50 |
| 46221 | Hemorrhoidectomy, by simple ligature (eg, rubber band) | 5.22 | $435.87 | | 010 | N | |
| 46230 | Excision of external hemorrhoid tags and/or multiple papillae | 5.81 | $485.14 | | 010 | N | $499.50 |
| 46250 | Hemorrhoidectomy, external, complete | 9.69 | $809.12 | | 090 | N | $765.00 |
| 46255 | Hemorrhoidectomy, internal and external, simple; | 10.94 | $913.49 | | 090 | N | $765.00 |
| 46257 | Hemorrhoidectomy, internal and external, simple; with fissurectomy | 8.86 | $739.81 | | 090 | N | $765.00 |
| 46258 | Hemorrhoidectomy, internal and external, simple; with fistulectomy, with or without fissurectomy | 9.79 | $817.47 | | 090 | Y | $765.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **46260** | Hemorrhoidectomy, internal and external, complex or extensive; | 10.14 | $846.69 | | 090 | N | $765.00 |
| **46261** | Hemorrhoidectomy, internal and external, complex or extensive; with fissurectomy | 11.44 | $955.24 | | 090 | N | $945.00 |
| **46262** | Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy | 11.82 | $986.97 | | 090 | N | $945.00 |
| **46270** | Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous | 10.10 | $843.35 | | 090 | N | $765.00 |
| **46275** | Surgical treatment of anal fistula (fistulectomy/fistulotomy); submuscular | 10.42 | $870.07 | | 090 | N | $765.00 |
| **46280** | Surgical treatment of anal fistula (fistulectomy/fistulotomy); complex or multiple, with or without placement of seton | 9.82 | $819.97 | | 090 | N | $945.00 |
| **46285** | Surgical treatment of anal fistula (fistulectomy/fistulotomy); second stage | 9.67 | $807.45 | | 090 | N | $499.50 |
| **46288** | Closure of anal fistula with rectal advancement flap | 11.63 | $971.11 | | 090 | N | $945.00 |
| **46320** | Enucleation or excision of external thrombotic hemorrhoid | 3.83 | $319.81 | | 010 | N | |
| **46500** | Injection of sclerosing solution, hemorrhoids | 4.12 | $344.02 | | 010 | N | |
| **46505** | Chemodenervation of internal anal sphincter | 6.06 | $506.01 | | 010 | N | |
| **46600** | Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) | 2.03 | $169.51 | | 000 | N | |
| **46604** | Anoscopy; with dilation (eg, balloon, guide wire, bougie) | 11.27 | $941.05 | | 000 | N | |
| **46606** | Anoscopy; with biopsy, single or multiple | 4.63 | $386.61 | | 000 | N | |
| **46608** | Anoscopy; with removal of foreign body | 5.80 | $484.30 | | 000 | N | $499.50 |
| **46610** | Anoscopy; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery | 5.39 | $450.07 | | 000 | N | $499.50 |
| **46611** | Anoscopy; with removal of single tumor, polyp, or other lesion by snare technique | 5.02 | $419.17 | | 000 | N | $499.50 |
| **46612** | Anoscopy; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique | 7.58 | $632.93 | | 000 | N | $499.50 |
| **46614** | Anoscopy; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator) | 4.39 | $366.57 | | 000 | N | |
| **46615** | Anoscopy; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique | 5.17 | $431.70 | | 000 | Y | $669.00 |
| **46700** | Anoplasty, plastic operation for stricture; adult | 14.10 | $1,177.35 | | 090 | N | $765.00 |
| **46705** | Anoplasty, plastic operation for stricture; infant | 11.26 | $940.21 | | 090 | Y | |
| **46706** | Repair of anal fistula with fibrin glue | 3.75 | $313.13 | | 010 | N | $499.50 |
| **46710** | Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach | 24.45 | $2,041.58 | | 090 | Y | |
| **46712** | Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; combined transperineal and transabdominal approach | 51.19 | $4,274.37 | | 090 | Y | |
| **46715** | Repair of low imperforate anus; with anoperineal fistula (cut-back procedure) | 11.31 | $944.39 | | 090 | Y | |
| **46716** | Repair of low imperforate anus; with transposition of anoperineal or anovestibular fistula | 25.38 | $2,119.23 | | 090 | Y | |
| **46730** | Repair of high imperforate anus without fistula; perineal or sacroperineal approach | 41.50 | $3,465.25 | | 090 | Y | |
| **46735** | Repair of high imperforate anus without fistula; combined transabdominal and sacroperineal approaches | 48.84 | $4,078.14 | | 090 | Y | |
| **46740** | Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach | 46.04 | $3,844.34 | | 090 | Y | |
| **46742** | Repair of high imperforate anus with rectourethral or rectovaginal fistula; combined transabdominal and sacroperineal approaches | 55.93 | $4,670.16 | | 090 | Y | |
| **46744** | Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach | 80.16 | $6,693.36 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **46746** | Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach; | 89.88 | $7,504.98 | | 090 | Y | |
| | **46748** | Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach; with vaginal lengthening by intestinal graft or pedicle flaps | 90.14 | $7,526.69 | | 090 | Y | |
| | **46750** | Sphincteroplasty, anal, for incontinence or prolapse; adult | 17.16 | $1,432.86 | | 090 | Y | $765.00 |
| | **46751** | Sphincteroplasty, anal, for incontinence or prolapse; child | 14.37 | $1,199.90 | | 090 | Y | |
| | **46753** | Graft (Thiersch operation) for rectal incontinence and/or prolapse | 12.90 | $1,077.15 | | 090 | N | $765.00 |
| | **46754** | Removal of Thiersch wire or suture, anal canal | 6.40 | $534.40 | | 010 | N | $669.00 |
| | **46760** | Sphincteroplasty, anal, for incontinence, adult; muscle transplant | 24.44 | $2,040.74 | | 090 | Y | $669.00 |
| | **46761** | Sphincteroplasty, anal, for incontinence, adult; levator muscle imbrication (Park posterior anal repair) | 21.19 | $1,769.37 | | 090 | Y | $765.00 |
| | **46762** | Sphincteroplasty, anal, for incontinence, adult; implantation artificial sphincter | 20.28 | $1,693.38 | | 090 | Y | $1,492.50 |
| | **46900** | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical | 4.73 | $394.96 | | 010 | N | |
| | **46910** | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation | 5.03 | $420.01 | | 010 | N | |
| | **46916** | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery | 5.11 | $426.69 | | 010 | N | |
| | **46917** | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery | 10.90 | $910.15 | | 010 | N | $499.50 |
| | **46922** | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision | 5.39 | $450.07 | | 010 | N | $499.50 |
| | **46924** | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 11.67 | $974.45 | | 010 | N | $499.50 |
| | **46934** | Destruction of hemorrhoids, any method; internal | 8.88 | $741.48 | | 090 | N | |
| | **46935** | Destruction of hemorrhoids, any method; external | 5.94 | $495.99 | | 010 | N | |
| | **46936** | Destruction of hemorrhoids, any method; internal and external | 8.86 | $739.81 | | 090 | N | |
| | **46937** | Cryosurgery of rectal tumor; benign | 5.69 | $475.12 | | 010 | Y | $669.00 |
| | **46938** | Cryosurgery of rectal tumor; malignant | 9.25 | $772.38 | | 090 | Y | $669.00 |
| | **46940** | Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); initial | 4.53 | $378.26 | | 010 | N | |
| | **46942** | Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); subsequent | 4.10 | $342.35 | | 010 | N | |
| | **46945** | Ligation of internal hemorrhoids; single procedure | 5.76 | $480.96 | | 090 | N | |
| | **46946** | Ligation of internal hemorrhoids; multiple procedures | 6.56 | $547.76 | | 090 | N | $499.50 |
| | **46947** | Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling | 8.50 | $709.75 | | 090 | N | $1,492.50 |
| | **46999** | Unlisted procedure, anus | 0.00 | BR | | 000 | N | |
| | **47000** | Biopsy of liver, needle; percutaneous | 5.95 | $496.83 | | 000 | N | $499.50 |
| + | **47001** | Biopsy of liver, needle; when done for indicated purpose at time of other major procedure (List separately in addition to code for primary procedure) | 2.57 | $214.60 | | 000 | N | |
| | **47010** | Hepatotomy; for open drainage of abscess or cyst, one or two stages | 27.47 | $2,293.75 | | 090 | Y | |
| ⊙ | **47011** | Hepatotomy; for percutaneous drainage of abscess or cyst, one or two stages | 4.71 | $393.29 | | 000 | Y | |
| | **47015** | Laparotomy, with aspiration and/or injection of hepatic parasitic (eg, amoebic or echinococcal) cyst(s) or abscess(es) | 25.92 | $2,164.32 | | 090 | Y | |
| | **47100** | Biopsy of liver, wedge | 19.13 | $1,597.36 | | 090 | Y | |
| | **47120** | Hepatectomy, resection of liver; partial lobectomy | 54.45 | $4,546.58 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **47122** | Hepatectomy, resection of liver; trisegmentectomy | 81.38 | $6,795.23 | | 090 | Y | |
| | **47125** | Hepatectomy, resection of liver; total left lobectomy | 72.96 | $6,092.16 | | 090 | Y | |
| | **47130** | Hepatectomy, resection of liver; total right lobectomy | 78.52 | $6,556.42 | | 090 | Y | |
| | **47133** | Donor hepatectomy (including cold preservation), from cadaver donor | 0.00 | BR | | 000 | Y | |
| | **47135** | Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age | 115.46 | $9,640.91 | | 090 | Y | |
| | **47136** | Liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age | 97.95 | $8,178.83 | | 090 | Y | |
| | **47140** | Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III) | 80.59 | $6,729.27 | | 090 | Y | |
| | **47141** | Donor hepatectomy (including cold preservation), from living donor; total left lobectomy (segments II, III and IV) | 95.84 | $8,002.64 | | 090 | Y | |
| | **47142** | Donor hepatectomy (including cold preservation), from living donor; total right lobectomy (segments V, VI, VII and VIII) | 105.41 | $8,801.74 | | 090 | Y | |
| | **47143** | Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; without trisegment or lobe split | 0.00 | BR | | 000 | Y | |
| | **47144** | Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with trisegment split of whole liver graft into two partial liver grafts (ie, left lateral segment (segments II and III) and right trisegment (segments I and IV through VIII)) | 0.00 | BR | | 090 | Y | |
| | **47145** | Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with lobe split of whole liver graft into two partial liver grafts (ie, left lobe (segments II, III, and IV) and right lobe (segments I and V through VIII)) | 0.00 | BR | | 000 | Y | |
| ⊘ | **47146** | Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each | 8.15 | $680.53 | | 000 | Y | |
| ⊘ | **47147** | Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; arterial anastomosis, each | 9.51 | $794.09 | | 000 | Y | |
| | **47300** | Marsupialization of cyst or abscess of liver | 25.52 | $2,130.92 | | 090 | Y | |
| | **47350** | Management of liver hemorrhage; simple suture of liver wound or injury | 31.57 | $2,636.10 | | 090 | Y | |
| | **47360** | Management of liver hemorrhage; complex suture of liver wound or injury, with or without hepatic artery ligation | 42.94 | $3,585.49 | | 090 | Y | |
| | **47361** | Management of liver hemorrhage; exploration of hepatic wound, extensive debridement, coagulation and/or suture, with or without packing of liver | 71.15 | $5,941.03 | | 090 | Y | |
| | **47362** | Management of liver hemorrhage; re-exploration of hepatic wound for removal of packing | 32.42 | $2,707.07 | | 090 | Y | |
| | **47370** | Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency | 29.17 | $2,435.70 | | 090 | Y | |
| | **47371** | Laparoscopy, surgical, ablation of one or more liver tumor(s); cryosurgical | 29.34 | $2,449.89 | | 090 | Y | |
| | **47379** | Unlisted laparoscopic procedure, liver | 0.00 | BR | | 000 | N | |
| | **47380** | Ablation, open, of one or more liver tumor(s); radiofrequency | 33.98 | $2,837.33 | | 090 | Y | |
| | **47381** | Ablation, open, of one or more liver tumor(s); cryosurgical | 34.52 | $2,882.42 | | 090 | Y | |
| | **47382** | Ablation, one or more liver tumor(s), percutaneous, radiofrequency | 20.45 | $1,707.58 | | 010 | Y | |
| | **47399** | Unlisted procedure, liver | 0.00 | BR | | 000 | N | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **47400** | Hepaticotomy or hepaticostomy with exploration, drainage, or removal of calculus | 49.02 | $4,093.17 | | 090 | Y | |
| | **47420** | Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; without transduodenal sphincterotomy or sphincteroplasty | 31.06 | $2,593.51 | | 090 | Y | |
| | **47425** | Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; with transduodenal sphincterotomy or sphincteroplasty | 31.34 | $2,616.89 | | 090 | Y | |
| | **47460** | Transduodenal sphincterotomy or sphincteroplasty, with or without transduodenal extraction of calculus (separate procedure) | 29.09 | $2,429.02 | | 090 | Y | |
| | **47480** | Cholecystotomy or cholecystostomy with exploration, drainage, or removal of calculus (separate procedure) | 19.31 | $1,612.39 | | 090 | Y | |
| | **47490** | Percutaneous cholecystostomy | 12.99 | $1,084.67 | | 090 | N | |
| | **47500** | Injection procedure for percutaneous transhepatic cholangiography | 2.50 | $208.75 | | 000 | N | |
| | **47505** | Injection procedure for cholangiography through an existing catheter (eg, percutaneous transhepatic or T-tube) | 0.96 | $80.16 | | 000 | N | |
| | **47510** | Introduction of percutaneous transhepatic catheter for biliary drainage | 12.36 | $1,032.06 | | 090 | N | $669.00 |
| | **47511** | Introduction of percutaneous transhepatic stent for internal and external biliary drainage | 15.15 | $1,265.03 | | 090 | N | $1,868.78 |
| | **47525** | Change of percutaneous biliary drainage catheter | 20.12 | $1,680.02 | | 010 | N | $499.50 |
| | **47530** | Revision and/or reinsertion of transhepatic tube | 38.29 | $3,197.22 | | 090 | N | $499.50 |
| + | **47550** | Biliary endoscopy, intraoperative (choledochoscopy) (List separately in addition to code for primary procedure) | 4.08 | $340.68 | | 000 | Y | |
| | **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) | 8.14 | $679.69 | | 000 | N | $669.00 |
| | **47553** | Biliary endoscopy, percutaneous via T-tube or other tract; with biopsy, single or multiple | 8.08 | $674.68 | | 000 | N | $765.00 |
| | **47554** | Biliary endoscopy, percutaneous via T-tube or other tract; with removal of calculus/calculi | 12.34 | $1,030.39 | | 000 | N | $765.00 |
| | **47555** | Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) without stent | 9.64 | $804.94 | | 000 | N | $765.00 |
| | **47556** | Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) with stent | 10.89 | $909.32 | | 000 | N | $1,868.78 |
| | **47560** | Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy | 6.61 | $551.94 | | 000 | Y | $765.00 |
| | **47561** | Laparoscopy, surgical; with guided transhepatic cholangiography with biopsy | 7.13 | $595.36 | | 000 | Y | $765.00 |
| | **47562** | Laparoscopy, surgical; cholecystectomy | 16.98 | $1,417.83 | | 090 | Y | |
| | **47563** | Laparoscopy, surgical; cholecystectomy with cholangiography | 17.64 | $1,472.94 | | 090 | Y | |
| | **47564** | Laparoscopy, surgical; cholecystectomy with exploration of common duct | 20.49 | $1,710.92 | | 090 | Y | |
| | **47570** | Laparoscopy, surgical; cholecystoenterostomy | 18.23 | $1,522.21 | | 090 | Y | |
| | **47579** | Unlisted laparoscopy procedure, biliary tract | 0.00 | BR | | 000 | N | |
| | **47600** | Cholecystectomy; | 23.80 | $1,987.30 | | 090 | Y | |
| | **47605** | Cholecystectomy; with cholangiography | 22.72 | $1,897.12 | | 090 | Y | |
| | **47610** | Cholecystectomy with exploration of common duct; | 29.10 | $2,429.85 | | 090 | Y | |
| | **47612** | Cholecystectomy with exploration of common duct; with choledochoenterostomy | 29.32 | $2,448.22 | | 090 | Y | |
| | **47620** | Cholecystectomy with exploration of common duct; with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography | 31.86 | $2,660.31 | | 090 | Y | |
| | **47630** | Biliary duct stone extraction, percutaneous via T-tube tract, basket, or snare (eg, Burhenne technique) | 13.97 | $1,166.50 | | 090 | N | $765.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **47700** | Exploration for congenital atresia of bile ducts, without repair, with or without liver biopsy, with or without cholangiography | 24.18 | $2,019.03 | | 090 | Y | |
| **47701** | Portoenterostomy (eg, Kasai procedure) | 40.55 | $3,385.93 | | 090 | Y | |
| **47711** | Excision of bile duct tumor, with or without primary repair of bile duct; extrahepatic | 36.06 | $3,011.01 | | 090 | Y | |
| **47712** | Excision of bile duct tumor, with or without primary repair of bile duct; intrahepatic | 46.34 | $3,869.39 | | 090 | Y | |
| **47715** | Excision of choledochal cyst | 30.22 | $2,523.37 | | 090 | Y | |
| **47719** | Anastomosis, choledochal cyst, without excision | 27.15 | $2,267.03 | | 090 | Y | |
| **47720** | Cholecystoenterostomy; direct | 26.02 | $2,172.67 | | 090 | Y | |
| **47721** | Cholecystoenterostomy; with gastroenterostomy | 30.76 | $2,568.46 | | 090 | Y | |
| **47740** | Cholecystoenterostomy; Roux-en-Y | 29.80 | $2,488.30 | | 090 | Y | |
| **47741** | Cholecystoenterostomy; Roux-en-Y with gastroenterostomy | 33.76 | $2,818.96 | | 090 | Y | |
| **47760** | Anastomosis, of extrahepatic biliary ducts and gastrointestinal tract | 49.13 | $4,102.36 | | 090 | Y | |
| **47765** | Anastomosis, of intrahepatic ducts and gastrointestinal tract | 62.41 | $5,211.24 | | 090 | Y | |
| **47780** | Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract | 53.33 | $4,453.06 | | 090 | Y | |
| **47785** | Anastomosis, Roux-en-Y, of intrahepatic biliary ducts and gastrointestinal tract | 68.64 | $5,731.44 | | 090 | Y | |
| **47800** | Reconstruction, plastic, of extrahepatic biliary ducts with end-to-end anastomosis | 36.48 | $3,046.08 | | 090 | Y | |
| **47801** | Placement of choledochal stent | 24.88 | $2,077.48 | | 090 | Y | |
| **47802** | U-tube hepaticoenterostomy | 34.79 | $2,904.97 | | 090 | Y | |
| **47900** | Suture of extrahepatic biliary duct for pre-existing injury (separate procedure) | 31.55 | $2,634.43 | | 090 | Y | |
| **47999** | Unlisted procedure, biliary tract | 0.00 | BR | | 000 | N | |
| **48000** | Placement of drains, peripancreatic, for acute pancreatitis; | 43.44 | $3,627.24 | | 090 | Y | |
| **48001** | Placement of drains, peripancreatic, for acute pancreatitis; with cholecystostomy, gastrostomy, and jejunostomy | 53.85 | $4,496.48 | | 090 | Y | |
| **48020** | Removal of pancreatic calculus | 26.56 | $2,217.76 | | 090 | Y | |
| **48100** | Biopsy of pancreas, open (eg, fine needle aspiration, needle core biopsy, wedge biopsy) | 20.21 | $1,687.54 | | 090 | Y | |
| **48102** | Biopsy of pancreas, percutaneous needle | 12.70 | $1,060.45 | | 010 | N | $499.50 |
| **48105** | Resection or debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis | 66.09 | $5,518.52 | | 090 | Y | |
| **48120** | Excision of lesion of pancreas (eg, cyst, adenoma) | 25.45 | $2,125.08 | | 090 | Y | |
| **48140** | Pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostomy | 36.08 | $3,012.68 | | 090 | Y | |
| **48145** | Pancreatectomy, distal subtotal, with or without splenectomy; with pancreaticojejunostomy | 37.50 | $3,131.25 | | 090 | Y | |
| **48146** | Pancreatectomy, distal, near-total with preservation of duodenum (Child-type procedure) | 42.81 | $3,574.64 | | 090 | Y | |
| **48148** | Excision of ampulla of Vater | 28.24 | $2,358.04 | | 090 | Y | |
| **48150** | Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreatojejunostomy | 72.80 | $6,078.80 | | 090 | Y | |
| **48152** | Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); without pancreatojejunostomy | 67.19 | $5,610.37 | | 090 | Y | |
| **48153** | Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy | 72.77 | $6,076.30 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | 48154 | Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); without pancreatojejunostomy | 67.55 | $5,640.43 | | 090 | Y | |
| | 48155 | Pancreatectomy, total | 41.33 | $3,451.06 | | 090 | Y | |
| | 48160 | Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells | 56.08 | $4,682.68 | | 000 | Y | |
| + | 48400 | Injection procedure for intraoperative pancreatography (List separately in addition to code for primary procedure) | 2.59 | $216.27 | | 000 | Y | |
| | 48500 | Marsupialization of pancreatic cyst | 25.75 | $2,150.13 | | 090 | Y | |
| | 48510 | External drainage, pseudocyst of pancreas; open | 24.63 | $2,056.61 | | 090 | Y | |
| ⊙ | 48511 | External drainage, pseudocyst of pancreas; percutaneous | 24.26 | $2,025.71 | | 000 | Y | |
| | 48520 | Internal anastomosis of pancreatic cyst to gastrointestinal tract; direct | 25.03 | $2,090.01 | | 090 | Y | |
| | 48540 | Internal anastomosis of pancreatic cyst to gastrointestinal tract; Roux-en-Y | 30.29 | $2,529.22 | | 090 | Y | |
| | 48545 | Pancreatorrhaphy for injury | 30.27 | $2,527.55 | | 090 | Y | |
| | 48547 | Duodenal exclusion with gastrojejunostomy for pancreatic injury | 41.06 | $3,428.51 | | 090 | Y | |
| | 48548 | Pancreaticojejunostomy, side-to-side anastomosis (Puestow-type operation) | 38.52 | $3,216.42 | | 090 | Y | |
| | 48550 | Donor pancreatectomy (including cold preservation), with or without duodenal segment for transplantation | 0.00 | BR | | 000 | Y | |
| | 48551 | Backbench standard preparation of cadaver donor pancreas allograft prior to transplantation, including dissection of allograft from surrounding soft tissues, splenectomy, duodenotomy, ligation of bile duct, ligation of mesenteric vessels, and Y-graft arterial anastomoses from iliac artery to superior mesenteric artery and to splenic artery | 0.00 | BR | | 000 | Y | |
| ⊘ | 48552 | Backbench reconstruction of cadaver donor pancreas allograft prior to transplantation, venous anastomosis, each | 5.56 | $464.26 | | 000 | Y | |
| | 48554 | Transplantation of pancreatic allograft | 56.31 | $4,701.89 | | 090 | Y | |
| | 48556 | Removal of transplanted pancreatic allograft | 27.78 | $2,319.63 | | 090 | Y | |
| | 48999 | Unlisted procedure, pancreas | 0.00 | BR | | 000 | N | |
| | 49000 | Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure) | 18.04 | $1,506.34 | | 090 | Y | |
| | 49002 | Reopening of recent laparotomy | 22.52 | $1,880.42 | | 090 | Y | |
| | 49010 | Exploration, retroperitoneal area with or without biopsy(s) (separate procedure) | 21.88 | $1,826.98 | | 090 | Y | |
| | 49020 | Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; open | 36.75 | $3,068.63 | | 090 | Y | |
| ⊙ | 49021 | Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous | 23.66 | $1,975.61 | | 000 | N | |
| | 49040 | Drainage of subdiaphragmatic or subphrenic abscess; open | 22.90 | $1,912.15 | | 090 | Y | |
| ⊙ | 49041 | Drainage of subdiaphragmatic or subphrenic abscess; percutaneous | 23.16 | $1,933.86 | | 000 | Y | |
| | 49060 | Drainage of retroperitoneal abscess; open | 25.68 | $2,144.28 | | 090 | Y | |
| ⊙ | 49061 | Drainage of retroperitoneal abscess; percutaneous | 22.92 | $1,913.82 | | 000 | Y | |
| | 49062 | Drainage of extraperitoneal lymphocele to peritoneal cavity, open | 17.66 | $1,474.61 | | 090 | Y | |
| | 49080 | Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial | 4.92 | $410.82 | | 000 | N | $334.17 |
| | 49081 | Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); subsequent | 3.87 | $323.15 | | 000 | N | $334.17 |
| | 49180 | Biopsy, abdominal or retroperitoneal mass, percutaneous needle | 4.55 | $379.93 | | 000 | N | $499.50 |
| | 49200 | Excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas; | 16.06 | $1,341.01 | | 090 | Y | |

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|---|---|---|---|---|---|---|---|---|
| | **49201** | Excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas; extensive | 22.85 | $1,907.98 | | 090 | Y | |
| | **49215** | Excision of presacral or sacrococcygeal tumor | 51.97 | $4,339.50 | | 090 | Y | |
| | **49220** | Staging laparotomy for Hodgkins 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) | 22.54 | $1,882.09 | | 090 | Y | |
| | **49250** | Umbilectomy, omphalectomy, excision of umbilicus (separate procedure) | 13.38 | $1,117.23 | | 090 | N | $945.00 |
| | **49255** | Omentectomy, epiploectomy, resection of omentum (separate procedure) | 18.20 | $1,519.70 | | 090 | Y | |
| | **49320** | Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) | 7.82 | $652.97 | | 010 | Y | $765.00 |
| | **49321** | Laparoscopy, surgical; with biopsy (single or multiple) | 8.17 | $682.20 | | 010 | Y | $945.00 |
| | **49322** | Laparoscopy, surgical; with aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple) | 8.97 | $749.00 | | 010 | Y | $945.00 |
| | **49323** | Laparoscopy, surgical; with drainage of lymphocele to peritoneal cavity | 14.85 | $1,239.98 | | 090 | Y | |
| | **49324** | Laparoscopy, surgical; with insertion of intraperitoneal cannula or catheter, permanent | 9.17 | $765.70 | | 010 | Y | |
| | **49325** | Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed | 9.88 | $824.98 | | 010 | Y | |
| + | **49326** | Laparoscopy, surgical; with omentopexy (omental tacking procedure) (List separately in addition to code for primary procedure) | 4.51 | $376.59 | | 000 | Y | |
| | **49329** | Unlisted laparoscopy procedure, abdomen, peritoneum and omentum | 0.00 | BR | | 000 | N | |
| | **49400** | Injection of air or contrast into peritoneal cavity (separate procedure) | 4.72 | $394.12 | | 000 | N | |
| | **49402** | Removal of peritoneal foreign body from peritoneal cavity | 19.73 | $1,647.46 | | 090 | Y | $669.00 |
| | **49419** | Insertion of intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent (ie, totally implantable) | 10.65 | $889.28 | | 090 | N | $499.50 |
| | **49420** | Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary | 3.32 | $277.22 | | 000 | N | $499.50 |
| | **49421** | Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent | 9.17 | $765.70 | | 090 | N | $499.50 |
| | **49422** | Removal of permanent intraperitoneal cannula or catheter | 9.28 | $774.88 | | 010 | N | $499.50 |
| | **49423** | Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure) | 15.07 | $1,258.35 | | 000 | N | |
| | **49424** | Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube (separate procedure) | 4.23 | $353.21 | | 000 | N | |
| | **49425** | Insertion of peritoneal-venous shunt | 17.96 | $1,499.66 | | 090 | Y | |
| | **49426** | Revision of peritoneal-venous shunt | 15.27 | $1,275.05 | | 090 | N | $669.00 |
| | **49427** | Injection procedure (eg, contrast media) for evaluation of previously placed peritoneal-venous shunt | 1.16 | $96.86 | | 000 | N | |
| | **49428** | Ligation of peritoneal-venous shunt | 10.62 | $886.77 | | 010 | N | |
| | **49429** | Removal of peritoneal-venous shunt | 10.99 | $917.67 | | 010 | N | |
| + | **49435** | Insertion of subcutaneous extension to intraperitoneal cannula or catheter with remote chest exit site (List separately in addition to code for primary procedure) | 2.90 | $242.15 | | 000 | Y | |
| | **49436** | Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter | 4.33 | $361.56 | | 010 | Y | |
| | **49491** | Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; reducible | 17.72 | $1,479.62 | | 090 | Y | |

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| | **49492** | Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; incarcerated or strangulated | 21.63 | $1,806.11 | | 090 | Y | |
| | **49495** | Repair, initial inguinal hernia, full term infant younger than age 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; reducible | 9.23 | $770.71 | | 090 | Y | $945.00 |
| | **49496** | Repair, initial inguinal hernia, full term infant younger than age 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; incarcerated or strangulated | 13.74 | $1,147.29 | | 090 | Y | $945.00 |
| | **49500** | Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducible | 9.13 | $762.36 | | 090 | Y | $945.00 |
| | **49501** | Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; incarcerated or strangulated | 13.68 | $1,142.28 | | 090 | Y | $2,008.50 |
| | **49505** | Repair initial inguinal hernia, age 5 years or older; reducible | 11.90 | $993.65 | | 090 | Y | $945.00 |
| | **49507** | Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated | 14.70 | $1,227.45 | | 090 | Y | $2,008.50 |
| | **49520** | Repair recurrent inguinal hernia, any age; reducible | 14.61 | $1,219.94 | | 090 | Y | $1,492.50 |
| | **49521** | Repair recurrent inguinal hernia, any age; incarcerated or strangulated | 17.89 | $1,493.82 | | 090 | Y | $2,008.50 |
| | **49525** | Repair inguinal hernia, sliding, any age | 13.18 | $1,100.53 | | 090 | Y | $945.00 |
| | **49540** | Repair lumbar hernia | 15.68 | $1,309.28 | | 090 | Y | $669.00 |
| | **49550** | Repair initial femoral hernia, any age; reducible | 13.27 | $1,108.05 | | 090 | Y | $1,075.50 |
| | **49553** | Repair initial femoral hernia, any age; incarcerated or strangulated | 14.50 | $1,210.75 | | 090 | Y | $2,008.50 |
| | **49555** | Repair recurrent femoral hernia; reducible | 13.82 | $1,153.97 | | 090 | Y | $1,075.50 |
| | **49557** | Repair recurrent femoral hernia; incarcerated or strangulated | 16.80 | $1,402.80 | | 090 | Y | $2,008.50 |
| | **49560** | Repair initial incisional or ventral hernia; reducible | 17.25 | $1,440.38 | | 090 | Y | $945.00 |
| | **49561** | Repair initial incisional or ventral hernia; incarcerated or strangulated | 21.65 | $1,807.78 | | 090 | Y | $2,008.50 |
| | **49565** | Repair recurrent incisional or ventral hernia; reducible | 17.76 | $1,482.96 | | 090 | Y | $945.00 |
| | **49566** | Repair recurrent incisional or ventral hernia; incarcerated or strangulated | 21.87 | $1,826.15 | | 090 | Y | $2,008.50 |
| + | **49568** | Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to code for the incisional or ventral hernia repair) | 6.60 | $551.10 | | 000 | Y | $1,492.50 |
| | **49570** | Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure) | 9.33 | $779.06 | | 090 | Y | $945.00 |
| | **49572** | Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated | 11.45 | $956.08 | | 090 | Y | $2,008.50 |
| | **49580** | Repair umbilical hernia, younger than age 5 years; reducible | 7.18 | $599.53 | | 090 | Y | $945.00 |
| | **49582** | Repair umbilical hernia, younger than age 5 years; incarcerated or strangulated | 10.72 | $895.12 | | 090 | Y | $2,008.50 |
| | **49585** | Repair umbilical hernia, age 5 years or older; reducible | 10.03 | $837.51 | | 090 | Y | $945.00 |
| | **49587** | Repair umbilical hernia, age 5 years or older; incarcerated or strangulated | 11.92 | $995.32 | | 090 | Y | $2,008.50 |
| | **49590** | Repair spigelian hernia | 13.15 | $1,098.03 | | 090 | Y | $765.00 |
| | **49600** | Repair of small omphalocele, with primary closure | 16.93 | $1,413.66 | | 090 | Y | $945.00 |
| | **49605** | Repair of large omphalocele or gastroschisis; with or without prosthesis | 115.49 | $9,643.42 | | 090 | Y | |
| | **49606** | Repair of large omphalocele or gastroschisis; with removal of prosthesis, final reduction and closure, in operating room | 26.90 | $2,246.15 | | 090 | Y | |
| | **49610** | Repair of omphalocele (Gross type operation); first stage | 15.88 | $1,325.98 | | 090 | Y | |
| | **49611** | Repair of omphalocele (Gross type operation); second stage | 15.25 | $1,273.38 | | 090 | Y | |

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|---|---|---|---|---|---|---|---|---|
| | **49650** | Laparoscopy, surgical; repair initial inguinal hernia | 9.83 | $820.81 | | 090 | Y | $945.00 |
| | **49651** | Laparoscopy, surgical; repair recurrent inguinal hernia | 12.69 | $1,059.62 | | 090 | Y | $1,492.50 |
| | **49659** | Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy | 0.00 | BR | | 000 | N | |
| | **49900** | Suture, secondary, of abdominal wall for evisceration or dehiscence | 18.89 | $1,577.32 | | 090 | Y | |
| | **49904** | Omental flap, extra-abdominal (eg, for reconstruction of sternal and chest wall defects) | 37.12 | $3,099.52 | | 090 | N | |
| + | **49905** | Omental flap, intra-abdominal (List separately in addition to code for primary procedure) | 8.79 | $733.97 | | 000 | Y | |
| | **49906** | Free omental flap with microvascular anastomosis | 0.00 | BR | | 090 | Y | |
| | **49999** | Unlisted procedure, abdomen, peritoneum and omentum | 0.00 | BR | | 000 | N | |
| | **50010** | Renal exploration, not necessitating other specific procedures | 17.48 | $1,459.58 | | 090 | Y | |
| | **50020** | Drainage of perirenal or renal abscess; open | 25.35 | $2,116.73 | | 090 | Y | |
| ⊙ | **50021** | Drainage of perirenal or renal abscess; percutaneous | 24.46 | $2,042.41 | | 000 | Y | |
| | **50040** | Nephrostomy, nephrotomy with drainage | 23.18 | $1,935.53 | | 090 | Y | |
| | **50045** | Nephrotomy, with exploration | 23.31 | $1,946.39 | | 090 | Y | |
| | **50060** | Nephrolithotomy; removal of calculus | 28.75 | $2,400.63 | | 090 | Y | |
| | **50065** | Nephrolithotomy; secondary surgical operation for calculus | 29.04 | $2,424.84 | | 090 | Y | |
| | **50070** | Nephrolithotomy; complicated by congenital kidney abnormality | 30.03 | $2,507.51 | | 090 | Y | |
| | **50075** | Nephrolithotomy; removal of large staghorn calculus filling renal pelvis and calyces (including anatrophic pyelolithotomy) | 36.92 | $3,082.82 | | 090 | Y | |
| | **50080** | Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm | 21.96 | $1,833.66 | | 090 | N | |
| | **50081** | Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm | 32.19 | $2,687.87 | | 090 | Y | |
| | **50100** | Transection or repositioning of aberrant renal vessels (separate procedure) | 25.27 | $2,110.05 | | 090 | Y | |
| | **50120** | Pyelotomy; with exploration | 23.85 | $1,991.48 | | 090 | Y | |
| | **50125** | Pyelotomy; with drainage, pyelostomy | 25.03 | $2,090.01 | | 090 | Y | |
| | **50130** | Pyelotomy; with removal of calculus (pyelolithotomy, pelviolithotomy, including coagulum pyelolithotomy) | 25.94 | $2,165.99 | | 090 | Y | |
| | **50135** | Pyelotomy; complicated (eg, secondary operation, congenital kidney abnormality) | 28.28 | $2,361.38 | | 090 | Y | |
| | **50200** | Renal biopsy; percutaneous, by trocar or needle | 3.77 | $314.80 | | 000 | N | $499.50 |
| | **50205** | Renal biopsy; by surgical exposure of kidney | 17.42 | $1,454.57 | | 090 | Y | |
| | **50220** | Nephrectomy, including partial ureterectomy, any open approach including rib resection; | 25.88 | $2,160.98 | | 090 | Y | |
| | **50225** | Nephrectomy, including partial ureterectomy, any open approach including rib resection; complicated because of previous surgery on same kidney | 29.96 | $2,501.66 | | 090 | Y | |
| | **50230** | Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy | 32.27 | $2,694.55 | | 090 | Y | |
| | **50234** | Nephrectomy with total ureterectomy and bladder cuff; through same incision | 32.80 | $2,738.80 | | 090 | Y | |
| | **50236** | Nephrectomy with total ureterectomy and bladder cuff; through separate incision | 37.07 | $3,095.35 | | 090 | Y | |
| | **50240** | Nephrectomy, partial | 33.12 | $2,765.52 | | 090 | Y | |
| | **50250** | Ablation, open, one or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound, if performed | 30.79 | $2,570.97 | | 090 | Y | |
| | **50280** | Excision or unroofing of cyst(s) of kidney | 23.80 | $1,987.30 | | 090 | Y | |
| | **50290** | Excision of perinephric cyst | 22.71 | $1,896.29 | | 090 | Y | |

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|---|---|---|---|---|---|---|---|---|
| | **50300** | Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral | 0.00 | BR | | 000 | Y | |
| | **50320** | Donor nephrectomy (including cold preservation); open, from living donor | 33.50 | $2,797.25 | | 090 | Y | |
| | **50323** | Backbench standard preparation of cadaver donor renal allograft prior to transplantation, including dissection and removal of perinephric fat, diaphragmatic and retroperitoneal attachments, excision of adrenal gland, and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary | 0.00 | BR | | 000 | Y | |
| | **50325** | Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation, including dissection and removal of perinephric fat and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary | 0.00 | BR | | 000 | Y | |
| ⊘ | **50327** | Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; venous anastomosis, each | 5.18 | $432.53 | | 000 | Y | |
| ⊘ | **50328** | Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; arterial anastomosis, each | 4.54 | $379.09 | | 000 | Y | |
| ⊘ | **50329** | Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; ureteral anastomosis, each | 4.34 | $362.39 | | 000 | Y | |
| | **50340** | Recipient nephrectomy (separate procedure) | 20.90 | $1,745.15 | | 090 | Y | |
| | **50360** | Renal allotransplantation, implantation of graft; without recipient nephrectomy | 56.52 | $4,719.42 | | 090 | Y | |
| | **50365** | Renal allotransplantation, implantation of graft; with recipient nephrectomy | 64.04 | $5,347.34 | | 090 | Y | |
| | **50370** | Removal of transplanted renal allograft | 26.16 | $2,184.36 | | 090 | Y | |
| | **50380** | Renal autotransplantation, reimplantation of kidney | 42.31 | $3,532.89 | | 090 | Y | |
| ⊙ | **50382** | Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation | 38.59 | $3,222.27 | | 000 | N | |
| ⊙ | **50384** | Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation | 36.11 | $3,015.19 | | 000 | N | |
| ⊙ | **50387** | Removal and replacement of externally accessible transnephric ureteral stent (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation | 18.58 | $1,551.43 | | 000 | N | |
| | **50389** | Removal of nephrostomy tube, requiring fluoroscopic guidance (eg, with concurrent indwelling ureteral stent) | 12.21 | $1,019.54 | | 000 | N | |
| | **50390** | Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous | 2.50 | $208.75 | | 000 | N | $499.50 |
| | **50391** | Instillation(s) of therapeutic agent into renal pelvis and/or ureter through established nephrostomy, pyelostomy or ureterostomy tube (eg, anticarcinogenic or antifungal agent) | 3.46 | $288.91 | | 000 | N | |
| | **50392** | Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous | 4.69 | $391.62 | | 000 | N | $499.50 |
| | **50393** | Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous | 5.69 | $475.12 | | 000 | N | $499.50 |
| | **50394** | Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter | 3.18 | $265.53 | | 000 | N | |
| | **50395** | Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous | 4.71 | $393.29 | | 000 | N | $499.50 |
| | **50396** | Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral catheter | 3.05 | $254.68 | | 000 | N | $197.25 |
| | **50398** | Change of nephrostomy or pyelostomy tube | 16.46 | $1,374.41 | | 000 | N | $499.50 |
| | **50400** | Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; simple | 29.10 | $2,429.85 | | 090 | Y | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **50405** | Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; complicated (congenital kidney abnormality, secondary pyeloplasty, solitary kidney, calycoplasty) | 34.99 | $2,921.67 | | 090 | Y | |
| **50500** | Nephrorrhaphy, suture of kidney wound or injury | 29.59 | $2,470.77 | | 090 | Y | |
| **50520** | Closure of nephrocutaneous or pyelocutaneous fistula | 26.29 | $2,195.22 | | 090 | Y | |
| **50525** | Closure of nephrovisceral fistula (eg, renocolic), including visceral repair; abdominal approach | 33.12 | $2,765.52 | | 090 | Y | |
| **50526** | Closure of nephrovisceral fistula (eg, renocolic), including visceral repair; thoracic approach | 34.90 | $2,914.15 | | 090 | Y | |
| **50540** | Symphysiotomy for horseshoe kidney with or without pyeloplasty and/or other plastic procedure, unilateral or bilateral (one operation) | 29.17 | $2,435.70 | | 090 | Y | |
| **50541** | Laparoscopy, surgical; ablation of renal cysts | 23.28 | $1,943.88 | | 090 | Y | |
| **50542** | Laparoscopy, surgical; ablation of renal mass lesion(s) | 29.37 | $2,452.40 | | 090 | Y | |
| **50543** | Laparoscopy, surgical; partial nephrectomy | 37.50 | $3,131.25 | | 090 | Y | |
| **50544** | Laparoscopy, surgical; pyeloplasty | 31.82 | $2,656.97 | | 090 | Y | |
| **50545** | Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy) | 34.14 | $2,850.69 | | 090 | Y | |
| **50546** | Laparoscopy, surgical; nephrectomy, including partial ureterectomy | 30.23 | $2,524.21 | | 090 | Y | |
| **50547** | Laparoscopy, surgical; donor nephrectomy (including cold preservation), from living donor | 37.87 | $3,162.15 | | 090 | Y | |
| **50548** | Laparoscopy, surgical; nephrectomy with total ureterectomy | 34.44 | $2,875.74 | | 090 | Y | |
| **50549** | Unlisted laparoscopy procedure, renal | 0.00 | BR | | 000 | N | |
| **50551** | Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; | 9.69 | $809.12 | | 000 | N | $499.50 |
| **50553** | Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter | 10.12 | $845.02 | | 000 | N | $499.50 |
| **50555** | Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy | 11.20 | $935.20 | | 000 | N | $499.50 |
| **50557** | Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy | 11.18 | $933.53 | | 000 | N | $499.50 |
| **50561** | Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus | 12.61 | $1,052.94 | | 000 | N | $499.50 |
| **50562** | Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with resection of tumor | 15.13 | $1,263.36 | | 090 | Y | |
| **50570** | Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; | 12.74 | $1,063.79 | | 000 | N | |
| **50572** | Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter | 13.93 | $1,163.16 | | 000 | Y | |
| **50574** | Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy | 14.67 | $1,224.95 | | 000 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **50575** | Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with endopyelotomy (includes cystoscopy, ureteroscopy, dilation of ureter and ureteral pelvic junction, incision of ureteral pelvic junction and insertion of endopyelotomy stent) | 18.56 | $1,549.76 | | 000 | N | |
| | **50576** | Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy | 14.63 | $1,221.61 | | 000 | Y | |
| | **50580** | Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus | 15.76 | $1,315.96 | | 000 | Y | |
| | **50590** | Lithotripsy, extracorporeal shock wave | 22.92 | $1,913.82 | | 090 | N | |
| ⊙ | **50592** | Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency | 136.68 | $11,412.78 | | 010 | Y | |
| | **50600** | Ureterotomy with exploration or drainage (separate procedure) | 23.63 | $1,973.11 | | 090 | Y | |
| | **50605** | Ureterotomy for insertion of indwelling stent, all types | 23.49 | $1,961.42 | | 090 | Y | |
| | **50610** | Ureterolithotomy; upper one-third of ureter | 24.36 | $2,034.06 | | 090 | Y | |
| | **50620** | Ureterolithotomy; middle one-third of ureter | 22.75 | $1,899.63 | | 090 | Y | |
| | **50630** | Ureterolithotomy; lower one-third of ureter | 22.35 | $1,866.23 | | 090 | Y | |
| | **50650** | Ureterectomy, with bladder cuff (separate procedure) | 26.00 | $2,171.00 | | 090 | Y | |
| | **50660** | Ureterectomy, total, ectopic ureter, combination abdominal, vaginal and/or perineal approach | 28.86 | $2,409.81 | | 090 | Y | |
| | **50684** | Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter | 5.46 | $455.91 | | 000 | N | |
| | **50686** | Manometric studies through ureterostomy or indwelling ureteral catheter | 4.56 | $380.76 | | 000 | N | |
| | **50688** | Change of ureterostomy tube or externally accessible ureteral stent via ileal conduit | 2.14 | $178.69 | | 010 | N | $499.50 |
| | **50690** | Injection procedure for visualization of ileal conduit and/or ureteropyelography, exclusive of radiologic service | 2.82 | $235.47 | | 000 | N | |
| | **50700** | Ureteroplasty, plastic operation on ureter (eg, stricture) | 23.59 | $1,969.77 | | 090 | Y | |
| | **50715** | Ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis | 29.30 | $2,446.55 | | 090 | Y | |
| | **50722** | Ureterolysis for ovarian vein syndrome | 25.78 | $2,152.63 | | 090 | Y | |
| | **50725** | Ureterolysis for retrocaval ureter, with reanastomosis of upper urinary tract or vena cava | 28.02 | $2,339.67 | | 090 | Y | |
| | **50727** | Revision of urinary-cutaneous anastomosis (any type urostomy); | 12.61 | $1,052.94 | | 090 | Y | |
| | **50728** | Revision of urinary-cutaneous anastomosis (any type urostomy); with repair of fascial defect and hernia | 17.77 | $1,483.80 | | 090 | Y | |
| | **50740** | Ureteropyelostomy, anastomosis of ureter and renal pelvis | 27.96 | $2,334.66 | | 090 | Y | |
| | **50750** | Ureterocalycostomy, anastomosis of ureter to renal calyx | 28.79 | $2,403.97 | | 090 | Y | |
| | **50760** | Ureteroureterostomy | 27.70 | $2,312.95 | | 090 | Y | |
| | **50770** | Transureteroureterostomy, anastomosis of ureter to contralateral ureter | 29.09 | $2,429.02 | | 090 | Y | |
| | **50780** | Ureteroneocystostomy; anastomosis of single ureter to bladder | 27.57 | $2,302.10 | | 090 | Y | |
| | **50782** | Ureteroneocystostomy; anastomosis of duplicated ureter to bladder | 27.87 | $2,327.15 | | 090 | Y | |
| | **50783** | Ureteroneocystostomy; with extensive ureteral tailoring | 29.14 | $2,433.19 | | 090 | Y | |
| | **50785** | Ureteroneocystostomy; with vesico-psoas hitch or bladder flap | 30.36 | $2,535.06 | | 090 | Y | |
| | **50800** | Ureteroenterostomy, direct anastomosis of ureter to intestine | 22.99 | $1,919.67 | | 090 | Y | |
| | **50810** | Ureterosigmoidostomy, with creation of sigmoid bladder and establishment of abdominal or perineal colostomy, including intestine anastomosis | 31.67 | $2,644.45 | | 090 | Y | |
| | **50815** | Ureterocolon conduit, including intestine anastomosis | 30.65 | $2,559.28 | | 090 | Y | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **50820** | Ureteroileal conduit (ileal bladder), including intestine anastomosis (Bricker operation) | 32.90 | $2,747.15 | | 090 | Y | |
| **50825** | Continent diversion, including intestine anastomosis using any segment of small and/or large intestine (Kock pouch or Camey enterocystoplasty) | 41.65 | $3,477.78 | | 090 | Y | |
| **50830** | Urinary undiversion (eg, taking down of ureteroileal conduit, ureterosigmoidostomy or ureteroenterostomy with ureteroureterostomy or ureteroneocystostomy) | 45.72 | $3,817.62 | | 090 | Y | |
| **50840** | Replacement of all or part of ureter by intestine segment, including intestine anastomosis | 30.77 | $2,569.30 | | 090 | Y | |
| **50845** | Cutaneous appendico-vesicostomy | 31.36 | $2,618.56 | | 090 | Y | |
| **50860** | Ureterostomy, transplantation of ureter to skin | 23.77 | $1,984.80 | | 090 | Y | |
| **50900** | Ureterorrhaphy, suture of ureter (separate procedure) | 21.17 | $1,767.70 | | 090 | Y | |
| **50920** | Closure of ureterocutaneous fistula | 22.14 | $1,848.69 | | 090 | Y | |
| **50930** | Closure of ureterovisceral fistula (including visceral repair) | 27.87 | $2,327.15 | | 090 | Y | |
| **50940** | Deligation of ureter | 22.32 | $1,863.72 | | 090 | Y | |
| **50945** | Laparoscopy, surgical; ureterolithotomy | 24.93 | $2,081.66 | | 090 | Y | |
| **50947** | Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placement | 35.64 | $2,975.94 | | 090 | Y | $2,008.50 |
| **50948** | Laparoscopy, surgical; ureteroneocystostomy without cystoscopy and ureteral stent placement | 32.58 | $2,720.43 | | 090 | Y | $2,008.50 |
| **50949** | Unlisted laparoscopy procedure, ureter | 0.00 | BR | | 000 | N | |
| **50951** | Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; | 10.09 | $842.52 | | 000 | N | $499.50 |
| **50953** | Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter | 10.59 | $884.27 | | 000 | N | $499.50 |
| **50955** | Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy | 12.66 | $1,057.11 | | 000 | N | $499.50 |
| **50957** | Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy | 11.34 | $946.89 | | 000 | N | $499.50 |
| **50961** | Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus | 10.31 | $860.89 | | 000 | N | $499.50 |
| **50970** | Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; | 9.61 | $802.44 | | 000 | N | $499.50 |
| **50972** | Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter | 9.29 | $775.72 | | 000 | N | $499.50 |
| **50974** | Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy | 12.20 | $1,018.70 | | 000 | N | $499.50 |
| **50976** | Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy | 12.00 | $1,002.00 | | 000 | N | $499.50 |
| **50980** | Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus | 9.19 | $767.37 | | 000 | N | $499.50 |
| **51000** | Aspiration of bladder by needle | 2.44 | $203.74 | | 000 | N | |
| **51005** | Aspiration of bladder; by trocar or intracatheter | 5.15 | $430.03 | | 000 | N | |
| **51010** | Aspiration of bladder; with insertion of suprapubic catheter | 9.51 | $794.09 | | 010 | N | $499.50 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| 51020 | Cystotomy or cystostomy; with fulguration and/or insertion of radioactive material | 11.50 | $960.25 | | 090 | Y | $945.00 |
| 51030 | Cystotomy or cystostomy; with cryosurgical destruction of intravesical lesion | 11.68 | $975.28 | | 090 | Y | $945.00 |
| 51040 | Cystostomy, cystotomy with drainage | 7.30 | $609.55 | | 090 | Y | $945.00 |
| 51045 | Cystotomy, with insertion of ureteral catheter or stent (separate procedure) | 11.69 | $976.12 | | 090 | Y | $598.86 |
| 51050 | Cystolithotomy, cystotomy with removal of calculus, without vesical neck resection | 11.66 | $973.61 | | 090 | Y | $945.00 |
| 51060 | Transvesical ureterolithotomy | 14.45 | $1,206.58 | | 090 | Y | |
| 51065 | Cystotomy, with calculus basket extraction and/or ultrasonic or electrohydraulic fragmentation of ureteral calculus | 14.33 | $1,196.56 | | 090 | Y | $945.00 |
| 51080 | Drainage of perivesical or prevesical space abscess | 10.11 | $844.19 | | 090 | Y | $499.50 |
| 51500 | Excision of urachal cyst or sinus, with or without umbilical hernia repair | 16.07 | $1,341.85 | | 090 | Y | $945.00 |
| 51520 | Cystotomy; for simple excision of vesical neck (separate procedure) | 14.91 | $1,244.99 | | 090 | Y | $945.00 |
| 51525 | Cystotomy; for excision of bladder diverticulum, single or multiple (separate procedure) | 21.52 | $1,796.92 | | 090 | Y | |
| 51530 | Cystotomy; for excision of bladder tumor | 19.41 | $1,620.74 | | 090 | Y | |
| 51535 | Cystotomy for excision, incision, or repair of ureterocele | 20.09 | $1,677.52 | | 090 | Y | |
| 51550 | Cystectomy, partial; simple | 23.98 | $2,002.33 | | 090 | Y | |
| 51555 | Cystectomy, partial; complicated (eg, postradiation, previous surgery, difficult location) | 31.81 | $2,656.14 | | 090 | Y | |
| 51565 | Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy) | 32.54 | $2,717.09 | | 090 | Y | |
| 51570 | Cystectomy, complete; (separate procedure) | 36.97 | $3,087.00 | | 090 | Y | |
| 51575 | Cystectomy, complete; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes | 46.02 | $3,842.67 | | 090 | Y | |
| 51580 | Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations; | 47.68 | $3,981.28 | | 090 | Y | |
| 51585 | Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes | 53.19 | $4,441.37 | | 090 | Y | |
| 51590 | Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis; | 48.67 | $4,063.95 | | 090 | Y | |
| 51595 | Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes | 55.19 | $4,608.37 | | 090 | Y | |
| 51596 | Cystectomy, complete, with continent diversion, any open technique, using any segment of small and/or large intestine to construct neobladder | 59.19 | $4,942.37 | | 090 | Y | |
| 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 | 57.35 | $4,788.73 | | 090 | Y | |
| 51600 | Injection procedure for cystography or voiding urethrocystography | 5.66 | $472.61 | | 000 | N | |
| 51605 | Injection procedure and placement of chain for contrast and/or chain urethrocystography | 0.99 | $82.67 | | 000 | N | |
| 51610 | Injection procedure for retrograde urethrocystography | 3.19 | $266.37 | | 000 | N | |
| 51700 | Bladder irrigation, simple, lavage and/or instillation | 2.43 | $202.91 | | 000 | N | |
| 51701 | Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine) | 1.94 | $161.99 | | 000 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **51702** | Insertion of temporary indwelling bladder catheter; simple (eg, Foley) | 2.43 | $202.91 | | 000 | N | |
| **51703** | Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon) | 4.04 | $337.34 | | 000 | N | |
| **51705** | Change of cystostomy tube; simple | 3.21 | $268.04 | | 010 | N | |
| **51710** | Change of cystostomy tube; complicated | 4.64 | $387.44 | | 010 | N | $499.50 |
| **51715** | Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck | 7.68 | $641.28 | | 000 | N | $765.00 |
| **51720** | Bladder instillation of anticarcinogenic agent (including retention time) | 3.21 | $268.04 | | 000 | N | |
| **51725** | Simple cystometrogram (CMG) (eg, spinal manometer) | 6.78 | $566.13 | $164.18 | 000 | N | |
| **51726** | Complex cystometrogram (eg, calibrated electronic equipment) | 9.13 | $762.36 | $198.21 | 000 | N | $314.22 |
| **51736** | Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter) | 1.28 | $106.88 | $73.75 | 000 | N | |
| **51741** | Complex uroflowmetry (eg, calibrated electronic equipment) | 2.05 | $171.18 | $133.52 | 000 | N | |
| **51772** | Urethral pressure profile studies (UPP) (urethral closure pressure profile), any technique | 7.09 | $592.02 | $183.53 | 000 | N | $197.25 |
| **51784** | Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique | 5.49 | $458.42 | $174.20 | 000 | N | |
| **51785** | Needle electromyography studies (EMG) of anal or urethral sphincter, any technique | 5.99 | $500.17 | $175.06 | 000 | N | $100.38 |
| **51792** | Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time) | 6.93 | $578.66 | $127.31 | 000 | N | |
| **51795** | Voiding pressure studies (VP); bladder voiding pressure, any technique | 8.75 | $730.63 | $175.35 | 000 | N | |
| **51797** | Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal) | 7.16 | $597.86 | $179.36 | 000 | N | |
| **51798** | Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging | 0.48 | $40.08 | $0.00 | 000 | N | |
| **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 | 26.39 | $2,203.57 | | 090 | Y | |
| **51820** | Cystourethroplasty with unilateral or bilateral ureteroneocystostomy | 28.08 | $2,344.68 | | 090 | Y | |
| **51840** | Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); simple | 16.83 | $1,405.31 | | 090 | Y | |
| **51841** | Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); complicated (eg, secondary repair) | 19.97 | $1,667.50 | | 090 | Y | |
| **51845** | Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, Stamey, Raz, modified Pereyra) | 14.89 | $1,243.32 | | 090 | Y | |
| **51860** | Cystorrhaphy, suture of bladder wound, injury or rupture; simple | 18.42 | $1,538.07 | | 090 | Y | |
| **51865** | Cystorrhaphy, suture of bladder wound, injury or rupture; complicated | 22.48 | $1,877.08 | | 090 | Y | |
| **51880** | Closure of cystostomy (separate procedure) | 11.89 | $992.82 | | 090 | Y | $499.50 |
| **51900** | Closure of vesicovaginal fistula, abdominal approach | 20.80 | $1,736.80 | | 090 | Y | |
| **51920** | Closure of vesicouterine fistula; | 19.30 | $1,611.55 | | 090 | Y | |
| **51925** | Closure of vesicouterine fistula; with hysterectomy | 26.69 | $2,228.62 | | 090 | Y | |
| **51940** | Closure, exstrophy of bladder | 41.49 | $3,464.42 | | 090 | Y | |
| **51960** | Enterocystoplasty, including intestinal anastomosis | 34.84 | $2,909.14 | | 090 | Y | |
| **51980** | Cutaneous vesicostomy | 17.92 | $1,496.32 | | 090 | Y | |
| **51990** | Laparoscopy, surgical; urethral suspension for stress incontinence | 19.42 | $1,621.57 | | 090 | Y | |
| **51992** | Laparoscopy, surgical; sling operation for stress incontinence (eg, fascia or synthetic) | 21.01 | $1,754.34 | | 090 | Y | $1,075.50 |
| **51999** | Unlisted laparoscopy procedure, bladder | 0.00 | BR | | 000 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **52000** | Cystourethroscopy (separate procedure) | 5.55 | $463.43 | | 000 | N | $499.50 |
| **52001** | Cystourethroscopy with irrigation and evacuation of multiple obstructing clots | 10.37 | $865.90 | | 000 | N | $598.86 |
| **52005** | Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; | 7.91 | $660.49 | | 000 | N | $669.00 |
| **52007** | Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis | 17.95 | $1,498.83 | | 000 | N | $669.00 |
| **52010** | Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service | 13.03 | $1,088.01 | | 000 | N | $598.86 |
| **52204** | Cystourethroscopy, with biopsy(s) | 15.47 | $1,291.75 | | 000 | N | $669.00 |
| **52214** | Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands | 37.14 | $3,101.19 | | 000 | N | $669.00 |
| **52224** | Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy | 35.15 | $2,935.03 | | 000 | N | $669.00 |
| **52234** | Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm) | 6.32 | $527.72 | | 000 | N | $669.00 |
| **52235** | Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm) | 7.41 | $618.74 | | 000 | N | $765.00 |
| **52240** | Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s) | 13.02 | $1,087.17 | | 000 | N | $765.00 |
| **52250** | Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration | 6.19 | $516.87 | | 000 | N | $945.00 |
| **52260** | Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia | 5.37 | $448.40 | | 000 | N | $669.00 |
| **52265** | Cystourethroscopy, with dilation of bladder for interstitial cystitis; local anesthesia | 14.79 | $1,234.97 | | 000 | N | |
| **52270** | Cystourethroscopy, with internal urethrotomy; female | 13.30 | $1,110.55 | | 000 | N | $669.00 |
| **52275** | Cystourethroscopy, with internal urethrotomy; male | 18.55 | $1,548.93 | | 000 | N | $669.00 |
| **52276** | Cystourethroscopy with direct vision internal urethrotomy | 6.80 | $567.80 | | 000 | N | $765.00 |
| **52277** | Cystourethroscopy, with resection of external sphincter (sphincterotomy) | 8.38 | $699.73 | | 000 | N | $669.00 |
| **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 | 9.37 | $782.40 | | 000 | N | $669.00 |
| **52282** | Cystourethroscopy, with insertion of urethral stent | 8.64 | $721.44 | | 000 | N | $2,008.50 |
| **52283** | Cystourethroscopy, with steroid injection into stricture | 7.60 | $634.60 | | 000 | N | $669.00 |
| **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 | 7.61 | $635.44 | | 000 | N | $669.00 |
| **52290** | Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral | 6.26 | $522.71 | | 000 | N | $669.00 |
| **52300** | Cystourethroscopy; with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral | 7.25 | $605.38 | | 000 | N | $669.00 |
| **52301** | Cystourethroscopy; with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral | 7.44 | $621.24 | | 000 | N | $765.00 |
| **52305** | Cystourethroscopy; with incision or resection of orifice of bladder diverticulum, single or multiple | 7.18 | $599.53 | | 000 | N | $669.00 |
| **52310** | Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple | 7.26 | $606.21 | | 000 | N | $598.86 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **52315** | Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated | 13.22 | $1,103.87 | | 000 | N | $669.00 |
| **52317** | Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm) | 32.50 | $2,713.75 | | 000 | N | $499.50 |
| **52318** | Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; complicated or large (over 2.5 cm) | 12.27 | $1,024.55 | | 000 | N | $669.00 |
| **52320** | Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus | 6.34 | $529.39 | | 000 | N | $1,075.50 |
| **52325** | Cystourethroscopy (including ureteral catheterization); with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique) | 8.28 | $691.38 | | 000 | N | $945.00 |
| **52327** | Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material | 33.35 | $2,784.73 | | 000 | N | $669.00 |
| **52330** | Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus | 39.11 | $3,265.69 | | 000 | N | $669.00 |
| **52332** | Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type) | 10.18 | $850.03 | | 000 | N | $669.00 |
| **52334** | Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde | 6.58 | $549.43 | | 000 | N | $765.00 |
| **52341** | Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision) | 8.37 | $698.90 | | 000 | N | $765.00 |
| **52342** | Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision) | 9.00 | $751.50 | | 000 | N | $765.00 |
| **52343** | Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision) | 9.92 | $828.32 | | 000 | N | $765.00 |
| **52344** | Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision) | 10.66 | $890.11 | | 000 | N | $765.00 |
| **52345** | Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision) | 11.32 | $945.22 | | 000 | N | $765.00 |
| **52346** | Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision) | 12.67 | $1,057.95 | | 000 | N | $765.00 |
| **52351** | Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic | 8.03 | $670.51 | | 000 | N | $765.00 |
| **52352** | Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included) | 9.44 | $788.24 | | 000 | N | $945.00 |
| **52353** | Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included) | 10.87 | $907.65 | | 000 | N | $945.00 |
| **52354** | Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion | 10.05 | $839.18 | | 000 | N | $945.00 |
| **52355** | Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor | 11.99 | $1,001.17 | | 000 | N | $945.00 |
| **52400** | Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds | 13.91 | $1,161.49 | | 090 | N | $765.00 |
| **52402** | Cystourethroscopy with transurethral resection or incision of ejaculatory ducts | 6.98 | $582.83 | | 000 | N | $765.00 |
| **52450** | Transurethral incision of prostate | 11.55 | $964.43 | | 090 | N | $765.00 |
| **52500** | Transurethral resection of bladder neck (separate procedure) | 13.57 | $1,133.10 | | 090 | N | $765.00 |
| **52510** | Transurethral balloon dilation of the prostatic urethra | 10.80 | $901.80 | | 090 | N | $765.00 |
| **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) | 20.47 | $1,709.25 | | 090 | N | $945.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| 52606 | Transurethral fulguration for postoperative bleeding occurring after the usual follow-up time | 12.59 | $1,051.27 | | 090 | N | $499.50 |
| 52612 | Transurethral resection of prostate; first stage of two-stage resection (partial resection) | 13.02 | $1,087.17 | | 090 | N | $669.00 |
| 52614 | Transurethral resection of prostate; second stage of two-stage resection (resection completed) | 11.38 | $950.23 | | 090 | N | $499.50 |
| 52620 | Transurethral resection; of residual obstructive tissue after 90 days postoperative | 10.35 | $864.23 | | 090 | N | $499.50 |
| 52630 | Transurethral resection; of regrowth of obstructive tissue longer than one year postoperative | 11.01 | $919.34 | | 090 | N | $669.00 |
| 52640 | Transurethral resection; of postoperative bladder neck contracture | 10.02 | $836.67 | | 090 | N | $669.00 |
| 52647 | Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed) | 76.73 | $6,406.96 | | 090 | N | $2,008.50 |
| 52648 | Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed) | 77.68 | $6,486.28 | | 090 | N | $2,008.50 |
| 52700 | Transurethral drainage of prostatic abscess | 10.78 | $900.13 | | 090 | N | $669.00 |
| 53000 | Urethrotomy or urethrostomy, external (separate procedure); pendulous urethra | 3.84 | $320.64 | | 010 | N | $499.50 |
| 53010 | Urethrotomy or urethrostomy, external (separate procedure); perineal urethra, external | 7.29 | $608.72 | | 090 | N | $499.50 |
| 53020 | Meatotomy, cutting of meatus (separate procedure); except infant | 2.47 | $206.25 | | 000 | N | $499.50 |
| 53025 | Meatotomy, cutting of meatus (separate procedure); infant | 1.69 | $141.12 | | 000 | N | |
| 53040 | Drainage of deep periurethral abscess | 9.98 | $833.33 | | 090 | N | $669.00 |
| 53060 | Drainage of Skene's gland abscess or cyst | 4.72 | $394.12 | | 010 | N | |
| 53080 | Drainage of perineal urinary extravasation; uncomplicated (separate procedure) | 12.36 | $1,032.06 | | 090 | N | $765.00 |
| 53085 | Drainage of perineal urinary extravasation; complicated | 17.56 | $1,466.26 | | 090 | Y | |
| 53200 | Biopsy of urethra | 3.95 | $329.83 | | 000 | N | $499.50 |
| 53210 | Urethrectomy, total, including cystostomy; female | 19.45 | $1,624.08 | | 090 | Y | $1,075.50 |
| 53215 | Urethrectomy, total, including cystostomy; male | 23.44 | $1,957.24 | | 090 | Y | $1,075.50 |
| 53220 | Excision or fulguration of carcinoma of urethra | 11.31 | $944.39 | | 090 | N | $669.00 |
| 53230 | Excision of urethral diverticulum (separate procedure); female | 15.17 | $1,266.70 | | 090 | Y | $669.00 |
| 53235 | Excision of urethral diverticulum (separate procedure); male | 15.93 | $1,330.16 | | 090 | Y | $765.00 |
| 53240 | Marsupialization of urethral diverticulum, male or female | 10.65 | $889.28 | | 090 | N | $669.00 |
| 53250 | Excision of bulbourethral gland (Cowper's gland) | 9.92 | $828.32 | | 090 | N | $669.00 |
| 53260 | Excision or fulguration; urethral polyp(s), distal urethra | 5.25 | $438.38 | | 010 | N | $669.00 |
| 53265 | Excision or fulguration; urethral caruncle | 5.84 | $487.64 | | 010 | N | $669.00 |
| 53270 | Excision or fulguration; Skene's glands | 5.33 | $445.06 | | 010 | N | $669.00 |
| 53275 | Excision or fulguration; urethral prolapse | 6.79 | $566.97 | | 010 | N | $669.00 |
| 53400 | Urethroplasty; first stage, for fistula, diverticulum, or stricture (eg, Johannsen type) | 20.14 | $1,681.69 | | 090 | Y | $765.00 |
| 53405 | Urethroplasty; second stage (formation of urethra), including urinary diversion | 22.05 | $1,841.18 | | 090 | Y | $669.00 |
| 53410 | Urethroplasty, one-stage reconstruction of male anterior urethra | 24.71 | $2,063.29 | | 090 | Y | $669.00 |
| 53415 | Urethroplasty, transpubic or perineal, one stage, for reconstruction or repair of prostatic or membranous urethra | 28.13 | $2,348.86 | | 090 | Y | |
| 53420 | Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; first stage | 20.85 | $1,740.98 | | 090 | Y | $765.00 |
| 53425 | Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; second stage | 23.89 | $1,994.82 | | 090 | Y | $669.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **53430** | Urethroplasty, reconstruction of female urethra | 24.16 | $2,017.36 | | 090 | Y | $669.00 |
| **53431** | Urethroplasty with tubularization of posterior urethra and/or lower bladder for incontinence (eg, Tenago, Leadbetter procedure) | 29.16 | $2,434.86 | | 090 | Y | $669.00 |
| **53440** | Sling operation for correction of male urinary incontinence (eg, fascia or synthetic) | 21.59 | $1,802.77 | | 090 | Y | $669.00 |
| **53442** | Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic) | 18.98 | $1,584.83 | | 090 | Y | $499.50 |
| **53444** | Insertion of tandem cuff (dual cuff) | 20.04 | $1,673.34 | | 090 | Y | $669.00 |
| **53445** | Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff | 22.22 | $1,855.37 | | 090 | Y | $499.50 |
| **53446** | Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff | 16.21 | $1,353.54 | | 090 | Y | $499.50 |
| **53447** | Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff at the same operative session | 20.64 | $1,723.44 | | 090 | Y | $499.50 |
| **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 | 32.37 | $2,702.90 | | 090 | Y | |
| **53449** | Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff | 15.29 | $1,276.72 | | 090 | Y | $499.50 |
| **53450** | Urethromeatoplasty, with mucosal advancement | 10.11 | $844.19 | | 090 | N | $499.50 |
| **53460** | Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure) | 11.45 | $956.08 | | 090 | N | $499.50 |
| **53500** | Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (eg, postsurgical obstruction, scarring) | 19.01 | $1,587.34 | | 090 | Y | |
| **53502** | Urethrorrhaphy, suture of urethral wound or injury, female | 12.22 | $1,020.37 | | 090 | N | $669.00 |
| **53505** | Urethrorrhaphy, suture of urethral wound or injury; penile | 12.15 | $1,014.53 | | 090 | Y | $669.00 |
| **53510** | Urethrorrhaphy, suture of urethral wound or injury; perineal | 16.06 | $1,341.01 | | 090 | Y | $669.00 |
| **53515** | Urethrorrhaphy, suture of urethral wound or injury; prostatomembranous | 20.15 | $1,682.53 | | 090 | Y | $669.00 |
| **53520** | Closure of urethrostomy or urethrocutaneous fistula, male (separate procedure) | 13.93 | $1,163.16 | | 090 | N | $669.00 |
| **53600** | Dilation of urethral stricture by passage of sound or urethral dilator, male; initial | 2.33 | $194.56 | | 000 | N | |
| **53601** | Dilation of urethral stricture by passage of sound or urethral dilator, male; subsequent | 2.25 | $187.88 | | 000 | N | |
| **53605** | Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia | 1.68 | $140.28 | | 000 | N | $669.00 |
| **53620** | Dilation of urethral stricture by passage of filiform and follower, male; initial | 3.49 | $291.42 | | 000 | N | |
| **53621** | Dilation of urethral stricture by passage of filiform and follower, male; subsequent | 3.32 | $277.22 | | 000 | N | |
| **53660** | Dilation of female urethra including suppository and/or instillation; initial | 2.00 | $167.00 | | 000 | N | |
| **53661** | Dilation of female urethra including suppository and/or instillation; subsequent | 2.00 | $167.00 | | 000 | N | |
| **53665** | Dilation of female urethra, general or conduction (spinal) anesthesia | 1.00 | $83.50 | | 000 | N | $499.50 |
| **53850** | Transurethral destruction of prostate tissue; by microwave thermotherapy | 92.52 | $7,725.42 | | 090 | N | |
| **53852** | Transurethral destruction of prostate tissue; by radiofrequency thermotherapy | 88.51 | $7,390.59 | | 090 | N | |
| **53853** | Transurethral destruction of prostate tissue; by water-induced thermotherapy | 54.14 | $4,520.69 | | 090 | N | |
| **53899** | Unlisted procedure, urinary system | 0.00 | BR | | 000 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| 54000 | Slitting of prepuce, dorsal or lateral (separate procedure); newborn | 4.37 | $364.90 | | 010 | N | $669.00 |
| 54001 | Slitting of prepuce, dorsal or lateral (separate procedure); except newborn | 5.29 | $441.72 | | 010 | N | $669.00 |
| 54015 | Incision and drainage of penis, deep | 7.89 | $658.82 | | 010 | N | $945.00 |
| 54050 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical | 2.98 | $248.83 | | 010 | N | |
| 54055 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation | 2.87 | $239.65 | | 010 | N | |
| 54056 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery | 3.05 | $254.68 | | 010 | N | |
| 54057 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery | 3.53 | $294.76 | | 010 | N | $499.50 |
| 54060 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision | 4.98 | $415.83 | | 010 | N | $499.50 |
| 54065 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 5.12 | $427.52 | | 010 | N | $499.50 |
| 54100 | Biopsy of penis; (separate procedure) | 4.75 | $396.63 | | 000 | N | $499.50 |
| 54105 | Biopsy of penis; deep structures | 7.63 | $637.11 | | 010 | N | $499.50 |
| 54110 | Excision of penile plaque (Peyronie disease); | 15.65 | $1,306.78 | | 090 | Y | $669.00 |
| 54111 | Excision of penile plaque (Peyronie disease); with graft to 5 cm in length | 20.19 | $1,685.87 | | 090 | Y | $669.00 |
| 54112 | Excision of penile plaque (Peyronie disease); with graft greater than 5 cm in length | 23.73 | $1,981.46 | | 090 | Y | $669.00 |
| 54115 | Removal foreign body from deep penile tissue (eg, plastic implant) | 11.31 | $944.39 | | 090 | Y | $499.50 |
| 54120 | Amputation of penis; partial | 15.70 | $1,310.95 | | 090 | Y | $669.00 |
| 54125 | Amputation of penis; complete | 20.38 | $1,701.73 | | 090 | Y | |
| 54130 | Amputation of penis, radical; with bilateral inguinofemoral lymphadenectomy | 30.02 | $2,506.67 | | 090 | Y | |
| 54135 | Amputation of penis, radical; in continuity with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes | 38.30 | $3,198.05 | | 090 | Y | |
| 54150 | Circumcision, using clamp or other device with regional dorsal penile or ring block | 3.37 | $281.40 | | 000 | N | $499.50 |
| 54160 | Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days of age or less) | 6.47 | $540.25 | | 010 | N | $669.00 |
| 54161 | Circumcision, surgical excision other than clamp, device, or dorsal slit; older than 28 days of age | 4.92 | $410.82 | | 010 | N | $669.00 |
| 54162 | Lysis or excision of penile post-circumcision adhesions | 7.64 | $637.94 | | 010 | N | $669.00 |
| 54163 | Repair incomplete circumcision | 5.38 | $449.23 | | 010 | N | $669.00 |
| 54164 | Frenulotomy of penis | 4.71 | $393.29 | | 010 | N | $669.00 |
| 54200 | Injection procedure for Peyronie disease; | 2.90 | $242.15 | | 010 | N | |
| 54205 | Injection procedure for Peyronie disease; with surgical exposure of plaque | 13.57 | $1,133.10 | | 090 | Y | $945.00 |
| 54220 | Irrigation of corpora cavernosa for priapism | 6.07 | $506.85 | | 000 | N | $197.25 |
| 54230 | Injection procedure for corpora cavernosography | 2.46 | $205.41 | | 000 | N | |
| 54231 | Dynamic cavernosometry, including intracavernosal injection of vasoactive drugs (eg, papaverine, phentolamine) | 3.49 | $291.42 | | 000 | N | |
| 54235 | Injection of corpora cavernosa with pharmacologic agent(s) (eg, papaverine, phentolamine) | 2.22 | $185.37 | | 000 | N | |
| 54240 | Penile plethysmography | 2.51 | $209.59 | $155.10 | 000 | N | |
| 54250 | Nocturnal penile tumescence and/or rigidity test | 3.18 | $265.53 | $246.94 | 000 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **54300** | Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra | 16.61 | $1,386.94 | | 090 | Y | $765.00 |
| **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 | 19.45 | $1,624.08 | | 090 | Y | $765.00 |
| **54308** | Urethroplasty for second stage hypospadias repair (including urinary diversion); less than 3 cm | 18.45 | $1,540.58 | | 090 | Y | $765.00 |
| **54312** | Urethroplasty for second stage hypospadias repair (including urinary diversion); greater than 3 cm | 21.57 | $1,801.10 | | 090 | Y | $765.00 |
| **54316** | Urethroplasty for second stage hypospadias repair (including urinary diversion) with free skin graft obtained from site other than genitalia | 25.82 | $2,155.97 | | 090 | Y | $765.00 |
| **54318** | Urethroplasty for third stage hypospadias repair to release penis from scrotum (eg, third stage Cecil repair) | 18.33 | $1,530.56 | | 090 | Y | $765.00 |
| **54322** | One stage distal hypospadias repair (with or without chordee or circumcision); with simple meatal advancement (eg, Magpi, V-flap) | 20.22 | $1,688.37 | | 090 | Y | $765.00 |
| **54324** | One stage distal hypospadias repair (with or without chordee or circumcision); with urethroplasty by local skin flaps (eg, flip-flap, prepucial flap) | 25.24 | $2,107.54 | | 090 | Y | $765.00 |
| **54326** | One stage distal hypospadias repair (with or without chordee or circumcision); with urethroplasty by local skin flaps and mobilization of urethra | 24.55 | $2,049.93 | | 090 | Y | $765.00 |
| **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 | 23.94 | $1,998.99 | | 090 | Y | $765.00 |
| **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 | 25.97 | $2,168.50 | | 090 | Y | |
| **54336** | One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap | 32.21 | $2,689.54 | | 090 | Y | |
| **54340** | Repair of hypospadias complications (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple | 14.65 | $1,223.28 | | 090 | Y | $765.00 |
| **54344** | Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring mobilization of skin flaps and urethroplasty with flap or patch graft | 25.04 | $2,090.84 | | 090 | Y | $765.00 |
| **54348** | Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring extensive dissection and urethroplasty with flap, patch or tubed graft (includes urinary diversion) | 25.41 | $2,121.74 | | 090 | Y | $765.00 |
| **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 | 37.44 | $3,126.24 | | 090 | Y | $765.00 |
| **54360** | Plastic operation on penis to correct angulation | 18.64 | $1,556.44 | | 090 | Y | $765.00 |
| **54380** | Plastic operation on penis for epispadias distal to external sphincter; | 19.92 | $1,663.32 | | 090 | Y | $765.00 |
| **54385** | Plastic operation on penis for epispadias distal to external sphincter; with incontinence | 23.88 | $1,993.98 | | 090 | Y | $765.00 |
| **54390** | Plastic operation on penis for epispadias distal to external sphincter; with exstrophy of bladder | 30.76 | $2,568.46 | | 090 | Y | |
| **54400** | Insertion of penile prosthesis; non-inflatable (semi-rigid) | 13.54 | $1,130.59 | | 090 | N | $765.00 |
| **54401** | Insertion of penile prosthesis; inflatable (self-contained) | 16.32 | $1,362.72 | | 090 | N | $765.00 |
| **54405** | Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir | 20.40 | $1,703.40 | | 090 | Y | $765.00 |
| **54406** | Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis | 18.35 | $1,532.23 | | 090 | Y | $765.00 |
| **54408** | Repair of component(s) of a multi-component, inflatable penile prosthesis | 19.64 | $1,639.94 | | 090 | Y | $765.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| 54410 | Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session | 23.27 | $1,943.05 | | 090 | Y | $765.00 |
| 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 | 25.38 | $2,119.23 | | 090 | Y | |
| 54415 | Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis | 13.12 | $1,095.52 | | 090 | Y | $765.00 |
| 54416 | Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session | 17.48 | $1,459.58 | | 090 | Y | $765.00 |
| 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 | 22.29 | $1,861.22 | | 090 | Y | |
| 54420 | Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral | 17.93 | $1,497.16 | | 090 | Y | $945.00 |
| 54430 | Corpora cavernosa-corpus spongiosum shunt (priapism operation), unilateral or bilateral | 16.14 | $1,347.69 | | 090 | Y | |
| 54435 | Corpora cavernosa-glans penis fistulization (eg, biopsy needle, Winter procedure, rongeur, or punch) for priapism | 10.42 | $870.07 | | 090 | N | $945.00 |
| 54440 | Plastic operation of penis for injury | 14.02 | $1,170.67 | | 090 | Y | $945.00 |
| 54450 | Foreskin manipulation including lysis of preputial adhesions and stretching | 2.02 | $168.67 | | 000 | N | $314.22 |
| 54500 | Biopsy of testis, needle (separate procedure) | 1.90 | $158.65 | | 000 | N | $499.50 |
| 54505 | Biopsy of testis, incisional (separate procedure) | 5.43 | $453.41 | | 010 | N | $499.50 |
| 54512 | Excision of extraparenchymal lesion of testis | 13.50 | $1,127.25 | | 090 | Y | $669.00 |
| 54520 | Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach | 8.25 | $688.88 | | 090 | N | $765.00 |
| 54522 | Orchiectomy, partial | 15.12 | $1,262.52 | | 090 | Y | $765.00 |
| 54530 | Orchiectomy, radical, for tumor; inguinal approach | 13.75 | $1,148.13 | | 090 | Y | $945.00 |
| 54535 | Orchiectomy, radical, for tumor; with abdominal exploration | 18.77 | $1,567.30 | | 090 | Y | |
| 54550 | Exploration for undescended testis (inguinal or scrotal area) | 12.27 | $1,024.55 | | 090 | Y | $945.00 |
| 54560 | Exploration for undescended testis with abdominal exploration | 17.12 | $1,429.52 | | 090 | Y | |
| 54600 | Reduction of torsion of testis, surgical, with or without fixation of contralateral testis | 11.25 | $939.38 | | 090 | N | $945.00 |
| 54620 | Fixation of contralateral testis (separate procedure) | 7.66 | $639.61 | | 010 | N | $765.00 |
| 54640 | Orchiopexy, inguinal approach, with or without hernia repair | 11.61 | $969.44 | | 090 | N | $945.00 |
| 54650 | Orchiopexy, abdominal approach, for intra-abdominal testis (eg, Fowler-Stephens) | 18.17 | $1,517.20 | | 090 | Y | |
| 54660 | Insertion of testicular prosthesis (separate procedure) | 8.87 | $740.65 | | 090 | N | $669.00 |
| 54670 | Suture or repair of testicular injury | 10.25 | $855.88 | | 090 | N | $765.00 |
| 54680 | Transplantation of testis(es) to thigh (because of scrotal destruction) | 20.24 | $1,690.04 | | 090 | Y | $765.00 |
| 54690 | Laparoscopy, surgical; orchiectomy | 16.71 | $1,395.29 | | 090 | Y | $2,008.50 |
| 54692 | Laparoscopy, surgical; orchiopexy for intra-abdominal testis | 19.57 | $1,634.10 | | 090 | N | |
| 54699 | Unlisted laparoscopy procedure, testis | 0.00 | BR | | 000 | N | |
| 54700 | Incision and drainage of epididymis, testis and/or scrotal space (eg, abscess or hematoma) | 5.42 | $452.57 | | 010 | N | $669.00 |
| 54800 | Biopsy of epididymis, needle | 3.26 | $272.21 | | 000 | N | $190.74 |
| 54830 | Excision of local lesion of epididymis | 9.12 | $761.52 | | 090 | N | $765.00 |
| 54840 | Excision of spermatocele, with or without epididymectomy | 8.11 | $677.19 | | 090 | N | $945.00 |
| 54860 | Epididymectomy; unilateral | 10.33 | $862.56 | | 090 | N | $765.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **54861** | Epididymectomy; bilateral | 14.06 | $1,174.01 | | 090 | N | $945.00 |
| **54865** | Exploration of epididymis, with or without biopsy | 8.79 | $733.97 | | 090 | N | $499.50 |
| **54900** | Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral | 19.21 | $1,604.04 | | 090 | Y | $945.00 |
| **54901** | Epididymovasostomy, anastomosis of epididymis to vas deferens; bilateral | 26.13 | $2,181.86 | | 090 | Y | $945.00 |
| **55000** | Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication | 3.41 | $284.74 | | 000 | N | |
| **55040** | Excision of hydrocele; unilateral | 8.45 | $705.58 | | 090 | N | $765.00 |
| **55041** | Excision of hydrocele; bilateral | 12.58 | $1,050.43 | | 090 | N | $1,075.50 |
| **55060** | Repair of tunica vaginalis hydrocele (Bottle type) | 9.33 | $779.06 | | 090 | N | $945.00 |
| **55100** | Drainage of scrotal wall abscess | 5.96 | $497.66 | | 010 | N | $499.50 |
| **55110** | Scrotal exploration | 9.51 | $794.09 | | 090 | N | $669.00 |
| **55120** | Removal of foreign body in scrotum | 8.73 | $728.96 | | 090 | Y | $669.00 |
| **55150** | Resection of scrotum | 12.02 | $1,003.67 | | 090 | Y | $499.50 |
| **55175** | Scrotoplasty; simple | 8.91 | $743.99 | | 090 | Y | $499.50 |
| **55180** | Scrotoplasty; complicated | 17.23 | $1,438.71 | | 090 | N | $669.00 |
| **55200** | Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure) | 15.67 | $1,308.45 | | 090 | N | $669.00 |
| **55250** | Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s) | 13.77 | $1,149.80 | | 090 | N | $669.00 |
| **55300** | Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral | 4.79 | $399.97 | | 000 | N | |
| **55400** | Vasovasostomy, vasovasorrhaphy | 12.74 | $1,063.79 | | 090 | Y | $499.50 |
| **55450** | Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure) | 10.97 | $916.00 | | 010 | N | |
| **55500** | Excision of hydrocele of spermatic cord, unilateral (separate procedure) | 9.43 | $787.41 | | 090 | N | $765.00 |
| **55520** | Excision of lesion of spermatic cord (separate procedure) | 10.04 | $838.34 | | 090 | Y | $945.00 |
| **55530** | Excision of varicocele or ligation of spermatic veins for varicocele; (separate procedure) | 8.87 | $740.65 | | 090 | N | $945.00 |
| **55535** | Excision of varicocele or ligation of spermatic veins for varicocele; abdominal approach | 10.62 | $886.77 | | 090 | Y | $945.00 |
| **55540** | Excision of varicocele or ligation of spermatic veins for varicocele; with hernia repair | 12.24 | $1,022.04 | | 090 | Y | $1,075.50 |
| **55550** | Laparoscopy, surgical, with ligation of spermatic veins for varicocele | 10.58 | $883.43 | | 090 | Y | $2,008.50 |
| **55559** | Unlisted laparoscopy procedure, spermatic cord | 0.00 | BR | | 000 | N | |
| **55600** | Vesiculotomy; | 10.57 | $882.60 | | 090 | Y | |
| **55605** | Vesiculotomy; complicated | 12.85 | $1,072.98 | | 090 | Y | |
| **55650** | Vesiculectomy, any approach | 17.97 | $1,500.50 | | 090 | Y | |
| **55680** | Excision of Mullerian duct cyst | 8.70 | $726.45 | | 090 | Y | $499.50 |
| **55700** | Biopsy, prostate; needle or punch, single or multiple, any approach | 6.51 | $543.59 | | 000 | N | $518.75 |
| **55705** | Biopsy, prostate; incisional, any approach | 6.89 | $575.32 | | 010 | Y | $518.75 |
| **55720** | Prostatotomy, external drainage of prostatic abscess, any approach; simple | 11.93 | $996.16 | | 090 | Y | $499.50 |
| **55725** | Prostatotomy, external drainage of prostatic abscess, any approach; complicated | 14.55 | $1,214.93 | | 090 | Y | $669.00 |
| **55801** | Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy) | 27.39 | $2,287.07 | | 090 | Y | |
| **55810** | Prostatectomy, perineal radical; | 33.17 | $2,769.70 | | 090 | Y | |
| **55812** | Prostatectomy, perineal radical; with lymph node biopsy(s) (limited pelvic lymphadenectomy) | 40.79 | $3,405.97 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **55815** | Prostatectomy, perineal radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes | 44.72 | $3,734.12 | | 090 | Y | |
| | **55821** | Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, one or two stages | 21.94 | $1,831.99 | | 090 | Y | |
| | **55831** | Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal | 23.79 | $1,986.47 | | 090 | Y | |
| | **55840** | Prostatectomy, retropubic radical, with or without nerve sparing; | 33.79 | $2,821.47 | | 090 | Y | |
| | **55842** | Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy) | 36.22 | $3,024.37 | | 090 | Y | |
| | **55845** | Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes | 41.49 | $3,464.42 | | 090 | Y | |
| | **55860** | Exposure of prostate, any approach, for insertion of radioactive substance; | 22.15 | $1,849.53 | | 090 | Y | |
| | **55862** | Exposure of prostate, any approach, for insertion of radioactive substance; with lymph node biopsy(s) (limited pelvic lymphadenectomy) | 28.00 | $2,338.00 | | 090 | Y | |
| | **55865** | Exposure of prostate, any approach, for insertion of radioactive substance; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes | 33.79 | $2,821.47 | | 090 | Y | |
| | **55866** | Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing | 44.05 | $3,678.18 | | 090 | Y | |
| | **55870** | Electroejaculation | 4.25 | $354.88 | | 000 | N | |
| | **55873** | Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement) | 29.18 | $2,436.53 | | 090 | N | $2,008.50 |
| | **55875** | Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy | 19.24 | $1,606.54 | | 090 | Y | $2,008.50 |
| | **55876** | Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple | 3.88 | $323.98 | | 000 | Y | |
| | **55899** | Unlisted procedure, male genital system | 0.00 | BR | | 000 | N | |
| | **55970** | Intersex surgery; male to female | 0.00 | BR | | 000 | Y | |
| | **55980** | Intersex surgery; female to male | 0.00 | BR | | 000 | Y | |
| | **56405** | Incision and drainage of vulva or perineal abscess | 2.77 | $231.30 | | 010 | N | |
| | **56420** | Incision and drainage of Bartholin's gland abscess | 3.51 | $293.09 | | 010 | N | |
| | **56440** | Marsupialization of Bartholin's gland cyst | 4.59 | $383.27 | | 010 | N | $669.00 |
| | **56441** | Lysis of labial adhesions | 3.78 | $315.63 | | 010 | N | $499.50 |
| | **56442** | Hymenotomy, simple incision | 1.20 | $100.20 | | 000 | N | $499.50 |
| | **56501** | Destruction of lesion(s), vulva; simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 3.31 | $276.39 | | 010 | N | |
| | **56515** | Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 5.56 | $464.26 | | 010 | N | $765.00 |
| | **56605** | Biopsy of vulva or perineum (separate procedure); one lesion | 2.15 | $179.53 | | 000 | N | |
| + | **56606** | Biopsy of vulva or perineum (separate procedure); each separate additional lesion (List separately in addition to code for primary procedure) | 1.02 | $85.17 | | 000 | N | |
| | **56620** | Vulvectomy simple; partial | 13.19 | $1,101.37 | | 090 | Y | $1,075.50 |
| | **56625** | Vulvectomy simple; complete | 14.79 | $1,234.97 | | 090 | Y | $1,492.50 |
| | **56630** | Vulvectomy, radical, partial; | 21.38 | $1,785.23 | | 090 | Y | |
| | **56631** | Vulvectomy, radical, partial; with unilateral inguinofemoral lymphadenectomy | 27.42 | $2,289.57 | | 090 | Y | |
| | **56632** | Vulvectomy, radical, partial; with bilateral inguinofemoral lymphadenectomy | 31.30 | $2,613.55 | | 090 | Y | |
| | **56633** | Vulvectomy, radical, complete; | 27.89 | $2,328.82 | | 090 | Y | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **56634** | Vulvectomy, radical, complete; with unilateral inguinofemoral lymphadenectomy | 29.71 | $2,480.79 | | 090 | Y | |
| **56637** | Vulvectomy, radical, complete; with bilateral inguinofemoral lymphadenectomy | 35.33 | $2,950.06 | | 090 | Y | |
| **56640** | Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy | 35.29 | $2,946.72 | | 090 | Y | |
| **56700** | Partial hymenectomy or revision of hymenal ring | 4.62 | $385.77 | | 010 | Y | $499.50 |
| **56740** | Excision of Bartholin's gland or cyst | 7.40 | $617.90 | | 010 | N | $765.00 |
| **56800** | Plastic repair of introitus | 6.09 | $508.52 | | 010 | Y | $765.00 |
| **56805** | Clitoroplasty for intersex state | 29.30 | $2,446.55 | | 090 | Y | |
| **56810** | Perineoplasty, repair of perineum, nonobstetrical (separate procedure) | 6.55 | $546.93 | | 010 | Y | $1,075.50 |
| **56820** | Colposcopy of the vulva; | 2.81 | $234.64 | | 000 | N | |
| **56821** | Colposcopy of the vulva; with biopsy(s) | 3.78 | $315.63 | | 000 | N | |
| **57000** | Colpotomy; with exploration | 4.72 | $394.12 | | 010 | Y | $499.50 |
| **57010** | Colpotomy; with drainage of pelvic abscess | 10.58 | $883.43 | | 090 | Y | $669.00 |
| **57020** | Colpocentesis (separate procedure) | 2.42 | $202.07 | | 000 | N | $614.00 |
| **57022** | Incision and drainage of vaginal hematoma; obstetrical/postpartum | 4.17 | $348.20 | | 010 | Y | |
| **57023** | Incision and drainage of vaginal hematoma; non-obstetrical (eg, post-trauma, spontaneous bleeding) | 7.72 | $644.62 | | 010 | Y | $499.50 |
| **57061** | Destruction of vaginal lesion(s); simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 2.90 | $242.15 | | 010 | N | |
| **57065** | Destruction of vaginal lesion(s); extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 4.90 | $409.15 | | 010 | N | $499.50 |
| **57100** | Biopsy of vaginal mucosa; simple (separate procedure) | 2.26 | $188.71 | | 000 | N | |
| **57105** | Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) | 3.48 | $290.58 | | 010 | N | $669.00 |
| **57106** | Vaginectomy, partial removal of vaginal wall; | 11.54 | $963.59 | | 090 | Y | |
| **57107** | Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) | 34.81 | $2,906.64 | | 090 | Y | |
| **57109** | Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy) | 39.66 | $3,311.61 | | 090 | Y | |
| **57110** | Vaginectomy, complete removal of vaginal wall; | 22.58 | $1,885.43 | | 090 | Y | |
| **57111** | Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) | 40.61 | $3,390.94 | | 090 | Y | |
| **57112** | Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy) | 42.38 | $3,538.73 | | 090 | Y | |
| **57120** | Colpocleisis (Le Fort type) | 12.74 | $1,063.79 | | 090 | Y | |
| **57130** | Excision of vaginal septum | 4.59 | $383.27 | | 010 | Y | $669.00 |
| **57135** | Excision of vaginal cyst or tumor | 4.92 | $410.82 | | 010 | N | $669.00 |
| **57150** | Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease | 1.53 | $127.76 | | 000 | N | |
| **57155** | Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy | 10.84 | $905.14 | | 090 | N | $614.00 |
| **57160** | Fitting and insertion of pessary or other intravaginal support device | 1.92 | $160.32 | | 000 | N | |
| **57170** | Diaphragm or cervical cap fitting with instructions | 2.18 | $182.03 | | 000 | N | |
| **57180** | Introduction of any hemostatic agent or pack for spontaneous or traumatic nonobstetrical vaginal hemorrhage (separate procedure) | 3.71 | $309.79 | | 010 | N | $267.08 |
| **57200** | Colporrhaphy, suture of injury of vagina (nonobstetrical) | 7.26 | $606.21 | | 090 | Y | $499.50 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | 57210 | Colpoperineorrhaphy, suture of injury of vagina and/or perineum (nonobstetrical) | 9.07 | $757.35 | | 090 | Y | $669.00 |
| | 57220 | Plastic operation on urethral sphincter, vaginal approach (eg, Kelly urethral plication) | 7.88 | $657.98 | | 090 | Y | $765.00 |
| | 57230 | Plastic repair of urethrocele | 9.62 | $803.27 | | 090 | Y | $765.00 |
| | 57240 | Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele | 15.11 | $1,261.69 | | 090 | Y | $1,075.50 |
| | 57250 | Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy | 14.85 | $1,239.98 | | 090 | Y | $1,075.50 |
| | 57260 | Combined anteroposterior colporrhaphy; | 18.97 | $1,584.00 | | 090 | Y | $1,075.50 |
| | 57265 | Combined anteroposterior colporrhaphy; with enterocele repair | 21.68 | $1,810.28 | | 090 | Y | $1,492.50 |
| + | 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) | 6.89 | $575.32 | | 000 | Y | $1,492.50 |
| | 57268 | Repair of enterocele, vaginal approach (separate procedure) | 11.72 | $978.62 | | 090 | Y | $765.00 |
| | 57270 | Repair of enterocele, abdominal approach (separate procedure) | 19.72 | $1,646.62 | | 090 | Y | |
| | 57280 | Colpopexy, abdominal approach | 23.90 | $1,995.65 | | 090 | Y | |
| | 57282 | Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus) | 12.55 | $1,047.93 | | 090 | Y | |
| | 57283 | Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy) | 17.18 | $1,434.53 | | 090 | Y | |
| | 57284 | Paravaginal defect repair (including repair of cystocele, stress urinary incontinence, and/or incomplete vaginal prolapse) | 20.60 | $1,720.10 | | 090 | Y | |
| | 57287 | Removal or revision of sling for stress incontinence (eg, fascia or synthetic) | 16.96 | $1,416.16 | | 090 | Y | |
| | 57288 | Sling operation for stress incontinence (eg, fascia or synthetic) | 19.93 | $1,664.16 | | 090 | Y | $1,075.50 |
| | 57289 | Pereyra procedure, including anterior colporrhaphy | 18.70 | $1,561.45 | | 090 | Y | $1,075.50 |
| | 57291 | Construction of artificial vagina; without graft | 13.39 | $1,118.07 | | 090 | Y | $1,075.50 |
| | 57292 | Construction of artificial vagina; with graft | 20.80 | $1,736.80 | | 090 | Y | |
| | 57295 | Revision (including removal) of prosthetic vaginal graft; vaginal approach | 12.20 | $1,018.70 | | 090 | Y | |
| | 57296 | Revision (including removal) of prosthetic vaginal graft; open abdominal approach | 23.23 | $1,939.71 | | 090 | Y | |
| | 57300 | Closure of rectovaginal fistula; vaginal or transanal approach | 12.92 | $1,078.82 | | 090 | Y | $765.00 |
| | 57305 | Closure of rectovaginal fistula; abdominal approach | 21.68 | $1,810.28 | | 090 | Y | |
| | 57307 | Closure of rectovaginal fistula; abdominal approach, with concomitant colostomy | 24.33 | $2,031.56 | | 090 | Y | |
| | 57308 | Closure of rectovaginal fistula; transperineal approach, with perineal body reconstruction, with or without levator plication | 15.61 | $1,303.44 | | 090 | Y | |
| | 57310 | Closure of urethrovaginal fistula; | 11.48 | $958.58 | | 090 | Y | |
| | 57311 | Closure of urethrovaginal fistula; with bulbocavernosus transplant | 12.96 | $1,082.16 | | 090 | Y | |
| | 57320 | Closure of vesicovaginal fistula; vaginal approach | 13.21 | $1,103.04 | | 090 | Y | |
| | 57330 | Closure of vesicovaginal fistula; transvesical and vaginal approach | 18.94 | $1,581.49 | | 090 | Y | |
| | 57335 | Vaginoplasty for intersex state | 28.82 | $2,406.47 | | 090 | Y | |
| | 57400 | Dilation of vagina under anesthesia | 3.38 | $282.23 | | 000 | Y | $669.00 |
| | 57410 | Pelvic examination under anesthesia | 2.65 | $221.28 | | 000 | N | $669.00 |
| | 57415 | Removal of impacted vaginal foreign body (separate procedure) under anesthesia | 3.87 | $323.15 | | 010 | N | $669.00 |
| | 57420 | Colposcopy of the entire vagina, with cervix if present; | 2.95 | $246.33 | | 000 | N | |
| | 57421 | Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix | 4.03 | $336.51 | | 000 | N | |
| | 57425 | Laparoscopy, surgical, colpopexy (suspension of vaginal apex) | 23.70 | $1,978.95 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **57452** | Colposcopy of the cervix including upper/adjacent vagina; | 2.78 | $232.13 | | 000 | N | |
| | **57454** | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage | 3.96 | $330.66 | | 000 | N | |
| | **57455** | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix | 3.69 | $308.12 | | 000 | N | |
| | **57456** | Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage | 3.48 | $290.58 | | 000 | N | |
| | **57460** | Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix | 8.34 | $696.39 | | 000 | N | |
| | **57461** | Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix | 9.20 | $768.20 | | 000 | N | |
| | **57500** | Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure) | 3.60 | $300.60 | | 000 | N | |
| | **57505** | Endocervical curettage (not done as part of a dilation and curettage) | 2.60 | $217.10 | | 010 | N | |
| | **57510** | Cautery of cervix; electro or thermal | 3.44 | $287.24 | | 010 | N | |
| | **57511** | Cautery of cervix; cryocautery, initial or repeat | 3.72 | $310.62 | | 010 | N | |
| | **57513** | Cautery of cervix; laser ablation | 3.64 | $303.94 | | 010 | N | $669.00 |
| | **57520** | Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser | 7.93 | $662.16 | | 090 | N | $669.00 |
| | **57522** | Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision | 6.72 | $561.12 | | 090 | N | $669.00 |
| | **57530** | Trachelectomy (cervicectomy), amputation of cervix (separate procedure) | 8.56 | $714.76 | | 090 | Y | $765.00 |
| | **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) | 42.69 | $3,564.62 | | 090 | Y | |
| | **57540** | Excision of cervical stump, abdominal approach; | 19.43 | $1,622.41 | | 090 | Y | |
| | **57545** | Excision of cervical stump, abdominal approach; with pelvic floor repair | 20.67 | $1,725.95 | | 090 | Y | |
| | **57550** | Excision of cervical stump, vaginal approach; | 10.05 | $839.18 | | 090 | Y | $765.00 |
| | **57555** | Excision of cervical stump, vaginal approach; with anterior and/or posterior repair | 14.94 | $1,247.49 | | 090 | Y | |
| | **57556** | Excision of cervical stump, vaginal approach; with repair of enterocele | 14.05 | $1,173.18 | | 090 | Y | $1,075.50 |
| | **57558** | Dilation and curettage of cervical stump | 3.16 | $263.86 | | 010 | N | $765.00 |
| | **57700** | Cerclage of uterine cervix, nonobstetrical | 7.35 | $613.73 | | 090 | Y | $499.50 |
| | **57720** | Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach | 7.61 | $635.44 | | 090 | Y | $765.00 |
| | **57800** | Dilation of cervical canal, instrumental (separate procedure) | 1.53 | $127.76 | | 000 | N | |
| | **58100** | Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) | 2.83 | $236.31 | | 000 | N | |
| + | **58110** | Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure) | 1.29 | $107.72 | | 000 | N | |
| | **58120** | Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical) | 5.97 | $498.50 | | 010 | N | $669.00 |
| | **58140** | Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; abdominal approach | 22.81 | $1,904.64 | | 090 | Y | |
| | **58145** | Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; vaginal approach | 13.54 | $1,130.59 | | 090 | Y | $1,075.50 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **58146** | Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g, abdominal approach | 29.11 | $2,430.69 | | 090 | Y | |
| **58150** | Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); | 24.58 | $2,052.43 | | 090 | Y | |
| **58152** | Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch) | 31.44 | $2,625.24 | | 090 | Y | |
| **58180** | Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s) | 23.65 | $1,974.78 | | 090 | Y | |
| **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) | 32.78 | $2,737.13 | | 090 | Y | |
| **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) | 43.64 | $3,643.94 | | 090 | Y | |
| **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 | 65.97 | $5,508.50 | | 090 | Y | |
| **58260** | Vaginal hysterectomy, for uterus 250 g or less; | 20.64 | $1,723.44 | | 090 | Y | |
| **58262** | Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s) | 23.12 | $1,930.52 | | 090 | Y | |
| **58263** | Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele | 24.90 | $2,079.15 | | 090 | Y | |
| **58267** | Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control | 26.50 | $2,212.75 | | 090 | Y | |
| **58270** | Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele | 22.19 | $1,852.87 | | 090 | Y | |
| **58275** | Vaginal hysterectomy, with total or partial vaginectomy; | 24.61 | $2,054.94 | | 090 | Y | |
| **58280** | Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele | 26.39 | $2,203.57 | | 090 | Y | |
| **58285** | Vaginal hysterectomy, radical (Schauta type operation) | 33.14 | $2,767.19 | | 090 | Y | |
| **58290** | Vaginal hysterectomy, for uterus greater than 250 g; | 29.13 | $2,432.36 | | 090 | Y | |
| **58291** | Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) | 31.64 | $2,641.94 | | 090 | Y | |
| **58292** | Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele | 33.43 | $2,791.41 | | 090 | Y | |
| **58293** | Vaginal hysterectomy, for uterus greater than 250 g; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control | 34.69 | $2,896.62 | | 090 | Y | |
| **58294** | Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele | 30.66 | $2,560.11 | | 090 | Y | |
| **58300** | Insertion of intrauterine device (IUD) | 2.25 | $187.88 | | 000 | N | |
| **58301** | Removal of intrauterine device (IUD) | 2.54 | $212.09 | | 000 | N | |
| **58321** | Artificial insemination; intra-cervical | 2.03 | $169.51 | | 000 | N | |
| **58322** | Artificial insemination; intra-uterine | 2.28 | $190.38 | | 000 | N | |
| **58323** | Sperm washing for artificial insemination | 0.68 | $56.78 | | 000 | N | |
| **58340** | Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography | 3.78 | $315.63 | | 000 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **58345** | Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography | 6.94 | $579.49 | | 010 | Y | |
| **58346** | Insertion of Heyman capsules for clinical brachytherapy | 11.18 | $933.53 | | 090 | N | $669.00 |
| **58350** | Chromotubation of oviduct, including materials | 2.50 | $208.75 | | 010 | N | $765.00 |
| **58353** | Endometrial ablation, thermal, without hysteroscopic guidance | 36.05 | $3,010.18 | | 010 | Y | $1,492.50 |
| **58356** | Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed | 63.34 | $5,288.89 | | 010 | Y | |
| **58400** | Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure) | 11.00 | $918.50 | | 090 | Y | |
| **58410** | Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; with presacral sympathectomy | 20.06 | $1,675.01 | | 090 | Y | |
| **58520** | Hysterorrhaphy, repair of ruptured uterus (nonobstetrical) | 19.39 | $1,619.07 | | 090 | Y | |
| **58540** | Hysteroplasty, repair of uterine anomaly (Strassman type) | 22.59 | $1,886.27 | | 090 | Y | |
| **58541** | Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; | 20.92 | $1,746.82 | | 090 | Y | |
| **58542** | Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s) | 23.13 | $1,931.36 | | 090 | Y | |
| **58543** | Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; | 23.52 | $1,963.92 | | 090 | Y | |
| **58544** | Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) | 25.46 | $2,125.91 | | 090 | Y | |
| **58545** | Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 g or less and/or removal of surface myomas | 22.55 | $1,882.93 | | 090 | Y | $2,008.50 |
| **58546** | Laparoscopy, surgical, myomectomy, excision; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g | 28.61 | $2,388.94 | | 090 | Y | $2,008.50 |
| **58548** | Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed | 44.55 | $3,719.93 | | 090 | Y | |
| **58550** | Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; | 22.20 | $1,853.70 | | 090 | Y | $2,008.50 |
| **58552** | Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s) | 24.48 | $2,044.08 | | 090 | Y | |
| **58553** | Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; | 28.73 | $2,398.96 | | 090 | Y | |
| **58554** | Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) | 32.83 | $2,741.31 | | 090 | Y | |
| **58555** | Hysteroscopy, diagnostic (separate procedure) | 5.72 | $477.62 | | 000 | N | $499.50 |
| **58558** | Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C | 7.35 | $613.73 | | 000 | N | $765.00 |
| **58559** | Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method) | 8.84 | $738.14 | | 000 | N | $669.00 |
| **58560** | Hysteroscopy, surgical; with division or resection of intrauterine septum (any method) | 10.01 | $835.84 | | 000 | Y | $765.00 |
| **58561** | Hysteroscopy, surgical; with removal of leiomyomata | 14.20 | $1,185.70 | | 000 | Y | $765.00 |
| **58562** | Hysteroscopy, surgical; with removal of impacted foreign body | 7.94 | $662.99 | | 000 | N | $765.00 |
| **58563** | Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation) | 57.66 | $4,814.61 | | 000 | Y | $2,008.50 |
| **58565** | Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants | 53.22 | $4,443.87 | | 090 | N | $2,008.50 |
| **58578** | Unlisted laparoscopy procedure, uterus | 0.00 | BR | | 000 | N | |
| **58579** | Unlisted hysteroscopy procedure, uterus | 0.00 | BR | | 000 | N | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | 58600 | Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral | 9.16 | $764.86 | | 090 | Y | |
| | 58605 | Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure) | 8.31 | $693.89 | | 090 | Y | |
| + | 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 code for primary procedure) | 2.01 | $167.84 | | 000 | Y | |
| | 58615 | Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach | 6.51 | $543.59 | | 010 | Y | |
| | 58660 | Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure) | 16.85 | $1,406.98 | | 090 | Y | $1,075.50 |
| | 58661 | Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy) | 16.34 | $1,364.39 | | 010 | Y | $1,075.50 |
| | 58662 | Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method | 17.82 | $1,487.97 | | 090 | Y | $1,075.50 |
| | 58670 | Laparoscopy, surgical; with fulguration of oviducts (with or without transection) | 9.13 | $762.36 | | 090 | N | $765.00 |
| | 58671 | Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring) | 9.14 | $763.19 | | 090 | N | $765.00 |
| | 58672 | Laparoscopy, surgical; with fimbrioplasty | 19.00 | $1,586.50 | | 090 | Y | $1,075.50 |
| | 58673 | Laparoscopy, surgical; with salpingostomy (salpingoneostomy) | 20.51 | $1,712.59 | | 090 | Y | $1,075.50 |
| | 58679 | Unlisted laparoscopy procedure, oviduct, ovary | 0.00 | BR | | 000 | N | |
| | 58700 | Salpingectomy, complete or partial, unilateral or bilateral (separate procedure) | 18.93 | $1,580.66 | | 090 | Y | |
| | 58720 | Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure) | 17.85 | $1,490.48 | | 090 | Y | |
| | 58740 | Lysis of adhesions (salpingolysis, ovariolysis) | 21.89 | $1,827.82 | | 090 | Y | |
| | 58750 | Tubotubal anastomosis | 22.88 | $1,910.48 | | 090 | Y | |
| | 58752 | Tubouterine implantation | 22.51 | $1,879.59 | | 090 | Y | |
| | 58760 | Fimbrioplasty | 20.70 | $1,728.45 | | 090 | Y | |
| | 58770 | Salpingostomy (salpingoneostomy) | 21.57 | $1,801.10 | | 090 | Y | |
| | 58800 | Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); vaginal approach | 8.02 | $669.67 | | 090 | N | $765.00 |
| | 58805 | Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); abdominal approach | 9.87 | $824.15 | | 090 | Y | |
| | 58820 | Drainage of ovarian abscess; vaginal approach, open | 7.87 | $657.15 | | 090 | Y | $765.00 |
| | 58822 | Drainage of ovarian abscess; abdominal approach | 16.86 | $1,407.81 | | 090 | Y | |
| ⊙ | 58823 | Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic) | 24.02 | $2,005.67 | | 000 | Y | |
| | 58825 | Transposition, ovary(s) | 17.43 | $1,455.41 | | 090 | Y | |
| | 58900 | Biopsy of ovary, unilateral or bilateral (separate procedure) | 10.08 | $841.68 | | 090 | Y | $765.00 |
| | 58920 | Wedge resection or bisection of ovary, unilateral or bilateral | 17.60 | $1,469.60 | | 090 | Y | |
| | 58925 | Ovarian cystectomy, unilateral or bilateral | 18.08 | $1,509.68 | | 090 | Y | |
| | 58940 | Oophorectomy, partial or total, unilateral or bilateral; | 12.30 | $1,027.05 | | 090 | Y | |
| | 58943 | Oophorectomy, partial or total, unilateral or bilateral; 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 | 27.99 | $2,337.17 | | 090 | Y | |
| | 58950 | Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; | 26.59 | $2,220.27 | | 090 | Y | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **58951** | Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy | 34.35 | $2,868.23 | | 090 | Y | |
| **58952** | Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal or retroperitoneal tumors) | 38.73 | $3,233.96 | | 090 | Y | |
| **58953** | Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; | 48.22 | $4,026.37 | | 090 | Y | |
| **58954** | Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy | 52.35 | $4,371.23 | | 090 | Y | |
| **58956** | Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy | 34.27 | $2,861.55 | | 090 | Y | |
| **58957** | Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed; | 36.02 | $3,007.67 | | 090 | Y | |
| **58958** | Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy | 39.87 | $3,329.15 | | 090 | Y | |
| **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 | 22.99 | $1,919.67 | | 090 | Y | |
| **58970** | Follicle puncture for oocyte retrieval, any method | 5.79 | $483.47 | | 000 | Y | $368.88 |
| **58974** | Embryo transfer, intrauterine | 4.49 | $374.58 | | 000 | Y | $368.88 |
| **58976** | Gamete, zygote, or embryo intrafallopian transfer, any method | 6.40 | $534.40 | | 000 | Y | $368.88 |
| **58999** | Unlisted procedure, female genital system (nonobstetrical) | 0.00 | BR | | 000 | N | |
| **59000** | Amniocentesis; diagnostic | 3.46 | $288.91 | | 000 | N | |
| **59001** | Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance) | 4.74 | $395.79 | | 000 | N | |
| **59012** | Cordocentesis (intrauterine), any method | 5.35 | $446.73 | | 000 | Y | |
| **59015** | Chorionic villus sampling, any method | 4.02 | $335.67 | | 000 | Y | |
| **59020** | Fetal contraction stress test | 1.70 | $141.95 | $90.85 | 000 | N | |
| **59025** | Fetal non-stress test | 1.12 | $93.52 | $72.95 | 000 | N | |
| **59030** | Fetal scalp blood sampling | 2.98 | $248.83 | | 000 | N | |
| **59050** | Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation | 1.34 | $111.89 | | 000 | N | |
| **59051** | Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; interpretation only | 1.11 | $92.69 | | 000 | N | |
| **59070** | Transabdominal amnioinfusion, including ultrasound guidance | 9.94 | $829.99 | | 000 | Y | |
| **59072** | Fetal umbilical cord occlusion, including ultrasound guidance | 11.31 | $944.39 | | 000 | N | |
| **59074** | Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance | 9.38 | $783.23 | | 000 | Y | |
| **59076** | Fetal shunt placement, including ultrasound guidance | 11.19 | $934.37 | | 000 | Y | |
| **59100** | Hysterotomy, abdominal (eg, for hydatidiform mole, abortion) | 21.17 | $1,767.70 | | 090 | Y | |
| **59120** | Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach | 20.07 | $1,675.85 | | 090 | Y | |
| **59121** | Surgical treatment of ectopic pregnancy; tubal or ovarian, without salpingectomy and/or oophorectomy | 20.24 | $1,690.04 | | 090 | Y | |
| **59130** | Surgical treatment of ectopic pregnancy; abdominal pregnancy | 21.97 | $1,834.50 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **59135** | Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy | 23.32 | $1,947.22 | | 090 | Y | |
| | **59136** | Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy with partial resection of uterus | 22.25 | $1,857.88 | | 090 | Y | |
| | **59140** | Surgical treatment of ectopic pregnancy; cervical, with evacuation | 8.94 | $746.49 | | 090 | Y | |
| | **59150** | Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy | 19.55 | $1,632.43 | | 090 | Y | |
| | **59151** | Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy | 19.30 | $1,611.55 | | 090 | Y | |
| | **59160** | Curettage, postpartum | 6.06 | $506.01 | | 010 | N | $765.00 |
| | **59200** | Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure) | 2.03 | $169.51 | | 000 | N | |
| | **59300** | Episiotomy or vaginal repair, by other than attending physician | 4.92 | $410.82 | | 000 | N | |
| | **59320** | Cerclage of cervix, during pregnancy; vaginal | 4.00 | $334.00 | | 000 | Y | $499.50 |
| | **59325** | Cerclage of cervix, during pregnancy; abdominal | 6.26 | $522.71 | | 000 | Y | |
| | **59350** | Hysterorrhaphy of ruptured uterus | 7.36 | $614.56 | | 000 | Y | |
| | **59400** | Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care | 44.66 | $3,729.11 | | 049 | N | |
| | **59409** | Vaginal delivery only (with or without episiotomy and/or forceps); | 20.25 | $1,690.88 | | 000 | N | |
| | **59410** | Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care | 23.23 | $1,939.71 | | 049 | N | |
| | **59412** | External cephalic version, with or without tocolysis | 2.71 | $226.29 | | 000 | N | |
| | **59414** | Delivery of placenta (separate procedure) | 2.42 | $202.07 | | 000 | N | |
| | **59425** | Antepartum care only; 4-6 visits | 10.94 | $913.49 | | 000 | N | |
| | **59426** | Antepartum care only; 7 or more visits | 19.51 | $1,629.09 | | 000 | N | |
| | **59430** | Postpartum care only (separate procedure) | 3.61 | $301.44 | | 000 | N | |
| | **59510** | Routine obstetric care including antepartum care, cesarean delivery, and postpartum care | 50.46 | $4,213.41 | | 090 | N | |
| | **59514** | Cesarean delivery only; | 23.93 | $1,998.16 | | 000 | Y | |
| | **59515** | Cesarean delivery only; including postpartum care | 27.98 | $2,336.33 | | 090 | N | |
| + | **59525** | Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure) | 12.69 | $1,059.62 | | 000 | Y | |
| | **59610** | Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery | 46.76 | $3,904.46 | | 049 | N | |
| | **59612** | Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); | 22.72 | $1,897.12 | | 000 | N | |
| | **59614** | Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care | 25.30 | $2,112.55 | | 049 | N | |
| | **59618** | Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery | 52.93 | $4,419.66 | | 090 | N | |
| | **59620** | Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; | 26.18 | $2,186.03 | | 000 | Y | |
| | **59622** | Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care | 30.36 | $2,535.06 | | 090 | N | |
| | **59812** | Treatment of incomplete abortion, any trimester, completed surgically | 7.58 | $632.93 | | 090 | N | $1,075.50 |
| | **59820** | Treatment of missed abortion, completed surgically; first trimester | 9.49 | $792.42 | | 090 | N | $1,075.50 |
| | **59821** | Treatment of missed abortion, completed surgically; second trimester | 9.68 | $808.28 | | 090 | N | $1,075.50 |
| | **59830** | Treatment of septic abortion, completed surgically | 11.15 | $931.03 | | 090 | N | |
| | **59840** | Induced abortion, by dilation and curettage | 5.51 | $460.09 | | 010 | N | $1,075.50 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **59841** | Induced abortion, by dilation and evacuation | 9.66 | $806.61 | | 010 | N | $1,075.50 |
| **59850** | Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; | 9.69 | $809.12 | | 090 | N | |
| **59851** | Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation | 10.23 | $854.21 | | 090 | N | |
| **59852** | Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed intra-amniotic injection) | 13.94 | $1,163.99 | | 090 | N | |
| **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; | 10.59 | $884.27 | | 090 | N | |
| **59856** | 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; with dilation and curettage and/or evacuation | 12.76 | $1,065.46 | | 090 | N | |
| **59857** | 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; with hysterotomy (failed medical evacuation) | 14.70 | $1,227.45 | | 090 | Y | |
| **59866** | Multifetal pregnancy reduction(s) (MPR) | 6.19 | $516.87 | | 000 | Y | |
| **59870** | Uterine evacuation and curettage for hydatidiform mole | 11.61 | $969.44 | | 090 | Y | $1,075.50 |
| **59871** | Removal of cerclage suture under anesthesia (other than local) | 3.50 | $292.25 | | 000 | Y | $1,075.50 |
| **59897** | Unlisted fetal invasive procedure, including ultrasound guidance | 0.00 | BR | | 000 | N | |
| **59898** | Unlisted laparoscopy procedure, maternity care and delivery | 0.00 | BR | | 000 | N | |
| **59899** | Unlisted procedure, maternity care and delivery | 0.00 | BR | | 000 | N | |
| **60000** | Incision and drainage of thyroglossal duct cyst, infected | 3.70 | $308.95 | | 010 | Y | $499.50 |
| **60001** | Aspiration and/or injection, thyroid cyst | 2.46 | $205.41 | | 000 | N | |
| **60100** | Biopsy thyroid, percutaneous core needle | 2.85 | $237.98 | | 000 | N | |
| **60200** | Excision of cyst or adenoma of thyroid, or transection of isthmus | 15.72 | $1,312.62 | | 090 | Y | $669.00 |
| **60210** | Partial thyroid lobectomy, unilateral; with or without isthmusectomy | 16.75 | $1,398.63 | | 090 | Y | |
| **60212** | Partial thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy | 24.08 | $2,010.68 | | 090 | Y | |
| **60220** | Total thyroid lobectomy, unilateral; with or without isthmusectomy | 18.33 | $1,530.56 | | 090 | Y | |
| **60225** | Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy | 22.05 | $1,841.18 | | 090 | Y | |
| **60240** | Thyroidectomy, total or complete | 23.64 | $1,973.94 | | 090 | Y | |
| **60252** | Thyroidectomy, total or subtotal for malignancy; with limited neck dissection | 31.66 | $2,643.61 | | 090 | Y | |
| **60254** | Thyroidectomy, total or subtotal for malignancy; with radical neck dissection | 41.27 | $3,446.05 | | 090 | Y | |
| **60260** | Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid | 26.53 | $2,215.26 | | 090 | Y | |
| **60270** | Thyroidectomy, including substernal thyroid; sternal split or transthoracic approach | 33.16 | $2,768.86 | | 090 | Y | |
| **60271** | Thyroidectomy, including substernal thyroid; cervical approach | 25.67 | $2,143.45 | | 090 | Y | |
| **60280** | Excision of thyroglossal duct cyst or sinus; | 10.51 | $877.59 | | 090 | Y | $945.00 |
| **60281** | Excision of thyroglossal duct cyst or sinus; recurrent | 14.10 | $1,177.35 | | 090 | Y | $945.00 |
| **60500** | Parathyroidectomy or exploration of parathyroid(s); | 24.25 | $2,024.88 | | 090 | Y | |
| **60502** | Parathyroidectomy or exploration of parathyroid(s); re-exploration | 30.57 | $2,552.60 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **60505** | Parathyroidectomy or exploration of parathyroid(s); with mediastinal exploration, sternal split or transthoracic approach | 33.76 | $2,818.96 | | 090 | Y | |
| + | **60512** | Parathyroid autotransplantation (List separately in addition to code for primary procedure) | 6.03 | $503.51 | | 000 | Y | |
| | **60520** | Thymectomy, partial or total; transcervical approach (separate procedure) | 25.50 | $2,129.25 | | 090 | Y | |
| | **60521** | Thymectomy, partial or total; sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure) | 29.23 | $2,440.71 | | 090 | Y | |
| | **60522** | Thymectomy, partial or total; sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure) | 35.18 | $2,937.53 | | 090 | Y | |
| | **60540** | Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure); | 25.58 | $2,135.93 | | 090 | Y | |
| | **60545** | Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure); with excision of adjacent retroperitoneal tumor | 29.43 | $2,457.41 | | 090 | Y | |
| | **60600** | Excision of carotid body tumor; without excision of carotid artery | 35.09 | $2,930.02 | | 090 | Y | |
| | **60605** | Excision of carotid body tumor; with excision of carotid artery | 43.40 | $3,623.90 | | 090 | Y | |
| | **60650** | Laparoscopy, surgical, with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal | 28.88 | $2,411.48 | | 090 | Y | |
| | **60659** | Unlisted laparoscopy procedure, endocrine system | 0.00 | BR | | 000 | N | |
| | **60699** | Unlisted procedure, endocrine system | 0.00 | BR | | 000 | N | |
| | **61000** | Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; initial | 2.57 | $214.60 | | 000 | N | |
| | **61001** | Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; subsequent taps | 2.60 | $217.10 | | 000 | N | |
| | **61020** | Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; without injection | 3.10 | $258.85 | | 000 | N | $275.75 |
| | **61026** | Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; with injection of medication or other substance for diagnosis or treatment | 3.27 | $273.05 | | 000 | N | $275.75 |
| | **61050** | Cisternal or lateral cervical (C1-C2) puncture; without injection (separate procedure) | 2.70 | $225.45 | | 000 | N | $275.75 |
| | **61055** | Cisternal or lateral cervical (C1-C2) puncture; with injection of medication or other substance for diagnosis or treatment (eg, C1-C2) | 3.43 | $286.41 | | 000 | N | $275.75 |
| | **61070** | Puncture of shunt tubing or reservoir for aspiration or injection procedure | 2.02 | $168.67 | | 000 | N | $275.75 |
| | **61105** | Twist drill hole for subdural or ventricular puncture | 10.36 | $865.06 | | 090 | N | |
| ⊘ | **61107** | Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for implanting ventricular catheter, pressure recording device, or other intracerebral monitoring device | 8.15 | $680.53 | | 000 | N | |
| | **61108** | Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for evacuation and/or drainage of subdural hematoma | 20.48 | $1,710.08 | | 090 | N | |
| | **61120** | Burr hole(s) for ventricular puncture (including injection of gas, contrast media, dye, or radioactive material) | 16.84 | $1,406.14 | | 090 | N | |
| | **61140** | Burr hole(s) or trephine; with biopsy of brain or intracranial lesion | 29.54 | $2,466.59 | | 090 | Y | |
| | **61150** | Burr hole(s) or trephine; with drainage of brain abscess or cyst | 31.73 | $2,649.46 | | 090 | N | |
| | **61151** | Burr hole(s) or trephine; with subsequent tapping (aspiration) of intracranial abscess or cyst | 23.08 | $1,927.18 | | 090 | N | |
| | **61154** | Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural | 29.26 | $2,443.21 | | 090 | Y | |
| | **61156** | Burr hole(s); with aspiration of hematoma or cyst, intracerebral | 29.73 | $2,482.46 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| ⊘ | **61210** | Burr hole(s); for implanting ventricular catheter, reservoir, EEG electrode(s), pressure recording device, or other cerebral monitoring device (separate procedure) | 9.48 | $791.58 | | 000 | N | |
| | **61215** | Insertion of subcutaneous reservoir, pump or continuous infusion system for connection to ventricular catheter | 10.82 | $903.47 | | 090 | N | $765.00 |
| | **61250** | Burr hole(s) or trephine, supratentorial, exploratory, not followed by other surgery | 20.08 | $1,676.68 | | 090 | Y | |
| | **61253** | Burr hole(s) or trephine, infratentorial, unilateral or bilateral | 22.44 | $1,873.74 | | 090 | Y | |
| | **61304** | Craniectomy or craniotomy, exploratory; supratentorial | 39.42 | $3,291.57 | | 090 | Y | |
| | **61305** | Craniectomy or craniotomy, exploratory; infratentorial (posterior fossa) | 47.04 | $3,927.84 | | 090 | Y | |
| | **61312** | Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural | 48.57 | $4,055.60 | | 090 | Y | |
| | **61313** | Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebral | 46.61 | $3,891.94 | | 090 | Y | |
| | **61314** | Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural | 42.84 | $3,577.14 | | 090 | Y | |
| | **61315** | Craniectomy or craniotomy for evacuation of hematoma, infratentorial; intracerebellar | 49.67 | $4,147.45 | | 090 | Y | |
| + | **61316** | Incision and subcutaneous placement of cranial bone graft (List separately in addition to code for primary procedure) | 2.18 | $182.03 | | 000 | N | |
| | **61320** | Craniectomy or craniotomy, drainage of intracranial abscess; supratentorial | 45.88 | $3,830.98 | | 090 | Y | |
| | **61321** | Craniectomy or craniotomy, drainage of intracranial abscess; infratentorial | 50.20 | $4,191.70 | | 090 | Y | |
| | **61322** | Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; without lobectomy | 54.54 | $4,554.09 | | 090 | Y | |
| | **61323** | Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; with lobectomy | 55.83 | $4,661.81 | | 090 | N | |
| | **61330** | Decompression of orbit only, transcranial approach | 38.27 | $3,195.55 | | 090 | Y | |
| | **61332** | Exploration of orbit (transcranial approach); with biopsy | 45.57 | $3,805.10 | | 090 | Y | |
| | **61333** | Exploration of orbit (transcranial approach); with removal of lesion | 45.23 | $3,776.71 | | 090 | Y | |
| | **61334** | Exploration of orbit (transcranial approach); with removal of foreign body | 29.58 | $2,469.93 | | 090 | Y | |
| | **61340** | Subtemporal cranial decompression (pseudotumor cerebri, slit ventricle syndrome) | 34.07 | $2,844.85 | | 090 | Y | |
| | **61343** | Craniectomy, suboccipital with cervical laminectomy for decompression of medulla and spinal cord, with or without dural graft (eg, Arnold-Chiari malformation) | 52.88 | $4,415.48 | | 090 | Y | |
| | **61345** | Other cranial decompression, posterior fossa | 48.62 | $4,059.77 | | 090 | Y | |
| | **61440** | Craniotomy for section of tentorium cerebelli (separate procedure) | 46.78 | $3,906.13 | | 090 | Y | |
| | **61450** | Craniectomy, subtemporal, for section, compression, or decompression of sensory root of gasserian ganglion | 44.53 | $3,718.26 | | 090 | Y | |
| | **61458** | Craniectomy, suboccipital; for exploration or decompression of cranial nerves | 48.29 | $4,032.22 | | 090 | Y | |
| | **61460** | Craniectomy, suboccipital; for section of one or more cranial nerves | 49.27 | $4,114.05 | | 090 | Y | |
| | **61470** | Craniectomy, suboccipital; for medullary tractotomy | 44.37 | $3,704.90 | | 090 | Y | |
| | **61480** | Craniectomy, suboccipital; for mesencephalic tractotomy or pedunculotomy | 45.36 | $3,787.56 | | 090 | Y | |
| | **61490** | Craniotomy for lobotomy, including cingulotomy | 45.69 | $3,815.12 | | 090 | Y | |
| | **61500** | Craniectomy; with excision of tumor or other bone lesion of skull | 32.03 | $2,674.51 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | 61501 | Craniectomy; for osteomyelitis | 27.13 | $2,265.36 | | 090 | Y | |
| | 61510 | Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma | 51.75 | $4,321.13 | | 090 | Y | |
| | 61512 | Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial | 61.82 | $5,161.97 | | 090 | Y | |
| | 61514 | Craniectomy, trephination, bone flap craniotomy; for excision of brain abscess, supratentorial | 45.42 | $3,792.57 | | 090 | Y | |
| | 61516 | Craniectomy, trephination, bone flap craniotomy; for excision or fenestration of cyst, supratentorial | 44.46 | $3,712.41 | | 090 | Y | |
| + | 61517 | Implantation of brain intracavitary chemotherapy agent (List separately in addition to code for primary procedure) | 2.20 | $183.70 | | 000 | N | |
| | 61518 | Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull | 66.36 | $5,541.06 | | 090 | Y | |
| | 61519 | Craniectomy for excision of brain tumor, infratentorial or posterior fossa; meningioma | 71.83 | $5,997.81 | | 090 | Y | |
| | 61520 | Craniectomy for excision of brain tumor, infratentorial or posterior fossa; cerebellopontine angle tumor | 91.65 | $7,652.78 | | 090 | Y | |
| | 61521 | Craniectomy for excision of brain tumor, infratentorial or posterior fossa; midline tumor at base of skull | 77.31 | $6,455.39 | | 090 | Y | |
| | 61522 | Craniectomy, infratentorial or posterior fossa; for excision of brain abscess | 52.12 | $4,352.02 | | 090 | Y | |
| | 61524 | Craniectomy, infratentorial or posterior fossa; for excision or fenestration of cyst | 49.68 | $4,148.28 | | 090 | Y | |
| | 61526 | Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor; | 83.20 | $6,947.20 | | 090 | Y | |
| | 61530 | Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor; combined with middle/posterior fossa craniotomy/craniectomy | 70.45 | $5,882.58 | | 090 | Y | |
| | 61531 | Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for long term seizure monitoring | 27.87 | $2,327.15 | | 090 | Y | |
| | 61533 | Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring | 35.96 | $3,002.66 | | 090 | Y | |
| | 61534 | Craniotomy with elevation of bone flap; for excision of epileptogenic focus without electrocorticography during surgery | 38.43 | $3,208.91 | | 090 | Y | |
| | 61535 | Craniotomy with elevation of bone flap; for removal of epidural or subdural electrode array, without excision of cerebral tissue (separate procedure) | 22.58 | $1,885.43 | | 090 | Y | |
| | 61536 | Craniotomy with elevation of bone flap; for excision of cerebral epileptogenic focus, with electrocorticography during surgery (includes removal of electrode array) | 62.55 | $5,222.93 | | 090 | Y | |
| | 61537 | Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, without electrocorticography during surgery | 55.14 | $4,604.19 | | 090 | Y | |
| | 61538 | Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, with electrocorticography during surgery | 58.59 | $4,892.27 | | 090 | Y | |
| | 61539 | Craniotomy with elevation of bone flap; for lobectomy, other than temporal lobe, partial or total, with electrocorticography during surgery | 56.29 | $4,700.22 | | 090 | Y | |
| | 61540 | Craniotomy with elevation of bone flap; for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery | 53.44 | $4,462.24 | | 090 | Y | |
| | 61541 | Craniotomy with elevation of bone flap; for transection of corpus callosum | 50.55 | $4,220.93 | | 090 | Y | |
| | 61542 | Craniotomy with elevation of bone flap; for total hemispherectomy | 55.22 | $4,610.87 | | 090 | Y | |
| | 61543 | Craniotomy with elevation of bone flap; for partial or subtotal (functional) hemispherectomy | 52.03 | $4,344.51 | | 090 | Y | |
| | 61544 | Craniotomy with elevation of bone flap; for excision or coagulation of choroid plexus | 44.51 | $3,716.59 | | 090 | Y | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **61545** | Craniotomy with elevation of bone flap; for excision of craniopharyngioma | 76.05 | $6,350.18 | | 090 | Y | |
| **61546** | Craniotomy for hypophysectomy or excision of pituitary tumor, intracranial approach | 54.97 | $4,590.00 | | 090 | Y | |
| **61548** | Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic | 36.84 | $3,076.14 | | 090 | Y | |
| **61550** | Craniectomy for craniosynostosis; single cranial suture | 21.48 | $1,793.58 | | 090 | Y | |
| **61552** | Craniectomy for craniosynostosis; multiple cranial sutures | 27.78 | $2,319.63 | | 090 | Y | |
| **61556** | Craniotomy for craniosynostosis; frontal or parietal bone flap | 38.00 | $3,173.00 | | 090 | Y | |
| **61557** | Craniotomy for craniosynostosis; bifrontal bone flap | 40.32 | $3,366.72 | | 090 | Y | |
| **61558** | Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); not requiring bone grafts | 37.74 | $3,151.29 | | 090 | Y | |
| **61559** | Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); recontouring with multiple osteotomies and bone autografts (eg, barrel-stave procedure) (includes obtaining grafts) | 58.26 | $4,864.71 | | 090 | Y | |
| **61563** | Excision, intra and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); without optic nerve decompression | 45.74 | $3,819.29 | | 090 | Y | |
| **61564** | Excision, intra and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); with optic nerve decompression | 57.73 | $4,820.46 | | 090 | Y | |
| **61566** | Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy | 53.57 | $4,473.10 | | 090 | Y | |
| **61567** | Craniotomy with elevation of bone flap; for multiple subpial transections, with electrocorticography during surgery | 59.45 | $4,964.08 | | 090 | Y | |
| **61570** | Craniectomy or craniotomy; with excision of foreign body from brain | 43.64 | $3,643.94 | | 090 | Y | |
| **61571** | Craniectomy or craniotomy; with treatment of penetrating wound of brain | 47.44 | $3,961.24 | | 090 | Y | |
| **61575** | Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion; | 56.81 | $4,743.64 | | 090 | Y | |
| **61576** | Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion; requiring splitting of tongue and/or mandible (including tracheostomy) | 87.76 | $7,327.96 | | 090 | Y | |
| **61580** | Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration | 58.70 | $4,901.45 | | 090 | Y | |
| **61581** | Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, orbital exenteration, ethmoidectomy, sphenoidectomy and/or maxillectomy | 62.78 | $5,242.13 | | 090 | Y | |
| **61582** | Craniofacial approach to anterior cranial fossa; extradural, including unilateral or bifrontal craniotomy, elevation of frontal lobe(s), osteotomy of base of anterior cranial fossa | 66.77 | $5,575.30 | | 090 | Y | |
| **61583** | Craniofacial approach to anterior cranial fossa; intradural, including unilateral or bifrontal craniotomy, elevation or resection of frontal lobe, osteotomy of base of anterior cranial fossa | 69.12 | $5,771.52 | | 090 | Y | |
| **61584** | Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); without orbital exenteration | 66.85 | $5,581.98 | | 090 | Y | |
| **61585** | Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); with orbital exenteration | 71.38 | $5,960.23 | | 090 | Y | |
| **61586** | Bicoronal, transzygomatic and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft | 51.89 | $4,332.82 | | 090 | Y | |
| **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 | 74.82 | $6,247.47 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | 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 | 76.01 | $6,346.84 | | 090 | Y | |
| | 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 | 75.58 | $6,310.93 | | 090 | Y | |
| | 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 | 55.83 | $4,661.81 | | 090 | Y | |
| | 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 | 61.79 | $5,159.47 | | 090 | Y | |
| | 61597 | Transcondylar (far lateral) approach to posterior cranial fossa, jugular foramen or midline skull base, including occipital condylectomy, mastoidectomy, resection of C1-C3 vertebral body(s), decompression of vertebral artery, with or without mobilization | 68.50 | $5,719.75 | | 090 | Y | |
| | 61598 | Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus | 61.20 | $5,110.20 | | 090 | Y | |
| | 61600 | Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; extradural | 50.11 | $4,184.19 | | 090 | Y | |
| | 61601 | Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; intradural, including dural repair, with or without graft | 55.56 | $4,639.26 | | 090 | Y | |
| | 61605 | Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; extradural | 52.95 | $4,421.33 | | 090 | Y | |
| | 61606 | Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; intradural, including dural repair, with or without graft | 71.71 | $5,987.79 | | 090 | Y | |
| | 61607 | Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; extradural | 66.68 | $5,567.78 | | 090 | Y | |
| | 61608 | Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; intradural, including dural repair, with or without graft | 78.29 | $6,537.22 | | 090 | Y | |
| + | 61609 | Transection or ligation, carotid artery in cavernous sinus; without repair (List separately in addition to code for primary procedure) | 16.04 | $1,339.34 | | 000 | Y | |
| + | 61610 | Transection or ligation, carotid artery in cavernous sinus; with repair by anastomosis or graft (List separately in addition to code for primary procedure) | 47.04 | $3,927.84 | | 000 | Y | |
| + | 61611 | Transection or ligation, carotid artery in petrous canal; without repair (List separately in addition to code for primary procedure) | 12.13 | $1,012.86 | | 000 | Y | |
| + | 61612 | Transection or ligation, carotid artery in petrous canal; with repair by anastomosis or graft (List separately in addition to code for primary procedure) | 41.42 | $3,458.57 | | 000 | Y | |
| | 61613 | Obliteration of carotid aneurysm, arteriovenous malformation, or carotid-cavernous fistula by dissection within cavernous sinus | 75.53 | $6,306.76 | | 090 | Y | |
| | 61615 | Resection or excision of neoplastic, vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or C1-C3 vertebral bodies; extradural | 58.72 | $4,903.12 | | 090 | Y | |
| | 61616 | Resection or excision of neoplastic, vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or C1-C3 vertebral bodies; intradural, including dural repair, with or without graft | 78.39 | $6,545.57 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **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) | 30.82 | $2,573.47 | | 090 | Y | |
| | **61619** | Secondary repair of dura for cerebrospinal fluid leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by local or regionalized vascularized pedicle flap or myocutaneous flap (including galea, temporalis, frontalis or occipitalis muscle) | 35.72 | $2,982.62 | | 090 | Y | |
| | **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 | 13.85 | $1,156.48 | | 000 | N | |
| | **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) | 26.80 | $2,237.80 | | 000 | N | |
| | **61626** | Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; non-central nervous system, head or neck (extracranial, brachiocephalic branch) | 21.53 | $1,797.76 | | 000 | N | |
| | **61630** | Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous | 32.85 | $2,742.98 | | 090 | N | |
| | **61635** | Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed | 35.94 | $3,000.99 | | 090 | N | |
| | **61640** | Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel | 14.64 | $1,222.44 | | 000 | N | |
| + | **61641** | Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in same vascular family (List separately in addition to code for primary procedure) | 5.14 | $429.19 | | 000 | N | |
| + | **61642** | Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular family (List separately in addition to code for primary procedure) | 10.29 | $859.22 | | 000 | N | |
| | **61680** | Surgery of intracranial arteriovenous malformation; supratentorial, simple | 54.44 | $4,545.74 | | 090 | Y | |
| | **61682** | Surgery of intracranial arteriovenous malformation; supratentorial, complex | 103.95 | $8,679.83 | | 090 | Y | |
| | **61684** | Surgery of intracranial arteriovenous malformation; infratentorial, simple | 69.33 | $5,789.06 | | 090 | Y | |
| | **61686** | Surgery of intracranial arteriovenous malformation; infratentorial, complex | 111.00 | $9,268.50 | | 090 | Y | |
| | **61690** | Surgery of intracranial arteriovenous malformation; dural, simple | 51.55 | $4,304.43 | | 090 | Y | |
| | **61692** | Surgery of intracranial arteriovenous malformation; dural, complex | 89.25 | $7,452.38 | | 090 | Y | |
| | **61697** | Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation | 98.04 | $8,186.34 | | 090 | Y | |
| | **61698** | Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation | 102.88 | $8,590.48 | | 090 | Y | |
| | **61700** | Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation | 85.34 | $7,125.89 | | 090 | Y | |
| | **61702** | Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation | 91.26 | $7,620.21 | | 090 | Y | |
| | **61703** | Surgery of intracranial aneurysm, cervical approach by application of occluding clamp to cervical carotid artery (Selverstone-Crutchfield type) | 31.47 | $2,627.75 | | 090 | Y | |
| | **61705** | Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial and cervical occlusion of carotid artery | 61.93 | $5,171.16 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **61708** | Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial electrothrombosis | 50.43 | $4,210.91 | | 090 | Y | |
| | **61710** | Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intra-arterial embolization, injection procedure, or balloon catheter | 45.99 | $3,840.17 | | 090 | N | |
| | **61711** | Anastomosis, arterial, extracranial-intracranial (eg, middle cerebral/cortical) arteries | 63.26 | $5,282.21 | | 090 | Y | |
| | **61720** | Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus | 28.09 | $2,345.52 | | 090 | N | |
| | **61735** | Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; subcortical structure(s) other than globus pallidus or thalamus | 34.70 | $2,897.45 | | 090 | N | |
| | **61750** | Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; | 33.21 | $2,773.04 | | 090 | N | |
| | **61751** | Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computed tomography and/or magnetic resonance guidance | 32.33 | $2,699.56 | | 090 | N | |
| | **61760** | Stereotactic implantation of depth electrodes into the cerebrum for long term seizure monitoring | 34.98 | $2,920.83 | | 090 | N | |
| | **61770** | Stereotactic localization, including burr hole(s), with insertion of catheter(s) or probe(s) for placement of radiation source | 36.02 | $3,007.67 | | 090 | N | |
| | **61790** | Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); gasserian ganglion | 19.56 | $1,633.26 | | 090 | N | $765.00 |
| | **61791** | Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); trigeminal medullary tract | 25.78 | $2,152.63 | | 090 | N | $527.88 |
| | **61793** | Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions | 30.50 | $2,546.75 | | 090 | N | |
| + | **61795** | Stereotactic computer-assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal (List separately in addition to code for primary procedure) | 6.28 | $524.38 | | 000 | N | $453.06 |
| | **61850** | Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical | 22.31 | $1,862.89 | | 090 | Y | |
| | **61860** | Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical | 36.77 | $3,070.30 | | 090 | Y | |
| | **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 | 35.91 | $2,998.49 | | 090 | Y | |
| + | **61864** | 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; each additional array (List separately in addition to primary procedure) | 11.61 | $969.44 | | 000 | Y | |
| | **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 | 52.75 | $4,404.63 | | 090 | Y | |
| + | **61868** | 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; each additional array (List separately in addition to primary procedure) | 16.30 | $1,361.05 | | 000 | Y | |
| | **61870** | Craniectomy for implantation of neurostimulator electrodes, cerebellar; cortical | 27.95 | $2,333.83 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **61875** | Craniectomy for implantation of neurostimulator electrodes, cerebellar; subcortical | 25.42 | $2,122.57 | | 090 | Y | |
| | **61880** | Revision or removal of intracranial neurostimulator electrodes | 12.65 | $1,056.28 | | 090 | Y | |
| | **61885** | Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array | 14.07 | $1,174.85 | | 090 | N | $669.00 |
| | **61886** | Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays | 17.69 | $1,477.12 | | 090 | Y | $765.00 |
| | **61888** | Revision or removal of cranial neurostimulator pulse generator or receiver | 9.67 | $807.45 | | 010 | N | $499.50 |
| | **62000** | Elevation of depressed skull fracture; simple, extradural | 19.45 | $1,624.08 | | 090 | N | |
| | **62005** | Elevation of depressed skull fracture; compound or comminuted, extradural | 28.64 | $2,391.44 | | 090 | Y | |
| | **62010** | Elevation of depressed skull fracture; with repair of dura and/or debridement of brain | 36.10 | $3,014.35 | | 090 | Y | |
| | **62100** | Craniotomy for repair of dural/cerebrospinal fluid leak, including surgery for rhinorrhea/otorrhea | 38.49 | $3,213.92 | | 090 | Y | |
| | **62115** | Reduction of craniomegalic skull (eg, treated hydrocephalus); not requiring bone grafts or cranioplasty | 38.21 | $3,190.54 | | 090 | Y | |
| | **62116** | Reduction of craniomegalic skull (eg, treated hydrocephalus); with simple cranioplasty | 41.89 | $3,497.82 | | 090 | Y | |
| | **62117** | Reduction of craniomegalic skull (eg, treated hydrocephalus); requiring craniotomy and reconstruction with or without bone graft (includes obtaining grafts) | 45.21 | $3,775.04 | | 090 | Y | |
| | **62120** | Repair of encephalocele, skull vault, including cranioplasty | 42.78 | $3,572.13 | | 090 | Y | |
| | **62121** | Craniotomy for repair of encephalocele, skull base | 39.93 | $3,334.16 | | 090 | Y | |
| | **62140** | Cranioplasty for skull defect; up to 5 cm diameter | 24.89 | $2,078.32 | | 090 | Y | |
| | **62141** | Cranioplasty for skull defect; larger than 5 cm diameter | 27.26 | $2,276.21 | | 090 | Y | |
| | **62142** | Removal of bone flap or prosthetic plate of skull | 20.48 | $1,710.08 | | 090 | Y | |
| | **62143** | Replacement of bone flap or prosthetic plate of skull | 24.26 | $2,025.71 | | 090 | Y | |
| | **62145** | Cranioplasty for skull defect with reparative brain surgery | 33.24 | $2,775.54 | | 090 | Y | |
| | **62146** | Cranioplasty with autograft (includes obtaining bone grafts); up to 5 cm diameter | 28.60 | $2,388.10 | | 090 | Y | |
| | **62147** | Cranioplasty with autograft (includes obtaining bone grafts); larger than 5 cm diameter | 33.98 | $2,837.33 | | 090 | Y | |
| + | **62148** | Incision and retrieval of subcutaneous cranial bone graft for cranioplasty (List separately in addition to code for primary procedure) | 3.12 | $260.52 | | 000 | N | |
| + | **62160** | Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage (List separately in addition to code for primary procedure) | 4.91 | $409.99 | | 000 | N | |
| | **62161** | Neuroendoscopy, intracranial; with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts (including placement, replacement, or removal of ventricular catheter) | 36.31 | $3,031.89 | | 090 | Y | |
| | **62162** | Neuroendoscopy, intracranial; with fenestration or excision of colloid cyst, including placement of external ventricular catheter for drainage | 44.55 | $3,719.93 | | 090 | Y | |
| | **62163** | Neuroendoscopy, intracranial; with retrieval of foreign body | 28.87 | $2,410.65 | | 090 | Y | |
| | **62164** | Neuroendoscopy, intracranial; with excision of brain tumor, including placement of external ventricular catheter for drainage | 46.71 | $3,900.29 | | 090 | Y | |
| | **62165** | Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach | 36.74 | $3,067.79 | | 090 | N | |
| | **62180** | Ventriculocisternostomy (Torkildsen type operation) | 37.42 | $3,124.57 | | 090 | Y | |
| | **62190** | Creation of shunt; subarachnoid/subdural-atrial, -jugular, -auricular | 20.91 | $1,745.99 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **62192** | Creation of shunt; subarachnoid/subdural-peritoneal, -pleural, other terminus | 22.78 | $1,902.13 | | 090 | Y | |
| | **62194** | Replacement or irrigation, subarachnoid/subdural catheter | 8.79 | $733.97 | | 010 | Y | $499.50 |
| | **62200** | Ventriculocisternostomy, third ventricle; | 32.75 | $2,734.63 | | 090 | Y | |
| | **62201** | Ventriculocisternostomy, third ventricle; stereotactic, neuroendoscopic method | 27.71 | $2,313.79 | | 090 | N | |
| | **62220** | Creation of shunt; ventriculo-atrial, -jugular, -auricular | 24.05 | $2,008.18 | | 090 | Y | |
| | **62223** | Creation of shunt; ventriculo-peritoneal, -pleural, other terminus | 24.20 | $2,020.70 | | 090 | Y | |
| | **62225** | Replacement or irrigation, ventricular catheter | 11.34 | $946.89 | | 090 | N | $499.50 |
| | **62230** | Replacement or revision of cerebrospinal fluid shunt, obstructed valve, or distal catheter in shunt system | 19.62 | $1,638.27 | | 090 | Y | $669.00 |
| | **62252** | Reprogramming of programmable cerebrospinal shunt | 2.43 | $202.91 | | 000 | N | |
| | **62256** | Removal of complete cerebrospinal fluid shunt system; without replacement | 13.29 | $1,109.72 | | 090 | Y | |
| | **62258** | Removal of complete cerebrospinal fluid shunt system; with replacement by similar or other shunt at same operation | 26.60 | $2,221.10 | | 090 | Y | |
| | **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 | 17.96 | $1,499.66 | | 010 | N | $499.50 |
| | **62264** | 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; 1 day | 11.45 | $956.08 | | 010 | N | $499.50 |
| | **62268** | Percutaneous aspiration, spinal cord cyst or syrinx | 14.94 | $1,247.49 | | 000 | N | $275.75 |
| | **62269** | Biopsy of spinal cord, percutaneous needle | 17.55 | $1,465.43 | | 000 | N | $499.50 |
| | **62270** | Spinal puncture, lumbar, diagnostic | 4.13 | $344.86 | | 000 | N | $208.50 |
| | **62272** | Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter) | 4.86 | $405.81 | | 000 | N | $208.50 |
| | **62273** | Injection, epidural, of blood or clot patch | 4.51 | $376.59 | | 000 | N | $499.50 |
| | **62280** | Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid | 8.92 | $744.82 | | 010 | N | $499.50 |
| | **62281** | Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic | 7.74 | $646.29 | | 010 | N | $499.50 |
| | **62282** | Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal) | 9.52 | $794.92 | | 010 | N | $499.50 |
| ⊘ | **62284** | Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa) | 6.14 | $583.30 | | 000 | N | |
| | **62287** | Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous discectomy, percutaneous laser discectomy) | 13.75 | $1,148.13 | | 090 | N | $2,008.50 |
| | **62290** | Injection procedure for discography, each level; lumbar | 9.36 | $781.56 | | 000 | N | |
| | **62291** | Injection procedure for discography, each level; cervical or thoracic | 8.35 | $697.23 | | 000 | N | |
| | **62292** | Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar | 13.19 | $1,101.37 | | 090 | N | |
| | **62294** | Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal | 18.31 | $1,528.89 | | 090 | N | $275.75 |
| | **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, steroid, other solution), epidural or subarachnoid; cervical or thoracic | 6.19 | $516.87 | | 000 | N | $499.50 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **62311** | 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, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal) | 5.83 | $486.81 | | 000 | N | $499.50 |
| **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, steroid, other solution), epidural or subarachnoid; cervical or thoracic | 7.04 | $587.84 | | 000 | N | $499.50 |
| **62319** | 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, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal) | 6.24 | $521.04 | | 000 | N | $499.50 |
| **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 | 12.25 | $1,022.88 | | 090 | N | $669.00 |
| **62351** | Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy | 19.92 | $1,663.32 | | 090 | Y | |
| **62355** | Removal of previously implanted intrathecal or epidural catheter | 9.92 | $828.32 | | 090 | Y | $669.00 |
| **62360** | Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir | 6.52 | $544.42 | | 090 | Y | $669.00 |
| **62361** | Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump | 10.67 | $890.95 | | 090 | Y | $669.00 |
| **62362** | Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming | 13.36 | $1,115.56 | | 090 | Y | $669.00 |
| **62365** | Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion | 10.42 | $870.07 | | 090 | Y | $669.00 |
| **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 | 1.02 | $85.17 | | 000 | N | |
| **62368** | Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming | 1.40 | $116.90 | | 000 | N | |
| **63001** | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), one or two vertebral segments; cervical | 29.16 | $2,434.86 | | 090 | Y | |
| **63003** | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), one or two vertebral segments; thoracic | 29.47 | $2,460.75 | | 090 | Y | |
| **63005** | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), one or two vertebral segments; lumbar, except for spondylolisthesis | 27.93 | $2,332.16 | | 090 | Y | |
| **63011** | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), one or two vertebral segments; sacral | 26.10 | $2,179.35 | | 090 | Y | |
| **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) | 28.61 | $2,388.94 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **63015** | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), more than 2 vertebral segments; cervical | 35.32 | $2,949.22 | | 090 | Y | |
| | **63016** | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), more than 2 vertebral segments; thoracic | 36.15 | $3,018.53 | | 090 | Y | |
| | **63017** | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), more than 2 vertebral segments; lumbar | 29.52 | $2,464.92 | | 090 | Y | |
| | **63020** | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; one interspace, cervical | 27.94 | $2,332.99 | | 090 | Y | |
| | **63030** | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; one interspace, lumbar (including open or endoscopically-assisted approach) | 23.23 | $2,206.85 | | 090 | Y | |
| + | **63035** | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure) | 5.12 | $486.40 | | 000 | Y | |
| | **63040** | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical | 34.26 | $2,860.71 | | 090 | Y | |
| | **63042** | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar | 32.20 | $3,059.00 | | 090 | Y | |
| + | **63043** | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure) | 16.82 | $1,404.80 | | 000 | Y | |
| + | **63044** | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure) | 15.98 | $1,334.58 | | 000 | Y | |
| | **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 | 30.42 | $2,540.07 | | 090 | Y | |
| | **63046** | 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; thoracic | 29.09 | $2,429.02 | | 090 | Y | |
| | **63047** | 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; lumbar | 26.72 | $2,538.40 | | 090 | Y | |
| + | **63048** | 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; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure) | 5.42 | $514.90 | | 000 | Y | |
| | **63050** | Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments; | 35.46 | $2,960.91 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **63051** | Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments; 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) | 40.55 | $3,385.93 | | 090 | Y | |
| | **63055** | Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic | 39.34 | $3,284.89 | | 090 | Y | |
| | **63056** | Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc) | 36.61 | $3,477.95 | | 090 | Y | |
| + | **63057** | Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure) | 8.41 | $702.24 | | 000 | Y | |
| | **63064** | Costovertebral approach with decompression of spinal cord or nerve root(s), (eg, herniated intervertebral disc), thoracic; single segment | 43.39 | $3,623.07 | | 090 | Y | |
| + | **63066** | Costovertebral approach with decompression of spinal cord or nerve root(s), (eg, herniated intervertebral disc), thoracic; each additional segment (List separately in addition to code for primary procedure) | 5.18 | $432.53 | | 000 | Y | |
| | **63075** | Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace | 34.01 | $3,230.95 | | 090 | Y | |
| + | **63076** | Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure) | 6.52 | $619.40 | | 000 | Y | |
| | **63077** | Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace | 36.86 | $3,077.81 | | 090 | Y | |
| + | **63078** | Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, each additional interspace (List separately in addition to code for primary procedure) | 5.15 | $430.03 | | 000 | Y | |
| | **63081** | Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment | 43.11 | $3,599.69 | | 090 | Y | |
| + | **63082** | Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure) | 7.03 | $587.01 | | 000 | Y | |
| | **63085** | Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment | 45.96 | $3,837.66 | | 090 | Y | |
| + | **63086** | Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, each additional segment (List separately in addition to code for primary procedure) | 4.95 | $413.33 | | 000 | Y | |
| | **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 | 58.68 | $4,899.78 | | 090 | Y | |
| + | **63088** | 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; each additional segment (List separately in addition to code for primary procedure) | 6.75 | $563.63 | | 000 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | 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 | 47.48 | $3,964.58 | | 090 | Y | |
| + | 63091 | 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; each additional segment (List separately in addition to code for primary procedure) | 4.59 | $383.27 | | 000 | Y | |
| | 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 | 55.02 | $4,594.17 | | 090 | Y | |
| | 63102 | 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); lumbar, single segment | 54.95 | $4,588.33 | | 090 | Y | |
| + | 63103 | 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 or lumbar, each additional segment (List separately in addition to code for primary procedure) | 7.36 | $614.56 | | 000 | Y | |
| | 63170 | Laminectomy with myelotomy (eg, Bischof or DREZ type), cervical, thoracic, or thoracolumbar | 36.83 | $3,075.31 | | 090 | Y | |
| | 63172 | Laminectomy with drainage of intramedullary cyst/syrinx; to subarachnoid space | 33.01 | $2,756.34 | | 090 | Y | |
| | 63173 | Laminectomy with drainage of intramedullary cyst/syrinx; to peritoneal or pleural space | 40.44 | $3,376.74 | | 090 | Y | |
| | 63180 | Laminectomy and section of dentate ligaments, with or without dural graft, cervical; one or two segments | 33.29 | $2,779.72 | | 090 | Y | |
| | 63182 | Laminectomy and section of dentate ligaments, with or without dural graft, cervical; more than two segments | 35.74 | $2,984.29 | | 090 | Y | |
| | 63185 | Laminectomy with rhizotomy; one or two segments | 26.13 | $2,181.86 | | 090 | Y | |
| | 63190 | Laminectomy with rhizotomy; more than two segments | 30.28 | $2,528.38 | | 090 | Y | |
| | 63191 | Laminectomy with section of spinal accessory nerve | 33.84 | $2,825.64 | | 090 | Y | |
| | 63194 | Laminectomy with cordotomy, with section of one spinothalamic tract, one stage; cervical | 34.04 | $2,842.34 | | 090 | Y | |
| | 63195 | Laminectomy with cordotomy, with section of one spinothalamic tract, one stage; thoracic | 35.62 | $2,974.27 | | 090 | Y | |
| | 63196 | Laminectomy with cordotomy, with section of both spinothalamic tracts, one stage; cervical | 41.95 | $3,502.83 | | 090 | Y | |
| | 63197 | Laminectomy with cordotomy, with section of both spinothalamic tracts, one stage; thoracic | 39.47 | $3,295.75 | | 090 | Y | |
| | 63198 | Laminectomy with cordotomy with section of both spinothalamic tracts, two stages within 14 days; cervical | 41.77 | $3,487.80 | | 090 | Y | |
| | 63199 | Laminectomy with cordotomy with section of both spinothalamic tracts, two stages within 14 days; thoracic | 43.17 | $3,604.70 | | 090 | Y | |
| | 63200 | Laminectomy, with release of tethered spinal cord, lumbar | 35.59 | $2,971.77 | | 090 | Y | |
| | 63250 | Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; cervical | 68.67 | $5,733.95 | | 090 | Y | |
| | 63251 | Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracic | 72.81 | $6,079.64 | | 090 | Y | |
| | 63252 | Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracolumbar | 72.75 | $6,074.63 | | 090 | Y | |
| | 63265 | Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical | 39.65 | $3,310.78 | | 090 | Y | |
| | 63266 | Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic | 40.88 | $3,413.48 | | 090 | Y | |
| | 63267 | Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar | 32.90 | $2,747.15 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **63268** | Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral | 32.10 | $2,680.35 | | 090 | Y | |
| | **63270** | Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical | 49.12 | $4,101.52 | | 090 | Y | |
| | **63271** | Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic | 49.27 | $4,114.05 | | 090 | Y | |
| | **63272** | Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar | 45.46 | $3,795.91 | | 090 | Y | |
| | **63273** | Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; sacral | 43.70 | $3,648.95 | | 090 | Y | |
| | **63275** | Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical | 42.70 | $3,565.45 | | 090 | Y | |
| | **63276** | Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, thoracic | 42.57 | $3,554.60 | | 090 | Y | |
| | **63277** | Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar | 37.51 | $3,132.09 | | 090 | Y | |
| | **63278** | Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, sacral | 36.68 | $3,062.78 | | 090 | Y | |
| | **63280** | Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, cervical | 50.69 | $4,232.62 | | 090 | Y | |
| | **63281** | Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, thoracic | 50.16 | $4,188.36 | | 090 | Y | |
| | **63282** | Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, lumbar | 47.29 | $3,948.72 | | 090 | Y | |
| | **63283** | Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, sacral | 44.79 | $3,739.97 | | 090 | Y | |
| | **63285** | Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical | 63.08 | $5,267.18 | | 090 | Y | |
| | **63286** | Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracic | 62.63 | $5,229.61 | | 090 | Y | |
| | **63287** | Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracolumbar | 65.59 | $5,476.77 | | 090 | Y | |
| | **63290** | Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level | 66.16 | $5,524.36 | | 090 | Y | |
| + | **63295** | Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure) | 7.69 | $642.12 | | 000 | Y | |
| | **63300** | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, cervical | 44.13 | $3,684.86 | | 090 | Y | |
| | **63301** | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by transthoracic approach | 49.13 | $4,102.36 | | 090 | Y | |
| | **63302** | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by thoracolumbar approach | 49.05 | $4,095.68 | | 090 | Y | |
| | **63303** | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, lumbar or sacral by transperitoneal or retroperitoneal approach | 51.12 | $4,268.52 | | 090 | Y | |
| | **63304** | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, cervical | 54.01 | $4,509.84 | | 090 | Y | |
| | **63305** | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by transthoracic approach | 56.16 | $4,689.36 | | 090 | Y | |
| | **63306** | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by thoracolumbar approach | 57.49 | $4,800.42 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | 63307 | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, lumbar or sacral by transperitoneal or retroperitoneal approach | 52.86 | $4,413.81 | | 090 | Y | |
| + | 63308 | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; each additional segment (List separately in addition to codes for single segment) | 8.44 | $704.74 | | 000 | Y | |
| | 63600 | Creation of lesion of spinal cord by stereotactic method, percutaneous, any modality (including stimulation and/or recording) | 20.21 | $1,687.54 | | 090 | N | $669.00 |
| | 63610 | Stereotactic stimulation of spinal cord, percutaneous, separate procedure not followed by other surgery | 56.95 | $4,755.33 | | 000 | N | $499.50 |
| | 63615 | Stereotactic biopsy, aspiration, or excision of lesion, spinal cord | 26.80 | $2,237.80 | | 090 | N | |
| | 63650 | Percutaneous implantation of neurostimulator electrode array, epidural | 10.45 | $872.58 | | 090 | N | $669.00 |
| | 63655 | Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural | 19.87 | $1,659.15 | | 090 | Y | |
| | 63660 | Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s) | 10.50 | $876.75 | | 090 | Y | $499.50 |
| | 63685 | Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling | 12.16 | $1,015.36 | | 090 | Y | $669.00 |
| | 63688 | Revision or removal of implanted spinal neurostimulator pulse generator or receiver | 9.94 | $829.99 | | 090 | N | $499.50 |
| | 63700 | Repair of meningocele; less than 5 cm diameter | 29.31 | $2,447.39 | | 090 | Y | |
| | 63702 | Repair of meningocele; larger than 5 cm diameter | 32.48 | $2,712.08 | | 090 | Y | |
| | 63704 | Repair of myelomeningocele; less than 5 cm diameter | 37.43 | $3,125.41 | | 090 | Y | |
| | 63706 | Repair of myelomeningocele; larger than 5 cm diameter | 42.87 | $3,579.65 | | 090 | Y | |
| | 63707 | Repair of dural/cerebrospinal fluid leak, not requiring laminectomy | 21.55 | $1,799.43 | | 090 | Y | |
| | 63709 | Repair of dural/cerebrospinal fluid leak or pseudomeningocele, with laminectomy | 26.39 | $2,203.57 | | 090 | Y | |
| | 63710 | Dural graft, spinal | 26.25 | $2,191.88 | | 090 | Y | |
| | 63740 | Creation of shunt, lumbar, subarachnoid-peritoneal, -pleural, or other; including laminectomy | 21.77 | $1,817.80 | | 090 | Y | |
| | 63741 | Creation of shunt, lumbar, subarachnoid-peritoneal, -pleural, or other; percutaneous, not requiring laminectomy | 14.55 | $1,214.93 | | 090 | Y | |
| | 63744 | Replacement, irrigation or revision of lumbosubarachnoid shunt | 15.34 | $1,280.89 | | 090 | Y | $765.00 |
| | 63746 | Removal of entire lumbosubarachnoid shunt system without replacement | 12.07 | $1,007.85 | | 090 | Y | $669.00 |
| | 64400 | Injection, anesthetic agent; trigeminal nerve, any division or branch | 2.84 | $237.14 | | 000 | N | |
| | 64402 | Injection, anesthetic agent; facial nerve | 2.78 | $232.13 | | 000 | N | |
| | 64405 | Injection, anesthetic agent; greater occipital nerve | 2.66 | $222.11 | | 000 | N | |
| | 64408 | Injection, anesthetic agent; vagus nerve | 2.92 | $243.82 | | 000 | N | |
| | 64410 | Injection, anesthetic agent; phrenic nerve | 3.71 | $309.79 | | 000 | N | $499.50 |
| | 64412 | Injection, anesthetic agent; spinal accessory nerve | 3.64 | $303.94 | | 000 | N | |
| | 64413 | Injection, anesthetic agent; cervical plexus | 3.04 | $253.84 | | 000 | N | |
| | 64415 | Injection, anesthetic agent; brachial plexus, single | 3.89 | $324.82 | | 000 | N | $208.50 |
| | 64416 | Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration | 4.51 | $376.59 | | 010 | N | |
| | 64417 | Injection, anesthetic agent; axillary nerve | 4.06 | $339.01 | | 000 | N | $208.50 |
| | 64418 | Injection, anesthetic agent; suprascapular nerve | 3.69 | $308.12 | | 000 | N | |
| | 64420 | Injection, anesthetic agent; intercostal nerve, single | 4.64 | $387.44 | | 000 | N | $208.50 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **64421** | Injection, anesthetic agent; intercostal nerves, multiple, regional block | 7.05 | $588.68 | | 000 | N | $499.50 |
| | **64425** | Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves | 3.27 | $273.05 | | 000 | N | |
| | **64430** | Injection, anesthetic agent; pudendal nerve | 3.89 | $324.82 | | 000 | N | $208.50 |
| | **64435** | Injection, anesthetic agent; paracervical (uterine) nerve | 3.84 | $320.64 | | 000 | N | |
| | **64445** | Injection, anesthetic agent; sciatic nerve, single | 3.85 | $321.48 | | 000 | N | |
| | **64446** | Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter, (including catheter placement) including daily management for anesthetic agent administration | 4.35 | $363.23 | | 010 | N | |
| | **64447** | Injection, anesthetic agent; femoral nerve, single | 1.82 | $151.97 | | 000 | N | |
| | **64448** | Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration | 3.93 | $328.16 | | 010 | N | |
| | **64449** | Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration | 3.90 | $325.65 | | 010 | N | |
| | **64450** | Injection, anesthetic agent; other peripheral nerve or branch | 2.52 | $210.42 | | 000 | N | |
| | **64470** | Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level | 8.14 | $679.69 | | 000 | N | $499.50 |
| + | **64472** | Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure) | 3.29 | $274.72 | | 000 | N | $499.50 |
| | **64475** | Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level | 7.44 | $621.24 | | 000 | N | $499.50 |
| + | **64476** | Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure) | 2.81 | $234.64 | | 000 | N | $499.50 |
| | **64479** | Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, single level | 8.65 | $722.28 | | 000 | N | $499.50 |
| + | **64480** | Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, each additional level (List separately in addition to code for primary procedure) | 3.99 | $333.17 | | 000 | N | $499.50 |
| | **64483** | Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level | 8.68 | $724.78 | | 000 | N | $499.50 |
| + | **64484** | Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level (List separately in addition to code for primary procedure) | 4.14 | $345.69 | | 000 | N | $499.50 |
| | **64505** | Injection, anesthetic agent; sphenopalatine ganglion | 2.53 | $211.26 | | 000 | N | |
| | **64508** | Injection, anesthetic agent; carotid sinus (separate procedure) | 4.04 | $337.34 | | 000 | Y | |
| | **64510** | Injection, anesthetic agent; stellate ganglion (cervical sympathetic) | 4.23 | $353.21 | | 000 | N | $499.50 |
| | **64517** | Injection, anesthetic agent; superior hypogastric plexus | 4.54 | $379.09 | | 000 | N | $208.50 |
| | **64520** | Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic) | 5.79 | $483.47 | | 000 | N | $499.50 |
| | **64530** | Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring | 5.50 | $459.25 | | 000 | N | $499.50 |
| | **64550** | Application of surface (transcutaneous) neurostimulator | 0.43 | $35.91 | | 000 | N | |
| | **64553** | Percutaneous implantation of neurostimulator electrodes; cranial nerve | 5.03 | $420.01 | | 010 | Y | $499.50 |
| | **64555** | Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve) | 5.21 | $435.04 | | 010 | N | |
| | **64560** | Percutaneous implantation of neurostimulator electrodes; autonomic nerve | 4.95 | $413.33 | | 010 | N | |
| | **64561** | Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement) | 34.38 | $2,870.73 | | 010 | N | $765.00 |
| | **64565** | Percutaneous implantation of neurostimulator electrodes; neuromuscular | 4.81 | $401.64 | | 010 | N | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | 64573 | Incision for implantation of neurostimulator electrodes; cranial nerve | 14.24 | $1,189.04 | | 090 | Y | $499.50 |
| | 64575 | Incision for implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve) | 7.03 | $587.01 | | 090 | N | $499.50 |
| | 64577 | Incision for implantation of neurostimulator electrodes; autonomic nerve | 8.38 | $699.73 | | 090 | N | $499.50 |
| | 64580 | Incision for implantation of neurostimulator electrodes; neuromuscular | 7.42 | $619.57 | | 090 | Y | $499.50 |
| | 64581 | Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement) | 19.51 | $1,629.09 | | 090 | N | $765.00 |
| | 64585 | Revision or removal of peripheral neurostimulator electrodes | 11.97 | $999.50 | | 010 | Y | $499.50 |
| | 64590 | Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling | 9.32 | $778.22 | | 010 | Y | $669.00 |
| | 64595 | Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver | 11.17 | $932.70 | | 010 | N | $499.50 |
| | 64600 | Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch | 11.77 | $982.80 | | 010 | N | $499.50 |
| | 64605 | Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale | 14.88 | $1,242.48 | | 010 | N | $499.50 |
| | 64610 | Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring | 17.03 | $1,422.01 | | 010 | N | $499.50 |
| | 64612 | Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm) | 4.16 | $347.36 | | 010 | N | |
| | 64613 | Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia) | 4.43 | $369.91 | | 010 | N | |
| | 64614 | Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis) | 4.90 | $409.15 | | 010 | N | |
| | 64620 | Destruction by neurolytic agent, intercostal nerve | 7.41 | $618.74 | | 010 | N | $499.50 |
| | 64622 | Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level | 9.72 | $811.62 | | 010 | N | $499.50 |
| + | 64623 | Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure) | 3.57 | $298.10 | | 000 | N | $499.50 |
| | 64626 | Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level | 10.63 | $887.61 | | 010 | N | $499.50 |
| + | 64627 | Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure) | 5.09 | $425.02 | | 000 | N | $499.50 |
| | 64630 | Destruction by neurolytic agent; pudendal nerve | 5.68 | $474.28 | | 010 | N | $527.88 |
| | 64640 | Destruction by neurolytic agent; other peripheral nerve or branch | 6.54 | $546.09 | | 010 | N | |
| | 64650 | Chemodenervation of eccrine glands; both axillae | 1.54 | $128.59 | | 000 | N | |
| | 64653 | Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day | 1.77 | $147.80 | | 000 | N | |
| | 64680 | Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus | 8.57 | $715.60 | | 010 | N | $586.43 |
| | 64681 | Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus | 11.85 | $989.48 | | 010 | N | $669.00 |
| | 64702 | Neuroplasty; digital, one or both, same digit | 10.33 | $862.56 | | 090 | N | $499.50 |
| | 64704 | Neuroplasty; nerve of hand or foot | 8.05 | $672.18 | | 090 | Y | $499.50 |
| | 64708 | Neuroplasty, major peripheral nerve, arm or leg; other than specified | 11.28 | $941.88 | | 090 | Y | $669.00 |
| | 64712 | Neuroplasty, major peripheral nerve, arm or leg; sciatic nerve | 12.99 | $1,084.67 | | 090 | Y | $669.00 |
| | 64713 | Neuroplasty, major peripheral nerve, arm or leg; brachial plexus | 18.01 | $1,503.84 | | 090 | Y | $669.00 |
| | 64714 | Neuroplasty, major peripheral nerve, arm or leg; lumbar plexus | 14.96 | $1,249.16 | | 090 | Y | $669.00 |
| | 64716 | Neuroplasty and/or transposition; cranial nerve (specify) | 12.59 | $1,051.27 | | 090 | Y | $765.00 |
| | 64718 | Neuroplasty and/or transposition; ulnar nerve at elbow | 13.46 | $1,123.91 | | 090 | Y | $669.00 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **64719** | Neuroplasty and/or transposition; ulnar nerve at wrist | 9.61 | $802.44 | | 090 | N | $669.00 |
| | **64721** | Neuroplasty and/or transposition; median nerve at carpal tunnel | 10.29 | $977.55 | | 090 | N | $669.00 |
| | **64722** | Decompression; unspecified nerve(s) (specify) | 7.73 | $645.46 | | 090 | Y | $499.50 |
| | **64726** | Decompression; plantar digital nerve | 7.11 | $593.69 | | 090 | N | $499.50 |
| + | **64727** | Internal neurolysis, requiring use of operating microscope (List separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis) | 4.71 | $393.29 | | 000 | N | $499.50 |
| | **64732** | Transection or avulsion of; supraorbital nerve | 9.02 | $753.17 | | 090 | Y | $669.00 |
| | **64734** | Transection or avulsion of; infraorbital nerve | 10.00 | $835.00 | | 090 | N | $669.00 |
| | **64736** | Transection or avulsion of; mental nerve | 9.12 | $761.52 | | 090 | Y | $669.00 |
| | **64738** | Transection or avulsion of; inferior alveolar nerve by osteotomy | 11.24 | $938.54 | | 090 | Y | $669.00 |
| | **64740** | Transection or avulsion of; lingual nerve | 11.14 | $930.19 | | 090 | Y | $669.00 |
| | **64742** | Transection or avulsion of; facial nerve, differential or complete | 11.43 | $954.41 | | 090 | Y | $669.00 |
| | **64744** | Transection or avulsion of; greater occipital nerve | 10.21 | $852.54 | | 090 | Y | $669.00 |
| | **64746** | Transection or avulsion of; phrenic nerve | 10.97 | $916.00 | | 090 | Y | $669.00 |
| | **64752** | Transection or avulsion of; vagus nerve (vagotomy), transthoracic | 11.98 | $1,000.33 | | 090 | Y | |
| | **64755** | Transection or avulsion of; vagus nerves limited to proximal stomach (selective proximal vagotomy, proximal gastric vagotomy, parietal cell vagotomy, supra- or highly selective vagotomy) | 20.97 | $1,751.00 | | 090 | Y | |
| | **64760** | Transection or avulsion of; vagus nerve (vagotomy), abdominal | 11.10 | $926.85 | | 090 | Y | |
| | **64761** | Transection or avulsion of; pudendal nerve | 10.40 | $868.40 | | 090 | Y | |
| | **64763** | Transection or avulsion of obturator nerve, extrapelvic, with or without adductor tenotomy | 12.83 | $1,071.31 | | 090 | Y | |
| | **64766** | Transection or avulsion of obturator nerve, intrapelvic, with or without adductor tenotomy | 14.72 | $1,229.12 | | 090 | Y | |
| | **64771** | Transection or avulsion of other cranial nerve, extradural | 13.94 | $1,163.99 | | 090 | Y | $669.00 |
| | **64772** | Transection or avulsion of other spinal nerve, extradural | 13.39 | $1,118.07 | | 090 | Y | $669.00 |
| | **64774** | Excision of neuroma; cutaneous nerve, surgically identifiable | 9.74 | $813.29 | | 090 | N | $669.00 |
| | **64776** | Excision of neuroma; digital nerve, one or both, same digit | 9.42 | $786.57 | | 090 | N | $765.00 |
| + | **64778** | Excision of neuroma; digital nerve, each additional digit (List separately in addition to code for primary procedure) | 4.69 | $391.62 | | 000 | N | $669.00 |
| | **64782** | Excision of neuroma; hand or foot, except digital nerve | 10.80 | $901.80 | | 090 | N | $765.00 |
| + | **64783** | Excision of neuroma; hand or foot, each additional nerve, except same digit (List separately in addition to code for primary procedure) | 5.58 | $465.93 | | 000 | N | $669.00 |
| | **64784** | Excision of neuroma; major peripheral nerve, except sciatic | 17.32 | $1,446.22 | | 090 | Y | $765.00 |
| | **64786** | Excision of neuroma; sciatic nerve | 26.76 | $2,234.46 | | 090 | Y | $765.00 |
| + | **64787** | Implantation of nerve end into bone or muscle (List separately in addition to neuroma excision) | 6.44 | $537.74 | | 000 | Y | $669.00 |
| | **64788** | Excision of neurofibroma or neurolemmoma; cutaneous nerve | 8.92 | $744.82 | | 090 | N | $765.00 |
| | **64790** | Excision of neurofibroma or neurolemmoma; major peripheral nerve | 20.00 | $1,670.00 | | 090 | Y | $765.00 |
| | **64792** | Excision of neurofibroma or neurolemmoma; extensive (including malignant type) | 25.36 | $2,117.56 | | 090 | Y | $765.00 |
| | **64795** | Biopsy of nerve | 4.76 | $397.46 | | 000 | N | $669.00 |
| | **64802** | Sympathectomy, cervical | 15.41 | $1,286.74 | | 090 | Y | $669.00 |
| | **64804** | Sympathectomy, cervicothoracic | 23.21 | $1,938.04 | | 090 | Y | |
| | **64809** | Sympathectomy, thoracolumbar | 20.62 | $1,721.77 | | 090 | Y | |
| | **64818** | Sympathectomy, lumbar | 16.47 | $1,375.25 | | 090 | Y | |
| | **64820** | Sympathectomy; digital arteries, each digit | 18.19 | $1,518.87 | | 090 | N | |
| | **64821** | Sympathectomy; radial artery | 16.70 | $1,394.45 | | 090 | Y | $945.00 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | 64822 | Sympathectomy; ulnar artery | 16.63 | $1,388.61 | | 090 | Y | |
| | 64823 | Sympathectomy; superficial palmar arch | 19.18 | $1,601.53 | | 090 | Y | |
| | 64831 | Suture of digital nerve, hand or foot; one nerve | 17.61 | $1,470.44 | | 090 | N | $945.00 |
| + | 64832 | Suture of digital nerve, hand or foot; each additional digital nerve (List separately in addition to code for primary procedure) | 8.73 | $728.96 | | 000 | Y | $499.50 |
| | 64834 | Suture of one nerve, hand or foot; common sensory nerve | 18.16 | $1,516.36 | | 090 | Y | $669.00 |
| | 64835 | Suture of one nerve, hand or foot; median motor thenar | 19.79 | $1,652.47 | | 090 | Y | $765.00 |
| | 64836 | Suture of one nerve, hand or foot; ulnar motor | 19.64 | $1,639.94 | | 090 | Y | $765.00 |
| + | 64837 | Suture of each additional nerve, hand or foot (List separately in addition to code for primary procedure) | 9.70 | $809.95 | | 000 | Y | $499.50 |
| | 64840 | Suture of posterior tibial nerve | 21.32 | $1,780.22 | | 090 | Y | $669.00 |
| | 64856 | Suture of major peripheral nerve, arm or leg, except sciatic; including transposition | 24.64 | $2,057.44 | | 090 | Y | $669.00 |
| | 64857 | Suture of major peripheral nerve, arm or leg, except sciatic; without transposition | 25.82 | $2,155.97 | | 090 | Y | $669.00 |
| | 64858 | Suture of sciatic nerve | 29.93 | $2,499.16 | | 090 | Y | $669.00 |
| + | 64859 | Suture of each additional major peripheral nerve (List separately in addition to code for primary procedure) | 6.62 | $552.77 | | 000 | Y | $499.50 |
| | 64861 | Suture of; brachial plexus | 34.11 | $2,848.19 | | 090 | Y | $765.00 |
| | 64862 | Suture of; lumbar plexus | 33.79 | $2,821.47 | | 090 | Y | $765.00 |
| | 64864 | Suture of facial nerve; extracranial | 21.60 | $1,803.60 | | 090 | Y | $765.00 |
| | 64865 | Suture of facial nerve; infratemporal, with or without grafting | 28.51 | $2,380.59 | | 090 | Y | $945.00 |
| | 64866 | Anastomosis; facial-spinal accessory | 30.05 | $2,509.18 | | 090 | Y | |
| | 64868 | Anastomosis; facial-hypoglossal | 25.61 | $2,138.44 | | 090 | Y | |
| | 64870 | Anastomosis; facial-phrenic | 25.22 | $2,105.87 | | 090 | Y | $945.00 |
| + | 64872 | Suture of nerve; requiring secondary or delayed suture (List separately in addition to code for primary neurorrhaphy) | 3.10 | $258.85 | | 000 | Y | $669.00 |
| + | 64874 | Suture of nerve; requiring extensive mobilization, or transposition of nerve (List separately in addition to code for nerve suture) | 4.56 | $380.76 | | 000 | Y | $765.00 |
| + | 64876 | Suture of nerve; requiring shortening of bone of extremity (List separately in addition to code for nerve suture) | 5.00 | $417.50 | | 000 | Y | $765.00 |
| | 64885 | Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length | 28.33 | $2,365.56 | | 090 | Y | $669.00 |
| | 64886 | Nerve graft (includes obtaining graft), head or neck; more than 4 cm length | 33.38 | $2,787.23 | | 090 | Y | $669.00 |
| | 64890 | Nerve graft (includes obtaining graft), single strand, hand or foot; up to 4 cm length | 26.59 | $2,220.27 | | 090 | Y | $669.00 |
| | 64891 | Nerve graft (includes obtaining graft), single strand, hand or foot; more than 4 cm length | 25.32 | $2,114.22 | | 090 | Y | $669.00 |
| | 64892 | Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length | 25.44 | $2,124.24 | | 090 | Y | $669.00 |
| | 64893 | Nerve graft (includes obtaining graft), single strand, arm or leg; more than 4 cm length | 27.55 | $2,300.43 | | 090 | Y | $669.00 |
| | 64895 | Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length | 30.61 | $2,555.94 | | 090 | Y | $765.00 |
| | 64896 | Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length | 34.04 | $2,842.34 | | 090 | Y | $765.00 |
| | 64897 | Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; up to 4 cm length | 30.53 | $2,549.26 | | 090 | Y | $765.00 |
| | 64898 | Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; more than 4 cm length | 33.23 | $2,774.71 | | 090 | Y | $765.00 |
| + | 64901 | Nerve graft, each additional nerve; single strand (List separately in addition to code for primary procedure) | 15.47 | $1,291.75 | | 000 | Y | $669.00 |
| + | 64902 | Nerve graft, each additional nerve; multiple strands (cable) (List separately in addition to code for primary procedure) | 17.74 | $1,481.29 | | 000 | Y | $669.00 |
| | 64905 | Nerve pedicle transfer; first stage | 23.60 | $1,970.60 | | 090 | Y | $669.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **64907** | Nerve pedicle transfer; second stage | 32.05 | $2,676.18 | | 090 | Y | $499.50 |
| **64910** | Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve | 17.03 | $1,422.01 | | 090 | Y | |
| **64911** | Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve | 20.66 | $1,725.11 | | 090 | Y | |
| **64999** | Unlisted procedure, nervous system | 0.00 | BR | | 000 | N | |
| **65091** | Evisceration of ocular contents; without implant | 14.73 | $1,229.96 | | 090 | Y | $765.00 |
| **65093** | Evisceration of ocular contents; with implant | 14.86 | $1,240.81 | | 090 | N | $765.00 |
| **65101** | Enucleation of eye; without implant | 16.83 | $1,405.31 | | 090 | N | $765.00 |
| **65103** | Enucleation of eye; with implant, muscles not attached to implant | 17.54 | $1,464.59 | | 090 | N | $765.00 |
| **65105** | Enucleation of eye; with implant, muscles attached to implant | 19.27 | $1,609.05 | | 090 | Y | $945.00 |
| **65110** | Exenteration of orbit (does not include skin graft), removal of orbital contents; only | 27.86 | $2,326.31 | | 090 | Y | $1,075.50 |
| **65112** | Exenteration of orbit (does not include skin graft), removal of orbital contents; with therapeutic removal of bone | 33.05 | $2,759.68 | | 090 | Y | $1,492.50 |
| **65114** | Exenteration of orbit (does not include skin graft), removal of orbital contents; with muscle or myocutaneous flap | 34.12 | $2,849.02 | | 090 | Y | $1,492.50 |
| **65125** | Modification of ocular implant with placement or replacement of pegs (eg, drilling receptacle for prosthesis appendage) (separate procedure) | 11.35 | $947.73 | | 090 | N | |
| **65130** | Insertion of ocular implant secondary; after evisceration, in scleral shell | 16.62 | $1,387.77 | | 090 | N | $765.00 |
| **65135** | Insertion of ocular implant secondary; after enucleation, muscles not attached to implant | 16.90 | $1,411.15 | | 090 | N | $669.00 |
| **65140** | Insertion of ocular implant secondary; after enucleation, muscles attached to implant | 18.27 | $1,525.55 | | 090 | N | $765.00 |
| **65150** | Reinsertion of ocular implant; with or without conjunctival graft | 13.60 | $1,135.60 | | 090 | Y | $669.00 |
| **65155** | Reinsertion of ocular implant; with use of foreign material for reinforcement and/or attachment of muscles to implant | 19.47 | $1,625.75 | | 090 | N | $765.00 |
| **65175** | Removal of ocular implant | 14.99 | $1,251.67 | | 090 | N | $499.50 |
| **65205** | Removal of foreign body, external eye; conjunctival superficial | 1.30 | $108.55 | | 000 | N | |
| **65210** | Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating | 1.59 | $132.77 | | 000 | N | |
| **65220** | Removal of foreign body, external eye; corneal, without slit lamp | 1.32 | $110.22 | | 000 | N | |
| **65222** | Removal of foreign body, external eye; corneal, with slit lamp | 1.75 | $146.13 | | 000 | N | |
| **65235** | Removal of foreign body, intraocular; from anterior chamber of eye or lens | 15.09 | $1,260.02 | | 090 | Y | $669.00 |
| **65260** | Removal of foreign body, intraocular; from posterior segment, magnetic extraction, anterior or posterior route | 21.14 | $1,765.19 | | 090 | Y | $765.00 |
| **65265** | Removal of foreign body, intraocular; from posterior segment, nonmagnetic extraction | 23.74 | $1,982.29 | | 090 | Y | $945.00 |
| **65270** | Repair of laceration; conjunctiva, with or without nonperforating laceration sclera, direct closure | 6.70 | $559.45 | | 010 | N | $669.00 |
| **65272** | Repair of laceration; conjunctiva, by mobilization and rearrangement, without hospitalization | 11.64 | $971.94 | | 090 | N | $669.00 |
| **65273** | Repair of laceration; conjunctiva, by mobilization and rearrangement, with hospitalization | 8.29 | $692.22 | | 090 | N | |
| **65275** | Repair of laceration; cornea, nonperforating, with or without removal foreign body | 12.13 | $1,012.86 | | 090 | N | $945.00 |
| **65280** | Repair of laceration; cornea and/or sclera, perforating, not involving uveal tissue | 14.56 | $1,215.76 | | 090 | Y | $945.00 |
| **65285** | Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue | 22.74 | $1,898.79 | | 090 | Y | $945.00 |
| **65286** | Repair of laceration; application of tissue glue, wounds of cornea and/or sclera | 16.67 | $1,391.95 | | 090 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **65290** | Repair of wound, extraocular muscle, tendon and/or Tenon's capsule | 10.73 | $895.96 | | 090 | N | $765.00 |
| **65400** | Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium | 15.02 | $1,254.17 | | 090 | N | $499.50 |
| **65410** | Biopsy of cornea | 3.40 | $283.90 | | 000 | N | $669.00 |
| **65420** | Excision or transposition of pterygium; without graft | 12.42 | $1,037.07 | | 090 | N | $669.00 |
| **65426** | Excision or transposition of pterygium; with graft | 15.32 | $1,279.22 | | 090 | N | $1,075.50 |
| **65430** | Scraping of cornea, diagnostic, for smear and/or culture | 2.64 | $220.44 | | 000 | N | |
| **65435** | Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage) | 1.84 | $153.64 | | 000 | N | |
| **65436** | Removal of corneal epithelium; with application of chelating agent (eg, EDTA) | 8.51 | $710.59 | | 090 | N | |
| **65450** | Destruction of lesion of cornea by cryotherapy, photocoagulation or thermocauterization | 7.17 | $598.70 | | 090 | N | |
| **65600** | Multiple punctures of anterior cornea (eg, for corneal erosion, tattoo) | 8.74 | $729.79 | | 090 | N | |
| **65710** | Keratoplasty (corneal transplant); lamellar | 24.33 | $2,031.56 | | 090 | Y | $1,492.50 |
| **65730** | Keratoplasty (corneal transplant); penetrating (except in aphakia) | 26.95 | $2,250.33 | | 090 | Y | $1,492.50 |
| **65750** | Keratoplasty (corneal transplant); penetrating (in aphakia) | 27.43 | $2,290.41 | | 090 | Y | $1,492.50 |
| **65755** | Keratoplasty (corneal transplant); penetrating (in pseudophakia) | 27.25 | $2,275.38 | | 090 | Y | $1,492.50 |
| **65760** | Keratomileusis | 35.05 | $2,926.68 | | 000 | Y | |
| **65765** | Keratophakia | 40.66 | $3,394.94 | | 000 | Y | |
| **65767** | Epikeratoplasty | 37.85 | $3,160.81 | | 000 | Y | |
| **65770** | Keratoprosthesis | 31.29 | $2,612.72 | | 090 | Y | $1,492.50 |
| **65771** | Radial keratotomy | 20.61 | $1,720.85 | | 000 | Y | |
| **65772** | Corneal relaxing incision for correction of surgically induced astigmatism | 10.07 | $840.85 | | 090 | N | $945.00 |
| **65775** | Corneal wedge resection for correction of surgically induced astigmatism | 12.17 | $1,016.20 | | 090 | N | $945.00 |
| **65780** | Ocular surface reconstruction; amniotic membrane transplantation | 19.86 | $1,658.31 | | 090 | Y | $1,075.50 |
| **65781** | Ocular surface reconstruction; limbal stem cell allograft (eg, cadaveric or living donor) | 29.77 | $2,485.80 | | 090 | Y | $1,075.50 |
| **65782** | Ocular surface reconstruction; limbal conjunctival autograft (includes obtaining graft) | 25.73 | $2,148.46 | | 090 | Y | $1,075.50 |
| **65800** | Paracentesis of anterior chamber of eye (separate procedure); with diagnostic aspiration of aqueous | 3.52 | $293.92 | | 000 | N | $499.50 |
| **65805** | Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous | 3.88 | $323.98 | | 000 | N | $499.50 |
| **65810** | Paracentesis of anterior chamber of eye (separate procedure); with removal of vitreous and/or discission of anterior hyaloid membrane, with or without air injection | 10.08 | $841.68 | | 090 | N | $765.00 |
| **65815** | Paracentesis of anterior chamber of eye (separate procedure); with removal of blood, with or without irrigation and/or air injection | 15.05 | $1,256.68 | | 090 | N | $669.00 |
| **65820** | Goniotomy | 17.01 | $1,420.34 | | 090 | Y | $499.50 |
| **65850** | Trabeculotomy ab externo | 18.87 | $1,575.65 | | 090 | N | $945.00 |
| **65855** | Trabeculoplasty by laser surgery, one or more sessions (defined treatment series) | 7.84 | $654.64 | | 010 | N | |
| **65860** | Severing adhesions of anterior segment, laser technique (separate procedure) | 7.26 | $606.21 | | 090 | N | |
| **65865** | Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); goniosynechiae | 10.81 | $902.64 | | 090 | N | $499.50 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **65870** | Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); anterior synechiae, except goniosynechiae | 13.08 | $1,092.18 | | 090 | N | $945.00 |
| | **65875** | Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); posterior synechiae | 13.85 | $1,156.48 | | 090 | N | $945.00 |
| | **65880** | Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); corneovitreal adhesions | 14.62 | $1,220.77 | | 090 | N | $945.00 |
| | **65900** | Removal of epithelial downgrowth, anterior chamber of eye | 21.57 | $1,801.10 | | 090 | Y | $1,075.50 |
| | **65920** | Removal of implanted material, anterior segment of eye | 17.25 | $1,440.38 | | 090 | N | $1,492.50 |
| | **65930** | Removal of blood clot, anterior segment of eye | 14.41 | $1,203.24 | | 090 | N | $1,075.50 |
| | **66020** | Injection, anterior chamber of eye (separate procedure); air or liquid | 4.49 | $374.92 | | 010 | N | $499.50 |
| | **66030** | Injection, anterior chamber of eye (separate procedure); medication | 4.01 | $334.84 | | 010 | N | $499.50 |
| | **66130** | Excision of lesion, sclera | 16.50 | $1,377.75 | | 090 | N | $1,492.50 |
| | **66150** | Fistulization of sclera for glaucoma; trephination with iridectomy | 18.95 | $1,582.33 | | 090 | N | $945.00 |
| | **66155** | Fistulization of sclera for glaucoma; thermocauterization with iridectomy | 18.85 | $1,573.98 | | 090 | N | $945.00 |
| | **66160** | Fistulization of sclera for glaucoma; sclerectomy with punch or scissors, with iridectomy | 21.44 | $1,790.24 | | 090 | N | $669.00 |
| | **66165** | Fistulization of sclera for glaucoma; iridencleisis or iridotasis | 18.50 | $1,544.75 | | 090 | Y | $945.00 |
| | **66170** | Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery | 25.87 | $2,160.15 | | 090 | Y | $945.00 |
| | **66172** | Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents) | 32.37 | $2,702.90 | | 090 | Y | $945.00 |
| | **66180** | Aqueous shunt to extraocular reservoir (eg, Molteno, Schocket, Denver-Krupin) | 25.74 | $2,149.29 | | 090 | Y | $1,075.50 |
| | **66185** | Revision of aqueous shunt to extraocular reservoir | 16.18 | $1,351.03 | | 090 | Y | $669.00 |
| | **66220** | Repair of scleral staphyloma; without graft | 15.63 | $1,305.11 | | 090 | Y | $765.00 |
| | **66225** | Repair of scleral staphyloma; with graft | 20.36 | $1,700.06 | | 090 | Y | $945.00 |
| | **66250** | Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure | 17.67 | $1,475.45 | | 090 | N | $669.00 |
| | **66500** | Iridotomy by stab incision (separate procedure); except transfixion | 8.05 | $672.18 | | 090 | N | $499.50 |
| | **66505** | Iridotomy by stab incision (separate procedure); with transfixion as for iris bombe | 8.77 | $732.30 | | 090 | N | $499.50 |
| | **66600** | Iridectomy, with corneoscleral or corneal section; for removal of lesion | 17.65 | $1,473.78 | | 090 | N | $765.00 |
| | **66605** | Iridectomy, with corneoscleral or corneal section; with cyclectomy | 23.24 | $1,940.54 | | 090 | N | $765.00 |
| | **66625** | Iridectomy, with corneoscleral or corneal section; peripheral for glaucoma (separate procedure) | 9.57 | $799.10 | | 090 | N | $559.41 |
| | **66630** | Iridectomy, with corneoscleral or corneal section; sector for glaucoma (separate procedure) | 12.38 | $1,033.73 | | 090 | N | $765.00 |
| | **66635** | Iridectomy, with corneoscleral or corneal section; optical (separate procedure) | 12.49 | $1,042.92 | | 090 | N | $765.00 |
| | **66680** | Repair of iris, ciliary body (as for iridodialysis) | 11.15 | $931.03 | | 090 | N | $765.00 |
| | **66682** | Suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (eg, McCannel suture) | 13.44 | $1,122.24 | | 090 | N | $669.00 |
| | **66700** | Ciliary body destruction; diathermy | 9.97 | $832.50 | | 090 | N | $669.00 |
| | **66710** | Ciliary body destruction; cyclophotocoagulation, transscleral | 9.85 | $822.48 | | 090 | N | $669.00 |
| | **66711** | Ciliary body destruction; cyclophotocoagulation, endoscopic | 13.72 | $1,145.62 | | 090 | N | $669.00 |
| ⊙ | **66720** | Ciliary body destruction; cryotherapy | 10.35 | $864.23 | | 090 | N | $669.00 |

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|---|---|---|---|---|---|---|---|---|
| | **66740** | Ciliary body destruction; cyclodialysis | 9.77 | $815.80 | | 090 | N | $669.00 |
| | **66761** | Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (one or more sessions) | 10.07 | $840.85 | | 090 | N | |
| | **66762** | Iridoplasty by photocoagulation (one or more sessions) (eg, for improvement of vision, for widening of anterior chamber angle) | 10.51 | $877.59 | | 090 | N | |
| | **66770** | Destruction of cyst or lesion iris or ciliary body (nonexcisional procedure) | 11.64 | $971.94 | | 090 | N | |
| | **66820** | Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler knife) | 9.27 | $774.05 | | 090 | N | |
| | **66821** | Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (one or more stages) | 7.15 | $597.03 | | 090 | N | $468.75 |
| | **66825** | Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure) | 17.14 | $1,431.19 | | 090 | N | $945.00 |
| | **66830** | Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy) | 15.58 | $1,300.93 | | 090 | N | $559.41 |
| | **66840** | Removal of lens material; aspiration technique, one or more stages | 15.26 | $1,274.21 | | 090 | N | $945.00 |
| | **66850** | Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration | 17.31 | $1,445.39 | | 090 | N | $1,492.50 |
| | **66852** | Removal of lens material; pars plana approach, with or without vitrectomy | 18.56 | $1,549.76 | | 090 | N | $945.00 |
| | **66920** | Removal of lens material; intracapsular | 16.58 | $1,384.43 | | 090 | N | $945.00 |
| | **66930** | Removal of lens material; intracapsular, for dislocated lens | 18.79 | $1,568.97 | | 090 | N | $1,075.50 |
| | **66940** | Removal of lens material; extracapsular (other than 66840, 66850, 66852) | 17.09 | $1,427.02 | | 090 | Y | $1,075.50 |
| | **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 | 23.72 | $1,980.62 | | 090 | N | $1,459.50 |
| | **66983** | Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure) | 15.49 | $1,293.42 | | 090 | N | $1,459.50 |
| | **66984** | Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification) | 16.95 | $1,415.33 | | 090 | N | $1,459.50 |
| | **66985** | Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal | 16.55 | $1,381.93 | | 090 | N | $1,239.00 |
| | **66986** | Exchange of intraocular lens | 20.62 | $1,721.77 | | 090 | N | $1,239.00 |
| + | **66990** | Use of ophthalmic endoscope (List separately in addition to code for primary procedure) | 2.09 | $174.52 | | 000 | N | |
| | **66999** | Unlisted procedure, anterior segment of eye | 0.00 | BR | | 000 | N | |
| | **67005** | Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal | 10.31 | $860.89 | | 090 | N | $945.00 |
| | **67010** | Removal of vitreous, anterior approach (open sky technique or limbal incision); subtotal removal with mechanical vitrectomy | 11.94 | $996.99 | | 090 | Y | $945.00 |
| | **67015** | Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy) | 12.96 | $1,082.16 | | 090 | N | $499.50 |
| | **67025** | Injection of vitreous substitute, pars plana or limbal approach, (fluid-gas exchange), with or without aspiration (separate procedure) | 16.40 | $1,369.40 | | 090 | N | $499.50 |
| | **67027** | Implantation of intravitreal drug delivery system (eg, ganciclovir implant), includes concomitant removal of vitreous | 18.75 | $1,565.63 | | 090 | Y | $945.00 |

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|---|---|---|---|---|---|---|---|---|
| | **67028** | Intravitreal injection of a pharmacologic agent (separate procedure) | 4.98 | $415.83 | | 000 | N | |
| | **67030** | Discission of vitreous strands (without removal), pars plana approach | 11.40 | $951.90 | | 090 | Y | $499.50 |
| | **67031** | Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages) | 8.59 | $717.27 | | 090 | N | $468.75 |
| | **67036** | Vitrectomy, mechanical, pars plana approach; | 21.31 | $1,779.39 | | 090 | Y | $945.00 |
| | **67038** | Vitrectomy, mechanical, pars plana approach; with epiretinal membrane stripping | 37.16 | $3,102.86 | | 090 | Y | $1,075.50 |
| | **67039** | Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation | 27.39 | $2,287.07 | | 090 | Y | $1,492.50 |
| | **67040** | Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation | 31.56 | $2,635.26 | | 090 | Y | $1,492.50 |
| | **67101** | Repair of retinal detachment, one or more sessions; cryotherapy or diathermy, with or without drainage of subretinal fluid | 17.14 | $1,431.19 | | 090 | N | |
| | **67105** | Repair of retinal detachment, one or more sessions; photocoagulation, with or without drainage of subretinal fluid | 15.87 | $1,325.15 | | 090 | N | |
| | **67107** | Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation, and drainage of subretinal fluid | 26.63 | $2,223.61 | | 090 | Y | $1,075.50 |
| | **67108** | Repair of retinal detachment; 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 | 35.47 | $2,961.75 | | 090 | Y | $1,492.50 |
| | **67110** | Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy) | 19.44 | $1,623.24 | | 090 | N | |
| | **67112** | Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques | 29.13 | $2,432.36 | | 090 | Y | $1,492.50 |
| | **67115** | Release of encircling material (posterior segment) | 10.67 | $890.95 | | 090 | N | $669.00 |
| | **67120** | Removal of implanted material, posterior segment; extraocular | 14.85 | $1,239.98 | | 090 | N | $669.00 |
| | **67121** | Removal of implanted material, posterior segment; intraocular | 19.81 | $1,654.14 | | 090 | Y | $669.00 |
| | **67141** | Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; cryotherapy, diathermy | 11.46 | $956.91 | | 090 | N | $362.66 |
| | **67145** | Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; photocoagulation (laser or xenon arc) | 11.50 | $960.25 | | 090 | N | |
| | **67208** | Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; cryotherapy, diathermy | 13.14 | $1,097.19 | | 090 | N | |
| | **67210** | Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; photocoagulation | 15.33 | $1,280.06 | | 090 | N | |
| | **67218** | Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; radiation by implantation of source (includes removal of source) | 31.03 | $2,591.01 | | 090 | N | $1,075.50 |
| | **67220** | Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), one or more sessions | 23.64 | $1,973.94 | | 090 | N | |
| | **67221** | Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion) | 7.31 | $610.39 | | 000 | N | |
| + | **67225** | Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment) | 0.69 | $57.62 | | 000 | N | |
| | **67227** | Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; cryotherapy, diathermy | 13.47 | $1,124.75 | | 090 | N | $499.50 |

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|---|---|---|---|---|---|---|---|---|
| | **67228** | Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; photocoagulation (laser or xenon arc) | 24.12 | $2,014.02 | | 090 | N | |
| | **67250** | Scleral reinforcement (separate procedure); without graft | 17.85 | $1,490.48 | | 090 | N | $765.00 |
| | **67255** | Scleral reinforcement (separate procedure); with graft | 19.02 | $1,588.17 | | 090 | Y | $765.00 |
| | **67299** | Unlisted procedure, posterior segment | 0.00 | BR | | 000 | N | |
| | **67311** | Strabismus surgery, recession or resection procedure; one horizontal muscle | 13.15 | $1,098.03 | | 090 | N | $765.00 |
| | **67312** | Strabismus surgery, recession or resection procedure; two horizontal muscles | 15.65 | $1,306.78 | | 090 | N | $945.00 |
| | **67314** | Strabismus surgery, recession or resection procedure; one vertical muscle (excluding superior oblique) | 14.64 | $1,222.44 | | 090 | N | $945.00 |
| | **67316** | Strabismus surgery, recession or resection procedure; two or more vertical muscles (excluding superior oblique) | 17.58 | $1,467.93 | | 090 | Y | $945.00 |
| | **67318** | Strabismus surgery, any procedure, superior oblique muscle | 15.34 | $1,280.89 | | 090 | N | $945.00 |
| + | **67320** | Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify) (List separately in addition to code for primary procedure) | 7.06 | $589.51 | | 000 | N | $945.00 |
| + | **67331** | Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (List separately in addition to code for primary procedure) | 6.68 | $557.78 | | 000 | N | $945.00 |
| + | **67332** | Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy) (List separately in addition to code for primary procedure) | 7.28 | $607.88 | | 000 | Y | $945.00 |
| + | **67334** | Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure) | 6.56 | $547.76 | | 000 | N | $945.00 |
| + | **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) | 3.45 | $288.08 | | 000 | N | $945.00 |
| + | **67340** | Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to code for primary procedure) | 7.87 | $657.15 | | 000 | Y | $945.00 |
| | **67343** | Release of extensive scar tissue without detaching extraocular muscle (separate procedure) | 14.29 | $1,193.22 | | 090 | Y | $1,492.50 |
| | **67345** | Chemodenervation of extraocular muscle | 5.36 | $447.56 | | 010 | N | |
| | **67346** | Biopsy of extraocular muscle | 4.56 | $380.76 | | 000 | Y | $499.50 |
| | **67399** | Unlisted procedure, ocular muscle | 0.00 | BR | | 000 | N | |
| | **67400** | Orbitotomy without bone flap (frontal or transconjunctival approach); for exploration, with or without biopsy | 21.32 | $1,780.22 | | 090 | Y | $765.00 |
| | **67405** | Orbitotomy without bone flap (frontal or transconjunctival approach); with drainage only | 17.99 | $1,502.17 | | 090 | Y | $945.00 |
| | **67412** | Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of lesion | 20.05 | $1,674.18 | | 090 | Y | $1,075.50 |
| | **67413** | Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of foreign body | 19.90 | $1,661.65 | | 090 | Y | $1,075.50 |
| | **67414** | Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of bone for decompression | 28.70 | $2,396.45 | | 090 | Y | |
| | **67415** | Fine needle aspiration of orbital contents | 2.40 | $200.40 | | 000 | N | $499.50 |
| | **67420** | Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of lesion | 37.33 | $3,117.06 | | 090 | Y | $1,075.50 |
| | **67430** | Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of foreign body | 28.70 | $2,396.45 | | 090 | Y | $1,075.50 |
| | **67440** | Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with drainage | 27.55 | $2,300.43 | | 090 | Y | $1,075.50 |
| | **67445** | Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of bone for decompression | 31.56 | $2,635.26 | | 090 | Y | $1,075.50 |

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|---|---|---|---|---|---|---|---|
| **67450** | Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); for exploration, with or without biopsy | 28.47 | $2,377.25 | | 090 | Y | $1,075.50 |
| **67500** | Retrobulbar injection; medication (separate procedure, does not include supply of medication) | 2.01 | $167.84 | | 000 | N | |
| **67505** | Retrobulbar injection; alcohol | 1.84 | $153.64 | | 000 | N | |
| **67515** | Injection of medication or other substance into Tenon's capsule | 1.94 | $161.99 | | 000 | N | |
| **67550** | Orbital implant (implant outside muscle cone); insertion | 22.09 | $1,844.52 | | 090 | N | $945.00 |
| **67560** | Orbital implant (implant outside muscle cone); removal or revision | 22.40 | $1,870.40 | | 090 | N | $669.00 |
| **67570** | Optic nerve decompression (eg, incision or fenestration of optic nerve sheath) | 26.50 | $2,212.75 | | 090 | Y | $945.00 |
| **67599** | Unlisted procedure, orbit | 0.00 | BR | | 000 | N | |
| **67700** | Blepharotomy, drainage of abscess, eyelid | 6.92 | $577.82 | | 010 | N | |
| **67710** | Severing of tarsorrhaphy | 5.96 | $497.66 | | 010 | N | |
| **67715** | Canthotomy (separate procedure) | 6.18 | $516.03 | | 010 | N | $499.50 |
| **67800** | Excision of chalazion; single | 2.90 | $242.15 | | 010 | N | |
| **67801** | Excision of chalazion; multiple, same lid | 3.70 | $308.95 | | 010 | N | |
| **67805** | Excision of chalazion; multiple, different lids | 4.58 | $382.43 | | 010 | N | |
| **67808** | Excision of chalazion; under general anesthesia and/or requiring hospitalization, single or multiple | 7.97 | $665.50 | | 090 | N | $669.00 |
| **67810** | Biopsy of eyelid | 4.88 | $407.48 | | 000 | N | |
| **67820** | Correction of trichiasis; epilation, by forceps only | 1.25 | $104.38 | | 000 | N | |
| **67825** | Correction of trichiasis; epilation by other than forceps (eg, by electrosurgery, cryotherapy, laser surgery) | 2.99 | $249.67 | | 010 | N | |
| **67830** | Correction of trichiasis; incision of lid margin | 6.80 | $567.80 | | 010 | N | $669.00 |
| **67835** | Correction of trichiasis; incision of lid margin, with free mucous membrane graft | 9.85 | $822.48 | | 090 | N | $669.00 |
| **67840** | Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure | 7.05 | $588.68 | | 010 | N | |
| **67850** | Destruction of lesion of lid margin (up to 1 cm) | 4.97 | $415.00 | | 010 | N | |
| **67875** | Temporary closure of eyelids by suture (eg, Frost suture) | 4.37 | $364.90 | | 000 | N | |
| **67880** | Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy; | 10.57 | $882.60 | | 090 | N | $765.00 |
| **67882** | Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy; with transposition of tarsal plate | 12.90 | $1,077.15 | | 090 | N | $765.00 |
| **67900** | Repair of brow ptosis (supraciliary, mid-forehead or coronal approach) | 15.09 | $1,260.02 | | 090 | N | $945.00 |
| **67901** | Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia) | 13.63 | $1,138.11 | | 090 | N | $1,075.50 |
| **67902** | Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia) | 15.07 | $1,258.35 | | 090 | N | $1,075.50 |
| **67903** | Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach | 15.13 | $1,263.36 | | 090 | N | $945.00 |
| **67904** | Repair of blepharoptosis; (tarso) levator resection or advancement, external approach | 16.79 | $1,401.97 | | 090 | N | $945.00 |
| **67906** | Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia) | 11.56 | $965.26 | | 090 | N | $1,075.50 |
| **67908** | Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type) | 11.36 | $948.56 | | 090 | N | $945.00 |
| **67909** | Reduction of overcorrection of ptosis | 12.85 | $1,072.98 | | 090 | N | $945.00 |
| **67911** | Correction of lid retraction | 11.86 | $990.31 | | 090 | N | $765.00 |
| **67912** | Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight) | 23.37 | $1,951.40 | | 090 | N | $765.00 |
| **67914** | Repair of ectropion; suture | 9.50 | $793.25 | | 090 | N | $765.00 |
| **67915** | Repair of ectropion; thermocauterization | 8.67 | $723.95 | | 090 | N | |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| 67916 | Repair of ectropion; excision tarsal wedge | 12.79 | $1,067.97 | | 090 | N | $945.00 |
| 67917 | Repair of ectropion; extensive (eg, tarsal strip operations) | 13.91 | $1,161.49 | | 090 | N | $945.00 |
| 67921 | Repair of entropion; suture | 9.08 | $758.18 | | 090 | N | $765.00 |
| 67922 | Repair of entropion; thermocauterization | 8.48 | $708.08 | | 090 | N | |
| 67923 | Repair of entropion; excision tarsal wedge | 13.40 | $1,118.90 | | 090 | N | $945.00 |
| 67924 | Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation) | 14.03 | $1,171.51 | | 090 | N | $945.00 |
| 67930 | Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva direct closure; partial thickness | 8.86 | $739.81 | | 010 | N | |
| 67935 | Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva direct closure; full thickness | 14.17 | $1,183.20 | | 090 | N | $669.00 |
| 67938 | Removal of embedded foreign body, eyelid | 6.29 | $525.22 | | 010 | N | |
| 67950 | Canthoplasty (reconstruction of canthus) | 13.83 | $1,154.81 | | 090 | N | $669.00 |
| 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 | 13.77 | $1,149.80 | | 090 | Y | $765.00 |
| 67966 | 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; over one-fourth of lid margin | 17.25 | $1,440.38 | | 090 | N | $765.00 |
| 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 | 16.49 | $1,376.92 | | 090 | Y | $765.00 |
| 67973 | Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, lower, one stage or first stage | 21.43 | $1,789.41 | | 090 | Y | $765.00 |
| 67974 | Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, upper, one stage or first stage | 21.34 | $1,781.89 | | 090 | Y | $765.00 |
| 67975 | Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; second stage | 15.56 | $1,299.26 | | 090 | N | $765.00 |
| 67999 | Unlisted procedure, eyelids | 0.00 | BR | | 000 | N | |
| 68020 | Incision of conjunctiva, drainage of cyst | 2.69 | $224.62 | | 010 | N | |
| 68040 | Expression of conjunctival follicles (eg, for trachoma) | 1.49 | $124.42 | | 000 | N | |
| 68100 | Biopsy of conjunctiva | 4.32 | $360.72 | | 000 | N | |
| 68110 | Excision of lesion, conjunctiva; up to 1 cm | 5.56 | $464.26 | | 010 | N | |
| 68115 | Excision of lesion, conjunctiva; over 1 cm | 7.84 | $654.64 | | 010 | N | $669.00 |
| 68130 | Excision of lesion, conjunctiva; with adjacent sclera | 12.98 | $1,083.83 | | 090 | N | $669.00 |
| 68135 | Destruction of lesion, conjunctiva | 3.53 | $294.76 | | 010 | N | |
| 68200 | Subconjunctival injection | 0.98 | $81.83 | | 000 | N | |
| 68320 | Conjunctivoplasty; with conjunctival graft or extensive rearrangement | 16.88 | $1,409.48 | | 090 | N | $945.00 |
| 68325 | Conjunctivoplasty; with buccal mucous membrane graft (includes obtaining graft) | 14.48 | $1,209.08 | | 090 | N | $945.00 |
| 68326 | Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement | 14.09 | $1,176.52 | | 090 | N | $945.00 |
| 68328 | Conjunctivoplasty, reconstruction cul-de-sac; with buccal mucous membrane graft (includes obtaining graft) | 16.01 | $1,336.84 | | 090 | N | $945.00 |
| 68330 | Repair of symblepharon; conjunctivoplasty, without graft | 14.27 | $1,191.55 | | 090 | N | $945.00 |
| 68335 | Repair of symblepharon; with free graft conjunctiva or buccal mucous membrane (includes obtaining graft) | 14.13 | $1,179.86 | | 090 | N | $945.00 |
| 68340 | Repair of symblepharon; division of symblepharon, with or without insertion of conformer or contact lens | 12.98 | $1,083.83 | | 090 | N | $945.00 |
| 68360 | Conjunctival flap; bridge or partial (separate procedure) | 12.44 | $1,038.74 | | 090 | N | $669.00 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **68362** | Conjunctival flap; total (such as Gunderson thin flap or purse string flap) | 14.28 | $1,192.38 | | 090 | N | $669.00 |
| **68371** | Harvesting conjunctival allograft, living donor | 9.52 | $794.92 | | 010 | N | $669.00 |
| **68399** | Unlisted procedure, conjunctiva | 0.00 | BR | | 000 | N | |
| **68400** | Incision, drainage of lacrimal gland | 7.15 | $597.03 | | 010 | N | |
| **68420** | Incision, drainage of lacrimal sac (dacryocystotomy or dacryocystostomy) | 8.02 | $669.67 | | 010 | N | |
| **68440** | Snip incision of lacrimal punctum | 2.79 | $232.97 | | 010 | N | |
| **68500** | Excision of lacrimal gland (dacryoadenectomy), except for tumor; total | 21.35 | $1,782.73 | | 090 | N | $765.00 |
| **68505** | Excision of lacrimal gland (dacryoadenectomy), except for tumor; partial | 22.00 | $1,837.00 | | 090 | N | $765.00 |
| **68510** | Biopsy of lacrimal gland | 11.21 | $936.04 | | 000 | N | $499.50 |
| **68520** | Excision of lacrimal sac (dacryocystectomy) | 15.34 | $1,280.89 | | 090 | N | $765.00 |
| **68525** | Biopsy of lacrimal sac | 6.14 | $512.69 | | 000 | N | $499.50 |
| **68530** | Removal of foreign body or dacryolith, lacrimal passages | 11.04 | $921.84 | | 010 | N | |
| **68540** | Excision of lacrimal gland tumor; frontal approach | 20.50 | $1,711.75 | | 090 | N | $765.00 |
| **68550** | Excision of lacrimal gland tumor; involving osteotomy | 25.34 | $2,115.89 | | 090 | N | $765.00 |
| **68700** | Plastic repair of canaliculi | 13.16 | $1,098.86 | | 090 | N | $669.00 |
| **68705** | Correction of everted punctum, cautery | 5.88 | $490.98 | | 010 | N | |
| **68720** | Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity) | 16.93 | $1,413.66 | | 090 | Y | $945.00 |
| **68745** | Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); without tube | 17.02 | $1,421.17 | | 090 | Y | $945.00 |
| **68750** | Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); with insertion of tube or stent | 17.44 | $1,456.24 | | 090 | Y | $945.00 |
| **68760** | Closure of the lacrimal punctum; by thermocauterization, ligation, or laser surgery | 4.98 | $415.83 | | 010 | N | |
| **68761** | Closure of the lacrimal punctum; by plug, each | 3.47 | $289.75 | | 010 | N | |
| **68770** | Closure of lacrimal fistula (separate procedure) | 11.50 | $960.25 | | 090 | N | $945.00 |
| **68801** | Dilation of lacrimal punctum, with or without irrigation | 2.82 | $235.47 | | 010 | N | |
| **68810** | Probing of nasolacrimal duct, with or without irrigation; | 6.09 | $508.52 | | 010 | N | $197.79 |
| **68811** | Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia | 4.64 | $387.44 | | 010 | N | $669.00 |
| **68815** | Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent | 10.90 | $910.15 | | 010 | N | $669.00 |
| **68840** | Probing of lacrimal canaliculi, with or without irrigation | 2.79 | $232.97 | | 010 | N | |
| **68850** | Injection of contrast medium for dacryocystography | 1.59 | $132.77 | | 000 | N | |
| **68899** | Unlisted procedure, lacrimal system | 0.00 | BR | | 000 | N | |
| **69000** | Drainage external ear, abscess or hematoma; simple | 4.28 | $357.38 | | 010 | N | |
| **69005** | Drainage external ear, abscess or hematoma; complicated | 4.98 | $415.83 | | 010 | N | |
| **69020** | Drainage external auditory canal, abscess | 5.43 | $453.41 | | 010 | N | |
| **69090** | Ear piercing | 0.70 | $58.53 | | 000 | N | |
| **69100** | Biopsy external ear | 2.51 | $209.59 | | 000 | N | |
| **69105** | Biopsy external auditory canal | 3.21 | $268.04 | | 000 | N | |
| **69110** | Excision external ear; partial, simple repair | 10.38 | $866.73 | | 090 | N | $499.50 |
| **69120** | Excision external ear; complete amputation | 9.96 | $831.66 | | 090 | N | $669.00 |
| **69140** | Excision exostosis(es), external auditory canal | 20.93 | $1,747.66 | | 090 | N | $669.00 |
| **69145** | Excision soft tissue lesion, external auditory canal | 8.56 | $714.76 | | 090 | N | $669.00 |
| **69150** | Radical excision external auditory canal lesion; without neck dissection | 26.07 | $2,176.85 | | 090 | N | $696.23 |
| **69155** | Radical excision external auditory canal lesion; with neck dissection | 41.08 | $3,430.18 | | 090 | Y | |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **69200** | Removal foreign body from external auditory canal; without general anesthesia | 3.04 | $253.84 | | 000 | N | |
| | **69205** | Removal foreign body from external auditory canal; with general anesthesia | 2.49 | $207.92 | | 010 | N | $499.50 |
| | **69210** | Removal impacted cerumen (separate procedure), one or both ears | 1.21 | $101.04 | | 000 | N | |
| | **69220** | Debridement, mastoidectomy cavity, simple (eg, routine cleaning) | 3.19 | $266.37 | | 000 | N | |
| | **69222** | Debridement, mastoidectomy cavity, complex (eg, with anesthesia or more than routine cleaning) | 5.21 | $435.04 | | 010 | N | |
| ⊙ | **69300** | Otoplasty, protruding ear, with or without size reduction | 12.35 | $1,031.23 | | 000 | N | $765.00 |
| | **69310** | Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to injury, infection) (separate procedure) | 26.40 | $2,204.40 | | 090 | N | $765.00 |
| | **69320** | Reconstruction external auditory canal for congenital atresia, single stage | 37.65 | $3,143.78 | | 090 | Y | $1,492.50 |
| | **69399** | Unlisted procedure, external ear | 0.00 | BR | | 000 | N | |
| | **69400** | Eustachian tube inflation, transnasal; with catheterization | 3.09 | $258.02 | | 000 | N | |
| | **69401** | Eustachian tube inflation, transnasal; without catheterization | 1.92 | $160.32 | | 000 | N | |
| | **69405** | Eustachian tube catheterization, transtympanic | 6.07 | $506.85 | | 010 | N | |
| | **69420** | Myringotomy including aspiration and/or eustachian tube inflation | 4.45 | $371.58 | | 010 | N | |
| | **69421** | Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia | 3.77 | $314.80 | | 010 | N | $765.00 |
| | **69424** | Ventilating tube removal requiring general anesthesia | 3.01 | $251.34 | | 000 | N | |
| | **69433** | Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia | 4.61 | $384.94 | | 010 | N | |
| | **69436** | Tympanostomy (requiring insertion of ventilating tube), general anesthesia | 4.12 | $344.02 | | 010 | N | $765.00 |
| | **69440** | Middle ear exploration through postauricular or ear canal incision | 16.14 | $1,347.69 | | 090 | N | $765.00 |
| | **69450** | Tympanolysis, transcanal | 12.53 | $1,046.26 | | 090 | N | $499.50 |
| | **69501** | Transmastoid antrotomy (simple mastoidectomy) | 17.66 | $1,474.61 | | 090 | N | $1,492.50 |
| | **69502** | Mastoidectomy; complete | 23.42 | $1,955.57 | | 090 | N | $1,492.50 |
| | **69505** | Mastoidectomy; modified radical | 29.42 | $2,456.57 | | 090 | N | $1,492.50 |
| | **69511** | Mastoidectomy; radical | 30.16 | $2,518.36 | | 090 | N | $1,492.50 |
| | **69530** | Petrous apicectomy including radical mastoidectomy | 40.51 | $3,382.59 | | 090 | Y | $1,492.50 |
| | **69535** | Resection temporal bone, external approach | 66.55 | $5,556.93 | | 090 | Y | |
| | **69540** | Excision aural polyp | 4.91 | $409.99 | | 010 | N | |
| | **69550** | Excision aural glomus tumor; transcanal | 25.26 | $2,109.21 | | 090 | Y | $1,075.50 |
| | **69552** | Excision aural glomus tumor; transmastoid | 38.99 | $3,255.67 | | 090 | Y | $1,492.50 |
| | **69554** | Excision aural glomus tumor; extended (extratemporal) | 63.48 | $5,300.58 | | 090 | Y | |
| | **69601** | Revision mastoidectomy; resulting in complete mastoidectomy | 25.29 | $2,111.72 | | 090 | N | $1,492.50 |
| | **69602** | Revision mastoidectomy; resulting in modified radical mastoidectomy | 26.22 | $2,189.37 | | 090 | N | $1,492.50 |
| | **69603** | Revision mastoidectomy; resulting in radical mastoidectomy | 31.37 | $2,619.40 | | 090 | N | $1,492.50 |
| | **69604** | Revision mastoidectomy; resulting in tympanoplasty | 27.02 | $2,256.17 | | 090 | N | $1,492.50 |
| | **69605** | Revision mastoidectomy; with apicectomy | 38.32 | $3,199.72 | | 090 | Y | $1,492.50 |
| | **69610** | Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch | 9.64 | $804.94 | | 010 | N | |
| | **69620** | Myringoplasty (surgery confined to drumhead and donor area) | 16.69 | $1,393.62 | | 090 | N | $669.00 |
| | **69631** | Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction | 20.78 | $1,735.13 | | 090 | N | $1,075.50 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|
| **69632** | Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg, postfenestration) | 25.72 | $2,147.62 | | 090 | N | $1,075.50 |
| **69633** | Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis (PORP), total ossicular replacement prosthesis (TORP) | 24.73 | $2,064.96 | | 090 | N | $1,075.50 |
| **69635** | Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction | 29.42 | $2,456.57 | | 090 | N | $1,492.50 |
| **69636** | Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction | 33.65 | $2,809.78 | | 090 | N | $1,492.50 |
| **69637** | Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis (PORP), total ossicular replacement prosthesis (TORP) | 33.47 | $2,794.75 | | 090 | N | $1,492.50 |
| **69641** | Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction | 24.97 | $2,085.00 | | 090 | N | $1,492.50 |
| **69642** | Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction | 32.34 | $2,700.39 | | 090 | N | $1,492.50 |
| **69643** | Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction | 29.50 | $2,463.25 | | 090 | N | $1,492.50 |
| **69644** | Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction | 36.36 | $3,036.06 | | 090 | N | $1,492.50 |
| **69645** | Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction | 35.54 | $2,967.59 | | 090 | N | $1,492.50 |
| **69646** | Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction | 37.83 | $3,158.81 | | 090 | N | $1,492.50 |
| **69650** | Stapes mobilization | 19.13 | $1,597.36 | | 090 | N | $1,492.50 |
| **69660** | Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material; | 22.50 | $1,878.75 | | 090 | N | $1,075.50 |
| **69661** | Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material; with footplate drill out | 29.59 | $2,470.77 | | 090 | N | $1,075.50 |
| **69662** | Revision of stapedectomy or stapedotomy | 28.36 | $2,368.06 | | 090 | N | $1,075.50 |
| **69666** | Repair oval window fistula | 19.33 | $1,614.06 | | 090 | N | $945.00 |
| **69667** | Repair round window fistula | 19.33 | $1,614.06 | | 090 | N | $945.00 |
| **69670** | Mastoid obliteration (separate procedure) | 22.73 | $1,897.96 | | 090 | Y | $765.00 |
| **69676** | Tympanic neurectomy | 19.93 | $1,664.16 | | 090 | N | $765.00 |
| **69700** | Closure postauricular fistula, mastoid (separate procedure) | 16.99 | $1,418.67 | | 090 | N | $765.00 |
| **69710** | Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone | 0.00 | BR | | 000 | N | |
| **69711** | Removal or repair of electromagnetic bone conduction hearing device in temporal bone | 20.75 | $1,732.63 | | 090 | Y | $499.50 |
| **69714** | Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy | 26.18 | $2,186.03 | | 090 | N | $2,008.50 |
| **69715** | Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy | 32.70 | $2,730.45 | | 090 | Y | $2,008.50 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | ASC Amount |
|---|---|---|---|---|---|---|---|---|
| | **69717** | Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy | 28.36 | $2,368.06 | | 090 | Y | $2,008.50 |
| | **69718** | Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy | 36.92 | $3,082.82 | | 090 | Y | $2,008.50 |
| | **69720** | Decompression facial nerve, intratemporal; lateral to geniculate ganglion | 28.38 | $2,369.73 | | 090 | Y | $1,075.50 |
| | **69725** | Decompression facial nerve, intratemporal; including medial to geniculate ganglion | 46.38 | $3,872.73 | | 090 | Y | |
| | **69740** | Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion | 28.71 | $2,397.29 | | 090 | Y | $1,075.50 |
| | **69745** | Suture facial nerve, intratemporal, with or without graft or decompression; including medial to geniculate ganglion | 30.59 | $2,554.27 | | 090 | Y | $1,075.50 |
| | **69799** | Unlisted procedure, middle ear | 0.00 | BR | | 000 | N | |
| | **69801** | Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); transcanal | 17.74 | $1,481.29 | | 090 | Y | $1,075.50 |
| | **69802** | Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); with mastoidectomy | 25.01 | $2,088.34 | | 090 | Y | $1,492.50 |
| | **69805** | Endolymphatic sac operation; without shunt | 25.61 | $2,138.44 | | 090 | Y | $1,492.50 |
| | **69806** | Endolymphatic sac operation; with shunt | 22.92 | $1,913.82 | | 090 | N | $1,492.50 |
| | **69820** | Fenestration semicircular canal | 21.14 | $1,765.19 | | 090 | Y | $1,075.50 |
| | **69840** | Revision fenestration operation | 22.88 | $1,910.48 | | 090 | Y | $1,075.50 |
| | **69905** | Labyrinthectomy; transcanal | 21.99 | $1,836.17 | | 090 | N | $1,492.50 |
| | **69910** | Labyrinthectomy; with mastoidectomy | 24.91 | $2,079.99 | | 090 | N | $1,492.50 |
| | **69915** | Vestibular nerve section, translabyrinthine approach | 37.81 | $3,157.14 | | 090 | Y | $1,492.50 |
| | **69930** | Cochlear device implantation, with or without mastoidectomy | 31.25 | $2,609.38 | | 090 | Y | $1,492.50 |
| | **69949** | Unlisted procedure, inner ear | 0.00 | BR | | 000 | N | |
| | **69950** | Vestibular nerve section, transcranial approach | 45.03 | $3,760.01 | | 090 | Y | |
| | **69955** | Total facial nerve decompression and/or repair (may include graft) | 49.20 | $4,108.20 | | 090 | Y | |
| | **69960** | Decompression internal auditory canal | 47.42 | $3,959.57 | | 090 | Y | |
| | **69970** | Removal of tumor, temporal bone | 53.36 | $4,455.56 | | 090 | Y | |
| | **69979** | Unlisted procedure, temporal bone, middle fossa approach | 0.00 | BR | | 000 | N | |
| + | **69990** | Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure) | 5.67 | $473.45 | | 000 | Y | |

# Radiology

## I. Scope

The following guidelines apply to radiology services provided in offices, clinics, and under some circumstances in hospital x-ray departments. This section also contains guidelines that include nuclear medicine and diagnostic ultrasound.

## II. Guidelines

A. **Total Component**
A total fee includes both the professional component for the radiologist and the technical component needed to accomplish the procedure. Explanations of the professional component and the technical component are listed below. The values as listed in the Amount column represent the total reimbursement.

B. **Professional Component**
The professional component represents the reimbursement allowance of the professional radiological services of the physician and is identified by the use of modifier 26. This includes examination of the patient when indicated, performance or supervision of the procedure, interpretation and written report of the examination, and consultation with the referring physician. In the majority of hospital radiology departments, the radiologist submits a separate statement to the patient for professional services rendered, which are listed as the professional component. Values in the PC Amount column are intended for the services of a radiologist for the professional component only and do not include any other charges. To identify a charge for a professional component only, use the five-digit code followed by modifier 26.

C. **Technical Component**
The technical component includes charges made by the institution or clinic to cover the services of technologists and other staff members, the film, contrast media, chemicals and other materials, and the use of the space and facilities of the x-ray department. To identify a charge for a technical component only, use the five-digit code followed by HCPCS Level II modifier TC.

D. **Review of X-rays**
Billing code 76140 is not appropriate in the following circumstances because review of the x- rays is inherent to the evaluation and management code:

- The physician, during the course of an office visit or consultation, reviews an x-ray made elsewhere.
- The treating or consulting physician reviews x-rays at an emergency room or hospital visit.
- CPT code 76140 Consultation on x-ray examination made elsewhere, written report, will only be paid when there is a documented need for the service and when performed by a radiologist or physician certified to perform radiological services.

E. **Additional X-rays**
No payment shall be made for additional x-rays when recent x-rays are available except when supported by adequate information regarding the need to retake x-rays. The use of photographic media and/or imaging is not reported separately, but is considered to be a component of the basic procedure and shall not merit any additional payment.

F. **Contrast Material**

1. Complete procedures, interventional radiological procedures, or diagnostic studies involving injection of contrast media include all usual pre-injection and post-injection services (e.g., necessary local anesthesia, placement of needle catheter, injection of contrast media, supervision of the study, and interpretation of results).
2. Low osmolar contrast material and paramagnetic contrast materials shall only be billed when not included in the descriptor of the procedure. When appropriately billed, the contrast media is reimbursed according to the maximum reimbursement allowance rate (MRA) listed in the HCPCS section of the Fee Schedule. Supplies should be billed with the appropriate HCPCS Level

II code and will be reimbursed according to the Fee Schedule.

3. When contrast can be administered orally (upper G.I.) or rectally (barium enema), the administration is included as part of the procedure.
4. When an intravenous line is placed simply for access in the event of a problem with a procedure or for administration of contrast, it is considered part of the procedure and does not command a separate fee.

G. **Urologic Procedures**
In the case of urologic procedures (e.g., CPT codes 74400–74485), insertion of a urethral catheter is part of the procedure and is not separately billed.

H. **Separate or Multiple Procedures**
1. When multiple procedures are performed on the same day or at the same session, it is appropriate to designate them by separate entries. Surgical procedures performed in conjunction with a radiology procedure will be subject to the rules and regulations of the Surgery section.
2. When x-rays of multiple sections of a body area are billed separately, the total reimbursement must not exceed the maximum reimbursement allowance of the complete body area.

I. **Outpatient CT Scans and MRIs**
CT scans and MRIs, when performed on an outpatient basis, are subject to the limitations of the fee schedule, regardless of site of service.

J. **Unlisted Service or Procedure**
A service or procedure may be provided that is not listed in the most recent edition of the CPT book. When reporting such a service, the appropriate unlisted procedure code may be used to indicate the service, identifying it by special report. The unlisted procedures and accompanying codes are as follows:

76496 Unlisted fluoroscopic procedure (eg, diagnostic, interventional)

76497 Unlisted computed tomography procedure (eg, diagnostic, interventional)

76498 Unlisted magnetic resonance procedure (eg, diagnostic, interventional)

76499 Unlisted diagnostic radiographic procedure

76999 Unlisted diagnostic ultrasound procedure

77299 Unlisted procedure, therapeutic radiolog, clinical treatment planning

77399 Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services

77499 Unlisted procedure, therapeutic radiology treatment management

77799 Unlisted procedure, clinical brachytherapy

78099 Unlisted endocrine procedure, diagnostic nuclear medicine

78199 Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine

78299 Unlisted gastrointestinal procedure, diagnostic nuclear medicine

78399 Unlisted musculoskeletal procedure, diagnostic nuclear medicine

78499 Unlisted cardiovascular procedure, diagnostic nuclear medicine

78599 Unlisted respiratory procedure, diagnostic nuclear medicine

78699 Unlisted nervous system procedure, diagnostic nuclear medicine

78799 Unlisted genitourinary procedure, diagnostic nuclear medicine

78999 Unlisted miscellaneous procedure, diagnostic nuclear medicine

79999 Unlisted radiopharmaceutical therapeutic procedure

K. **Special 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. Special reports to justify the necessity of a service do not warrant a separate fee.

L. **By Report (BR)**
"BR" in the Amount column indicates services that are too new, unusual, or variable in the nature of their performance to permit the assignment of a definable fee. Such services should be substantiated by documentation submitted with the bill. Sufficient information should be included to permit proper identification and a sound evaluation. If the service is justified by the report, the actual charge shall be paid in full, unless the payer has evidence that the actual charge exceeds the usual and customary charge for such service.

M. **Radiology Supervision and Interpretation Procedures**
There are times when a single physician may perform the procedure and supervise the imaging and interpretation. On other occasions, one physician may perform the procedure, and the imaging supervision with interpretation may be performed by another physician. The appropriate radiology codes are to be used for supervision and interpretation of the imaging. The appropriate surgical codes are to be used for the procedure, including necessary local anesthesia, placement of needle or catheters, injection of contrast media, etc. The surgical codes are subject to the rules and regulations of the Surgery section, and the radiology codes are subject to this section of radiology rules and regulations.

N. **Written Report(s)**
A written report, signed by the interpreting physician, should be considered an integral part of a radiological procedure or interpretation.

O. **Facility Fee**
The facility fee is the Amount increased by ten percent (10%).

## III. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier code. The modifier may be reported by a two-digit number placed after the usual procedure number, separated by a hyphen. If more than one modifier is used, place the multiple modifiers code 99 immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in radiology (including nuclear medicine and diagnostic ultrasound) are as follows:

### *22 Unusual Procedural Services*

When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

*Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.*

### *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 modifier 26 to the usual procedure number.

### *TC Technical Component (HCPCS Level II Modifier)*

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

*Mississippi's note: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.*

### *32 Mandated Service*

Services related to mandated consultation and/or related services (e.g., PRO, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

### *51 Multiple Procedures*

When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see the applicable CPT book).

### *52 Reduced Services*

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

### *53 Discontinued Procedure*

Under certain circumstances the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the

patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

### *76 Repeat Procedure by Same Physician*

The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

### *77 Repeat Procedure by Another Physician*

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 procedure/service.

### *99 Multiple Modifiers*

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

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **70010** | Myelography, posterior fossa, radiological supervision and interpretation | 5.54 | $351.79 | $120.27 | 000 | N | $386.97 |
| **70015** | Cisternography, positive contrast, radiological supervision and interpretation | 3.21 | $203.84 | $110.07 | 000 | N | $224.22 |
| **70030** | Radiologic examination, eye, for detection of foreign body | 0.69 | $43.82 | $15.34 | 000 | N | $48.20 |
| **70100** | Radiologic examination, mandible; partial, less than four views | 0.78 | $49.53 | $15.85 | 000 | N | $54.48 |
| **70110** | Radiologic examination, mandible; complete, minimum of four views | 0.99 | $62.87 | $21.38 | 000 | N | $69.16 |
| **70120** | Radiologic examination, mastoids; less than three views per side | 0.89 | $56.52 | $15.26 | 000 | N | $62.17 |
| **70130** | Radiologic examination, mastoids; complete, minimum of three views per side | 1.33 | $84.46 | $30.41 | 000 | N | $92.91 |
| **70134** | Radiologic examination, internal auditory meati, complete | 1.23 | $78.11 | $29.68 | 000 | N | $85.92 |
| **70140** | Radiologic examination, facial bones; less than three views | 0.86 | $54.61 | $15.29 | 000 | N | $60.07 |
| **70150** | Radiologic examination, facial bones; complete, minimum of three views | 1.14 | $72.39 | $21.72 | 000 | N | $79.63 |
| **70160** | Radiologic examination, nasal bones, complete, minimum of three views | 0.78 | $49.53 | $15.35 | 000 | N | $54.48 |
| **70170** | Dacryocystography, nasolacrimal duct, radiological supervision and interpretation | 1.36 | $86.23 | $25.01 | 000 | N | $94.85 |
| **70190** | Radiologic examination; optic foramina | 0.93 | $59.06 | $18.31 | 000 | N | $64.97 |
| **70200** | Radiologic examination; orbits, complete, minimum of four views | 1.17 | $74.30 | $23.03 | 000 | N | $81.73 |
| **70210** | Radiologic examination, sinuses, paranasal, less than three views | 0.85 | $53.98 | $14.57 | 000 | N | $59.38 |
| **70220** | Radiologic examination, sinuses, paranasal, complete, minimum of three views | 1.10 | $69.85 | $20.26 | 000 | N | $76.84 |
| **70240** | Radiologic examination, sella turcica | 0.71 | $45.09 | $16.68 | 000 | N | $49.60 |
| **70250** | Radiologic examination, skull; less than four views | 0.97 | $61.60 | $20.33 | 000 | N | $67.76 |
| **70260** | Radiologic examination, skull; complete, minimum of four views | 1.35 | $85.73 | $28.29 | 000 | N | $94.30 |
| **70300** | Radiologic examination, teeth; single view | 0.42 | $26.67 | $9.60 | 000 | N | $29.34 |
| **70310** | Radiologic examination, teeth; partial examination, less than full mouth | 0.75 | $47.63 | $17.15 | 000 | N | $52.39 |
| **70320** | Radiologic examination, teeth; complete, full mouth | 1.15 | $73.03 | $19.72 | 000 | N | $80.33 |
| **70328** | Radiologic examination, temporomandibular joint, open and closed mouth; unilateral | 0.75 | $47.63 | $15.72 | 000 | N | $52.39 |
| **70330** | Radiologic examination, temporomandibular joint, open and closed mouth; bilateral | 1.21 | $76.84 | $20.75 | 000 | N | $84.52 |
| **70332** | Temporomandibular joint arthrography, radiological supervision and interpretation | 2.71 | $172.09 | $43.02 | 000 | N | $189.30 |
| **70336** | Magnetic resonance (eg, proton) imaging, temporomandibular joint(s) | 13.66 | $867.41 | $130.11 | 000 | N | $954.15 |
| **70350** | Cephalogram, orthodontic | 0.60 | $38.10 | $14.48 | 000 | N | $41.91 |
| **70355** | Orthopantogram | 0.79 | $50.17 | $15.55 | 000 | N | $55.19 |
| **70360** | Radiologic examination; neck, soft tissue | 0.68 | $43.18 | $15.11 | 000 | N | $47.50 |
| **70370** | Radiologic examination; pharynx or larynx, including fluoroscopy and/or magnification technique | 1.83 | $116.21 | $27.89 | 000 | N | $127.83 |
| **70371** | Complex dynamic pharyngeal and speech evaluation by cine or video recording | 3.06 | $194.31 | $66.07 | 000 | N | $213.74 |
| **70373** | Laryngography, contrast, radiological supervision and interpretation | 2.36 | $149.86 | $35.97 | 000 | N | $164.85 |
| **70380** | Radiologic examination, salivary gland for calculus | 0.95 | $60.33 | $15.08 | 000 | N | $66.36 |
| **70390** | Sialography, radiological supervision and interpretation | 2.45 | $155.58 | $32.67 | 000 | N | $171.14 |
| **70450** | Computed tomography, head or brain; without contrast material | 5.96 | $378.46 | $71.91 | 000 | N | $416.31 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **70460** | Computed tomography, head or brain; with contrast material(s) | 7.43 | $471.81 | $99.08 | 000 | N | $518.99 |
| **70470** | Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections | 9.06 | $575.31 | $109.31 | 000 | N | $632.84 |
| **70480** | Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material | 7.32 | $464.82 | $120.85 | 000 | N | $511.30 |
| **70481** | Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s) | 8.55 | $542.93 | $130.30 | 000 | N | $597.22 |
| **70482** | Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections | 10.09 | $640.72 | $134.55 | 000 | N | $704.79 |
| **70486** | Computed tomography, maxillofacial area; without contrast material | 6.75 | $428.63 | $102.87 | 000 | N | $471.49 |
| **70487** | Computed tomography, maxillofacial area; with contrast material(s) | 8.08 | $513.08 | $118.01 | 000 | N | $564.39 |
| **70488** | Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections | 9.82 | $623.57 | $130.95 | 000 | N | $685.93 |
| **70490** | Computed tomography, soft tissue neck; without contrast material | 6.85 | $434.98 | $113.09 | 000 | N | $478.48 |
| **70491** | Computed tomography, soft tissue neck; with contrast material(s) | 8.08 | $513.08 | $123.14 | 000 | N | $564.39 |
| **70492** | Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections | 9.77 | $620.40 | $130.28 | 000 | N | $682.44 |
| **70496** | Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing | 14.66 | $930.91 | $167.56 | 000 | N | $1024.00 |
| **70498** | Computed tomographic angiography, neck, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing | 14.68 | $932.18 | $167.79 | 000 | N | $1025.40 |
| **70540** | Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s) | 13.77 | $874.40 | $122.42 | 000 | N | $961.84 |
| **70542** | Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s) | 16.09 | $1,021.72 | $143.04 | 000 | N | $1123.89 |
| **70543** | Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences | 26.52 | $1,684.02 | $168.40 | 000 | N | $1852.42 |
| **70544** | Magnetic resonance angiography, head; without contrast material(s) | 14.18 | $900.43 | $108.05 | 000 | N | $990.47 |
| **70545** | Magnetic resonance angiography, head; with contrast material(s) | 14.16 | $899.16 | $107.90 | 000 | N | $989.08 |
| **70546** | Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences | 25.26 | $1,604.01 | $160.40 | 000 | N | $1764.41 |
| **70547** | Magnetic resonance angiography, neck; without contrast material(s) | 14.17 | $899.80 | $107.98 | 000 | N | $989.78 |
| **70548** | Magnetic resonance angiography, neck; with contrast material(s) | 14.37 | $912.50 | $109.50 | 000 | N | $1003.75 |
| **70549** | Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences | 25.25 | $1,603.38 | $160.34 | 000 | N | $1763.72 |
| **70551** | Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material | 14.19 | $901.07 | $135.16 | 000 | N | $991.18 |
| **70552** | Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s) | 16.60 | $1,054.10 | $158.12 | 000 | N | $1159.51 |
| **70553** | Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences | 27.06 | $1,718.31 | $189.01 | 000 | N | $1890.14 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **70554** | Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration | 16.31 | $1,035.69 | $176.07 | 000 | N | $1139.26 |
| **70555** | Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing | 19.04 | $1,209.10 | $205.55 | 000 | N | $1330.01 |
| **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 | 35.30 | $2,241.23 | $246.54 | 000 | N | $2465.35 |
| **70558** | 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); with contrast material(s) | 39.22 | $2,490.66 | $273.97 | 000 | N | $2739.73 |
| **70559** | 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(s), followed by contrast material(s) and further sequences | 46.46 | $2,950.40 | $324.54 | 000 | N | $3245.44 |
| **71010** | Radiologic examination, chest; single view, frontal | 0.69 | $43.82 | $14.90 | 000 | N | $48.20 |
| **71015** | Radiologic examination, chest; stereo, frontal | 0.80 | $50.80 | $17.78 | 000 | N | $55.88 |
| **71020** | Radiologic examination, chest, two views, frontal and lateral; | 0.91 | $57.79 | $17.91 | 000 | N | $63.57 |
| **71021** | Radiologic examination, chest, two views, frontal and lateral; with apical lordotic procedure | 1.09 | $69.22 | $22.15 | 000 | N | $76.14 |
| **71022** | Radiologic examination, chest, two views, frontal and lateral; with oblique projections | 1.18 | $74.93 | $26.23 | 000 | N | $82.42 |
| **71023** | Radiologic examination, chest, two views, frontal and lateral; with fluoroscopy | 1.46 | $92.71 | $36.16 | 000 | N | $101.98 |
| **71030** | Radiologic examination, chest, complete, minimum of four views; | 1.22 | $77.47 | $26.34 | 000 | N | $85.22 |
| **71034** | Radiologic examination, chest, complete, minimum of four views; with fluoroscopy | 2.20 | $139.70 | $41.91 | 000 | N | $153.67 |
| **71035** | Radiologic examination, chest, special views (eg, lateral decubitus, Bucky studies) | 0.81 | $51.44 | $16.46 | 000 | N | $56.58 |
| **71040** | Bronchography, unilateral, radiological supervision and interpretation | 2.37 | $150.50 | $51.17 | 000 | N | $165.55 |
| **71060** | Bronchography, bilateral, radiological supervision and interpretation | 3.39 | $215.27 | $64.58 | 000 | N | $236.80 |
| **71090** | Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation | 2.17 | $137.92 | $41.38 | 000 | N | $151.71 |
| **71100** | Radiologic examination, ribs, unilateral; two views | 0.88 | $55.88 | $18.44 | 000 | N | $61.47 |
| **71101** | Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of three views | 1.04 | $66.04 | $22.45 | 000 | N | $72.64 |
| **71110** | Radiologic examination, ribs, bilateral; three views | 1.14 | $72.39 | $22.44 | 000 | N | $79.63 |
| **71111** | Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of four views | 1.36 | $86.36 | $26.77 | 000 | N | $95.00 |
| **71120** | Radiologic examination; sternum, minimum of two views | 0.92 | $58.42 | $16.94 | 000 | N | $64.26 |
| **71130** | Radiologic examination; sternoclavicular joint or joints, minimum of three views | 1.02 | $64.77 | $18.78 | 000 | N | $71.25 |
| **71250** | Computed tomography, thorax; without contrast material | 7.64 | $485.14 | $97.03 | 000 | N | $533.65 |
| **71260** | Computed tomography, thorax; with contrast material(s) | 9.04 | $574.04 | $109.07 | 000 | N | $631.44 |
| **71270** | Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections | 11.12 | $706.12 | $120.04 | 000 | N | $776.73 |
| **71275** | Computed tomographic angiography, chest (noncoronary), without contrast material(s), followed by contrast material(s) and further sections, including image postprocessing | 14.74 | $935.99 | $159.12 | 000 | N | $1029.59 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **71550** | Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s) | 14.47 | $918.85 | $137.83 | 000 | N | $1010.74 |
| **71551** | Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s) | 16.92 | $1,074.42 | $161.16 | 000 | N | $1181.86 |
| **71552** | Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences | 27.37 | $1,738.00 | $191.18 | 000 | N | $1911.80 |
| **71555** | Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s) | 14.82 | $941.07 | $159.98 | 000 | N | $1035.18 |
| **72010** | Radiologic examination, spine, entire, survey study, anteroposterior and lateral | 1.71 | $108.59 | $39.09 | 000 | N | $119.45 |
| **72020** | Radiologic examination, spine, single view, specify level | 0.62 | $39.37 | $12.60 | 000 | N | $43.31 |
| **72040** | Radiologic examination, spine, cervical; two or three views | 0.94 | $59.69 | $19.10 | 000 | N | $65.66 |
| **72050** | Radiologic examination, spine, cervical; minimum of four views | 1.35 | $85.73 | $26.58 | 000 | N | $94.30 |
| **72052** | Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies | 1.67 | $106.05 | $31.82 | 000 | N | $116.66 |
| **72069** | Radiologic examination, spine, thoracolumbar, standing (scoliosis) | 0.84 | $53.34 | $20.27 | 000 | N | $58.67 |
| **72070** | Radiologic examination, spine; thoracic, two views | 0.94 | $59.69 | $17.91 | 000 | N | $65.66 |
| **72072** | Radiologic examination, spine; thoracic, three views | 1.04 | $66.04 | $18.49 | 000 | N | $72.64 |
| **72074** | Radiologic examination, spine; thoracic, minimum of four views | 1.23 | $78.11 | $18.75 | 000 | N | $85.92 |
| **72080** | Radiologic examination, spine; thoracolumbar, two views | 0.97 | $61.60 | $18.48 | 000 | N | $67.76 |
| **72090** | Radiologic examination, spine; scoliosis study, including supine and erect studies | 1.11 | $70.49 | $24.67 | 000 | N | $77.54 |
| **72100** | Radiologic examination, spine, lumbosacral; two or three views | 1.00 | $63.50 | $19.05 | 000 | N | $69.85 |
| **72110** | Radiologic examination, spine, lumbosacral; minimum of four views | 1.38 | $87.63 | $26.29 | 000 | N | $96.39 |
| **72114** | Radiologic examination, spine, lumbosacral; complete, including bending views | 1.76 | $111.76 | $32.41 | 000 | N | $122.94 |
| **72120** | Radiologic examination, spine, lumbosacral, bending views only, minimum of four views | 1.25 | $79.38 | $19.05 | 000 | N | $87.32 |
| **72125** | Computed tomography, cervical spine; without contrast material | 7.64 | $485.14 | $97.03 | 000 | N | $533.65 |
| **72126** | Computed tomography, cervical spine; with contrast material | 9.01 | $572.14 | $102.99 | 000 | N | $629.35 |
| **72127** | Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections | 10.96 | $695.96 | $111.35 | 000 | N | $765.56 |
| **72128** | Computed tomography, thoracic spine; without contrast material | 7.64 | $485.14 | $97.03 | 000 | N | $533.65 |
| **72129** | Computed tomography, thoracic spine; with contrast material | 9.01 | $572.14 | $102.99 | 000 | N | $629.35 |
| **72130** | Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections | 10.95 | $695.33 | $111.25 | 000 | N | $764.86 |
| **72131** | Computed tomography, lumbar spine; without contrast material | 7.64 | $485.14 | $97.03 | 000 | N | $533.65 |
| **72132** | Computed tomography, lumbar spine; with contrast material | 9.01 | $572.14 | $102.99 | 000 | N | $629.35 |
| **72133** | Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections | 11.00 | $698.50 | $111.76 | 000 | N | $768.35 |
| **72141** | Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material | 13.86 | $880.11 | $140.82 | 000 | N | $968.12 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **72142** | Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s) | 16.78 | $1,065.53 | $170.48 | 000 | N | $1172.08 |
| **72146** | Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material | 14.84 | $942.34 | $131.93 | 000 | N | $1036.57 |
| **72147** | Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s) | 16.28 | $1,033.78 | $165.40 | 000 | N | $1137.16 |
| **72148** | Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material | 14.70 | $933.45 | $121.35 | 000 | N | $1026.80 |
| **72149** | Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s) | 16.61 | $1,054.74 | $158.21 | 000 | N | $1160.21 |
| **72156** | Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical | 27.25 | $1,730.38 | $207.65 | 000 | N | $1903.42 |
| **72157** | Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic | 26.85 | $1,704.98 | $204.60 | 000 | N | $1875.48 |
| **72158** | Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar | 26.98 | $1,713.23 | $188.46 | 000 | N | $1884.55 |
| **72159** | Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s) | 15.67 | $995.05 | $169.16 | 000 | N | $1094.56 |
| **72170** | Radiologic examination, pelvis; one or two views | 0.74 | $46.99 | $14.57 | 000 | N | $51.69 |
| **72190** | Radiologic examination, pelvis; complete, minimum of three views | 1.00 | $63.50 | $18.42 | 000 | N | $69.85 |
| **72191** | Computed tomographic angiography, pelvis, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing | 14.25 | $904.88 | $153.83 | 000 | N | $995.37 |
| **72192** | Computed tomography, pelvis; without contrast material | 7.46 | $473.71 | $90.00 | 000 | N | $521.08 |
| **72193** | Computed tomography, pelvis; with contrast material(s) | 8.65 | $549.28 | $98.87 | 000 | N | $604.21 |
| **72194** | Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections | 10.64 | $675.64 | $108.10 | 000 | N | $743.20 |
| **72195** | Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s) | 14.01 | $889.64 | $133.45 | 000 | N | $978.60 |
| **72196** | Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s) | 16.34 | $1,037.59 | $155.64 | 000 | N | $1141.35 |
| **72197** | Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences | 26.76 | $1,699.26 | $186.92 | 000 | N | $1869.19 |
| **72198** | Magnetic resonance angiography, pelvis, with or without contrast material(s) | 14.70 | $933.45 | $158.69 | 000 | N | $1026.80 |
| **72200** | Radiologic examination, sacroiliac joints; less than three views | 0.76 | $48.26 | $14.96 | 000 | N | $53.09 |
| **72202** | Radiologic examination, sacroiliac joints; three or more views | 0.91 | $57.79 | $16.18 | 000 | N | $63.57 |
| **72220** | Radiologic examination, sacrum and coccyx, minimum of two views | 0.81 | $51.44 | $14.40 | 000 | N | $56.58 |
| **72240** | Myelography, cervical, radiological supervision and interpretation | 5.48 | $347.98 | $69.60 | 000 | N | $382.78 |
| **72255** | Myelography, thoracic, radiological supervision and interpretation | 5.06 | $321.31 | $67.48 | 000 | N | $353.44 |
| **72265** | Myelography, lumbosacral, radiological supervision and interpretation | 4.84 | $307.34 | $64.54 | 000 | N | $338.07 |
| **72270** | Myelography, two or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation | 7.40 | $469.90 | $103.38 | 000 | N | $516.89 |
| **72275** | Epidurography, radiological supervision and interpretation | 3.09 | $196.22 | $58.87 | 000 | N | $215.84 |
| **72285** | Discography, cervical or thoracic, radiological supervision and interpretation | 8.44 | $535.94 | $80.39 | 000 | N | $589.53 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **72291** | Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance | 8.20 | $520.64 | $119.75 | 000 | N | $572.70 |
| **72292** | Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under CT guidance | 8.38 | $532.13 | $122.39 | 000 | N | $585.34 |
| **72295** | Discography, lumbar, radiological supervision and interpretation | 7.65 | $485.78 | $58.29 | 000 | N | $534.36 |
| **73000** | Radiologic examination; clavicle, complete | 0.73 | $46.36 | $13.44 | 000 | N | $51.00 |
| **73010** | Radiologic examination; scapula, complete | 0.76 | $48.26 | $14.96 | 000 | N | $53.09 |
| **73020** | Radiologic examination, shoulder; one view | 0.66 | $41.91 | $12.57 | 000 | N | $46.10 |
| **73030** | Radiologic examination, shoulder; complete, minimum of two views | 0.82 | $52.07 | $15.10 | 000 | N | $57.28 |
| **73040** | Radiologic examination, shoulder, arthrography, radiological supervision and interpretation | 2.87 | $182.25 | $45.56 | 000 | N | $200.48 |
| **73050** | Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction | 0.96 | $60.96 | $17.07 | 000 | N | $67.06 |
| **73060** | Radiologic examination; humerus, minimum of two views | 0.81 | $51.44 | $14.40 | 000 | N | $56.58 |
| **73070** | Radiologic examination, elbow; two views | 0.72 | $45.72 | $12.80 | 000 | N | $50.29 |
| **73080** | Radiologic examination, elbow; complete, minimum of three views | 0.86 | $54.61 | $15.29 | 000 | N | $60.07 |
| **73085** | Radiologic examination, elbow, arthrography, radiological supervision and interpretation | 2.78 | $176.53 | $44.13 | 000 | N | $194.18 |
| **73090** | Radiologic examination; forearm, two views | 0.73 | $46.36 | $13.44 | 000 | N | $51.00 |
| **73092** | Radiologic examination; upper extremity, infant, minimum of two views | 0.72 | $45.72 | $13.72 | 000 | N | $50.29 |
| **73100** | Radiologic examination, wrist; two views | 0.72 | $45.72 | $13.72 | 000 | N | $50.29 |
| **73110** | Radiologic examination, wrist; complete, minimum of three views | 0.81 | $51.44 | $15.43 | 000 | N | $56.58 |
| **73115** | Radiologic examination, wrist, arthrography, radiological supervision and interpretation | 2.50 | $158.75 | $49.21 | 000 | N | $174.63 |
| **73120** | Radiologic examination, hand; two views | 0.71 | $45.09 | $13.53 | 000 | N | $49.60 |
| **73130** | Radiologic examination, hand; minimum of three views | 0.78 | $49.53 | $14.86 | 000 | N | $54.48 |
| **73140** | Radiologic examination, finger(s), minimum of two views | 0.66 | $41.91 | $12.15 | 000 | N | $46.10 |
| **73200** | Computed tomography, upper extremity; without contrast material | 6.78 | $430.53 | $94.72 | 000 | N | $473.58 |
| **73201** | Computed tomography, upper extremity; with contrast material(s) | 7.98 | $506.73 | $101.35 | 000 | N | $557.40 |
| **73202** | Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections | 9.92 | $629.92 | $113.39 | 000 | N | $692.91 |
| **73206** | Computed tomographic angiography, upper extremity, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing | 13.32 | $845.82 | $152.25 | 000 | N | $930.40 |
| **73218** | Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s) | 13.90 | $882.65 | $123.57 | 000 | N | $970.92 |
| **73219** | Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s) | 16.15 | $1,025.53 | $143.57 | 000 | N | $1128.08 |
| **73220** | Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s), followed by contrast material(s) and further sequences | 26.59 | $1,688.47 | $168.85 | 000 | N | $1857.32 |
| **73221** | Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s) | 13.64 | $866.14 | $121.26 | 000 | N | $952.75 |
| **73222** | Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s) | 15.89 | $1,009.02 | $141.26 | 000 | N | $1109.92 |
| **73223** | Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences | 26.27 | $1,668.15 | $166.82 | 000 | N | $1834.97 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **73225** | Magnetic resonance angiography, upper extremity, with or without contrast material(s) | 14.63 | $929.01 | $167.22 | 000 | N | $1021.91 |
| **73500** | Radiologic examination, hip, unilateral; one view | 0.70 | $44.45 | $14.67 | 000 | N | $48.90 |
| **73510** | Radiologic examination, hip, unilateral; complete, minimum of two views | 0.91 | $57.79 | $18.49 | 000 | N | $63.57 |
| **73520** | Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis | 1.04 | $66.04 | $22.45 | 000 | N | $72.64 |
| **73525** | Radiologic examination, hip, arthrography, radiological supervision and interpretation | 2.79 | $177.17 | $44.29 | 000 | N | $194.89 |
| **73530** | Radiologic examination, hip, during operative procedure | 1.18 | $74.74 | $32.14 | 000 | N | $82.21 |
| **73540** | Radiologic examination, pelvis and hips, infant or child, minimum of two views | 0.91 | $57.79 | $17.91 | 000 | N | $63.57 |
| **73542** | Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation | 2.66 | $168.91 | $43.92 | 000 | N | $185.80 |
| **73550** | Radiologic examination, femur, two views | 0.81 | $51.44 | $14.40 | 000 | N | $56.58 |
| **73560** | Radiologic examination, knee; one or two views | 0.76 | $48.26 | $14.96 | 000 | N | $53.09 |
| **73562** | Radiologic examination, knee; three views | 0.86 | $54.61 | $15.84 | 000 | N | $60.07 |
| **73564** | Radiologic examination, knee; complete, four or more views | 0.98 | $62.23 | $19.29 | 000 | N | $68.45 |
| **73565** | Radiologic examination, knee; both knees, standing, anteroposterior | 0.75 | $47.63 | $15.24 | 000 | N | $52.39 |
| **73580** | Radiologic examination, knee, arthrography, radiological supervision and interpretation | 3.33 | $211.46 | $44.41 | 000 | N | $232.61 |
| **73590** | Radiologic examination; tibia and fibula, two views | 0.75 | $47.63 | $14.77 | 000 | N | $52.39 |
| **73592** | Radiologic examination; lower extremity, infant, minimum of two views | 0.72 | $45.72 | $13.72 | 000 | N | $50.29 |
| **73600** | Radiologic examination, ankle; two views | 0.71 | $45.09 | $13.53 | 000 | N | $49.60 |
| **73610** | Radiologic examination, ankle; complete, minimum of three views | 0.79 | $50.17 | $15.05 | 000 | N | $55.19 |
| **73615** | Radiologic examination, ankle, arthrography, radiological supervision and interpretation | 2.81 | $178.44 | $44.61 | 000 | N | $196.28 |
| **73620** | Radiologic examination, foot; two views | 0.71 | $45.09 | $13.53 | 000 | N | $49.60 |
| **73630** | Radiologic examination, foot; complete, minimum of three views | 0.78 | $49.53 | $14.86 | 000 | N | $54.48 |
| **73650** | Radiologic examination; calcaneus, minimum of two views | 0.70 | $44.45 | $13.78 | 000 | N | $48.90 |
| **73660** | Radiologic examination; toe(s), minimum of two views | 0.65 | $41.28 | $11.97 | 000 | N | $45.41 |
| **73700** | Computed tomography, lower extremity; without contrast material | 6.78 | $430.53 | $94.72 | 000 | N | $473.58 |
| **73701** | Computed tomography, lower extremity; with contrast material(s) | 8.00 | $508.00 | $101.60 | 000 | N | $558.80 |
| **73702** | Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections | 9.94 | $631.19 | $113.61 | 000 | N | $694.31 |
| **73706** | Computed tomographic angiography, lower extremity, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing | 13.79 | $875.67 | $166.38 | 000 | N | $963.24 |
| **73718** | Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s) | 13.80 | $876.30 | $122.68 | 000 | N | $963.93 |
| **73719** | Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s) | 16.12 | $1,023.62 | $143.31 | 000 | N | $1125.98 |
| **73720** | Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences | 26.57 | $1,687.20 | $168.72 | 000 | N | $1855.92 |
| **73721** | Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material | 13.71 | $870.59 | $121.88 | 000 | N | $957.65 |
| **73722** | Magnetic resonance (eg, proton) imaging, any joint of lower extremity; with contrast material(s) | 15.95 | $1,012.83 | $141.80 | 000 | N | $1114.11 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **73723** | Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s), followed by contrast material(s) and further sequences | 26.24 | $1,666.24 | $166.62 | 000 | N | $1832.86 |
| **73725** | Magnetic resonance angiography, lower extremity, with or without contrast material(s) | 14.75 | $936.63 | $159.23 | 000 | N | $1030.29 |
| **74000** | Radiologic examination, abdomen; single anteroposterior view | 0.74 | $46.99 | $15.04 | 000 | N | $51.69 |
| **74010** | Radiologic examination, abdomen; anteroposterior and additional oblique and cone views | 0.94 | $59.69 | $20.29 | 000 | N | $65.66 |
| **74020** | Radiologic examination, abdomen; complete, including decubitus and/or erect views | 1.01 | $64.14 | $23.09 | 000 | N | $70.55 |
| **74022** | Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest | 1.20 | $76.20 | $27.43 | 000 | N | $83.82 |
| **74150** | Computed tomography, abdomen; without contrast material | 7.39 | $469.27 | $98.55 | 000 | N | $516.20 |
| **74160** | Computed tomography, abdomen; with contrast material(s) | 9.09 | $577.22 | $115.44 | 000 | N | $634.94 |
| **74170** | Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections | 11.35 | $720.73 | $129.73 | 000 | N | $792.80 |
| **74175** | Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing | 14.57 | $925.20 | $157.28 | 000 | N | $1017.72 |
| **74181** | Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s) | 13.53 | $859.16 | $128.87 | 000 | N | $945.08 |
| **74182** | Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s) | 16.79 | $1,066.17 | $159.93 | 000 | N | $1172.79 |
| **74183** | Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences | 26.77 | $1,699.90 | $186.99 | 000 | N | $1869.89 |
| **74185** | Magnetic resonance angiography, abdomen, with or without contrast material(s) | 14.71 | $934.09 | $158.80 | 000 | N | $1027.50 |
| **74190** | Peritoneogram (eg, after injection of air or contrast), radiological supervision and interpretation | 1.27 | $80.45 | $25.74 | 000 | N | $88.50 |
| **74210** | Radiologic examination; pharynx and/or cervical esophagus | 1.80 | $114.30 | $33.15 | 000 | N | $125.73 |
| **74220** | Radiologic examination; esophagus | 1.97 | $125.10 | $42.53 | 000 | N | $137.61 |
| **74230** | Swallowing function, with cineradiography/videoradiography | 2.14 | $135.89 | $46.20 | 000 | N | $149.48 |
| **74235** | Removal of foreign body(s), esophageal, with use of balloon catheter, radiological supervision and interpretation | 3.44 | $218.38 | $76.43 | 000 | N | $240.22 |
| **74240** | Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB | 2.53 | $160.66 | $61.05 | 000 | N | $176.73 |
| **74241** | Radiologic examination, gastrointestinal tract, upper; with or without delayed films, with KUB | 2.62 | $166.37 | $63.22 | 000 | N | $183.01 |
| **74245** | Radiologic examination, gastrointestinal tract, upper; with small intestine, includes multiple serial films | 3.93 | $249.56 | $82.35 | 000 | N | $274.52 |
| **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 | 2.81 | $178.44 | $62.45 | 000 | N | $196.28 |
| **74247** | Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films, with KUB | 2.94 | $186.69 | $65.34 | 000 | N | $205.36 |
| **74249** | Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with small intestine follow-through | 4.17 | $264.80 | $82.09 | 000 | N | $291.28 |
| **74250** | Radiologic examination, small intestine, includes multiple serial films; | 2.19 | $139.07 | $44.50 | 000 | N | $152.98 |

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|---|---|---|---|---|---|---|---|---|
| | **74251** | Radiologic examination, small intestine, includes multiple serial films; via enteroclysis tube | 4.24 | $269.24 | $110.39 | 000 | N | $296.16 |
| | **74260** | Duodenography, hypotonic | 3.76 | $238.76 | $71.63 | 000 | N | $262.64 |
| | **74270** | Radiologic examination, colon; barium enema, with or without KUB | 3.05 | $193.68 | $65.85 | 000 | N | $213.05 |
| | **74280** | Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon | 4.13 | $262.26 | $94.41 | 000 | N | $288.49 |
| | **74283** | Therapeutic enema, contrast or air, for reduction of intussusception or other intraluminal obstruction (eg, meconium ileus) | 5.28 | $335.28 | $170.99 | 000 | N | $368.81 |
| | **74290** | Cholecystography, oral contrast; | 1.34 | $85.09 | $30.63 | 000 | N | $93.60 |
| | **74291** | Cholecystography, oral contrast; additional or repeat examination or multiple day examination | 0.97 | $61.60 | $24.02 | 000 | N | $67.76 |
| | **74300** | Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation | 1.54 | $97.73 | $34.21 | 000 | N | $107.50 |
| + | **74301** | Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure) | 0.91 | $57.47 | $20.11 | 000 | N | $63.22 |
| | **74305** | Cholangiography and/or pancreatography; through existing catheter, radiological supervision and interpretation | 1.54 | $97.73 | $40.07 | 000 | N | $107.50 |
| | **74320** | Cholangiography, percutaneous, transhepatic, radiological supervision and interpretation | 3.68 | $233.68 | $42.06 | 000 | N | $257.05 |
| | **74327** | Postoperative biliary duct calculus removal, percutaneous via T-tube tract, basket, or snare (eg, Burhenne technique), radiological supervision and interpretation | 2.96 | $187.96 | $63.91 | 000 | N | $206.76 |
| | **74328** | Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation | 4.16 | $264.35 | $58.16 | 000 | N | $290.79 |
| | **74329** | Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation | 2.95 | $187.33 | $65.57 | 000 | N | $206.06 |
| | **74330** | Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation | 4.44 | $281.62 | $76.04 | 000 | N | $309.78 |
| | **74340** | Introduction of long gastrointestinal tube (eg, Miller-Abbott), including multiple fluoroscopies and films, radiological supervision and interpretation | 2.17 | $137.92 | $28.96 | 000 | N | $151.71 |
| | **74350** | Percutaneous placement of gastrostomy tube, radiological supervision and interpretation | 3.95 | $250.83 | $60.20 | 000 | N | $275.91 |
| | **74355** | Percutaneous placement of enteroclysis tube, radiological supervision and interpretation | 3.26 | $206.88 | $55.86 | 000 | N | $227.57 |
| | **74360** | Intraluminal dilation of strictures and/or obstructions (eg, esophagus), radiological supervision and interpretation | 3.98 | $252.86 | $45.51 | 000 | N | $278.15 |
| | **74363** | Percutaneous transhepatic dilation of biliary duct stricture with or without placement of stent, radiological supervision and interpretation | 3.26 | $206.88 | $72.41 | 000 | N | $227.57 |
| | **74400** | Urography (pyelography), intravenous, with or without KUB, with or without tomography | 2.57 | $163.20 | $44.06 | 000 | N | $179.52 |
| | **74410** | Urography, infusion, drip technique and/or bolus technique; | 2.80 | $177.80 | $42.67 | 000 | N | $195.58 |
| | **74415** | Urography, infusion, drip technique and/or bolus technique; with nephrotomography | 3.07 | $194.95 | $44.84 | 000 | N | $214.45 |
| | **74420** | Urography, retrograde, with or without KUB | 1.81 | $114.94 | $17.24 | 000 | N | $126.43 |
| | **74425** | Urography, antegrade, (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation | 1.81 | $114.94 | $31.03 | 000 | N | $126.43 |
| | **74430** | Cystography, minimum of three views, radiological supervision and interpretation | 1.70 | $107.95 | $30.23 | 000 | N | $118.75 |
| | **74440** | Vasography, vesiculography, or epididymography, radiological supervision and interpretation | 1.90 | $120.65 | $36.20 | 000 | N | $132.72 |
| | **74445** | Corpora cavernosography, radiological supervision and interpretation | 2.90 | $183.90 | $104.82 | 000 | N | $202.29 |
| | **74450** | Urethrocystography, retrograde, radiological supervision and interpretation | 2.14 | $135.64 | $31.20 | 000 | N | $149.20 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **74455** | Urethrocystography, voiding, radiological supervision and interpretation | 2.21 | $140.34 | $29.47 | 000 | N | $154.37 |
| **74470** | Radiologic examination, renal cyst study, translumbar, contrast visualization, radiological supervision and interpretation | 2.17 | $137.92 | $49.65 | 000 | N | $151.71 |
| **74475** | Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation | 4.42 | $280.67 | $42.10 | 000 | N | $308.74 |
| **74480** | Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation | 4.42 | $280.67 | $42.10 | 000 | N | $308.74 |
| **74485** | Dilation of nephrostomy, ureters, or urethra, radiological supervision and interpretation | 3.72 | $236.22 | $42.52 | 000 | N | $259.84 |
| **74710** | Pelvimetry, with or without placental localization | 1.42 | $90.17 | $27.05 | 000 | N | $99.19 |
| **74740** | Hysterosalpingography, radiological supervision and interpretation | 1.93 | $122.56 | $34.32 | 000 | N | $134.82 |
| **74742** | Transcervical catheterization of fallopian tube, radiological supervision and interpretation | 2.44 | $155.19 | $54.32 | 000 | N | $170.71 |
| **74775** | Perineogram (eg, vaginogram, for sex determination or extent of anomalies) | 2.81 | $178.18 | $64.14 | 000 | N | $196.00 |
| **75552** | Cardiac magnetic resonance imaging for morphology; without contrast material | 15.48 | $982.98 | $157.28 | 000 | N | $1081.28 |
| **75553** | Cardiac magnetic resonance imaging for morphology; with contrast material | 17.26 | $1,096.01 | $208.24 | 000 | N | $1205.61 |
| **75554** | Cardiac magnetic resonance imaging for function, with or without morphology; complete study | 17.81 | $1,130.94 | $203.57 | 000 | N | $1244.03 |
| **75555** | Cardiac magnetic resonance imaging for function, with or without morphology; limited study | 17.86 | $1,134.11 | $192.80 | 000 | N | $1247.52 |
| **75556** | Cardiac magnetic resonance imaging for velocity flow mapping | 0.00 | BR | $0.00 | 000 | N | BR |
| **75600** | Aortography, thoracic, without serialography, radiological supervision and interpretation | 12.31 | $781.69 | $39.08 | 000 | N | $859.86 |
| **75605** | Aortography, thoracic, by serialography, radiological supervision and interpretation | 12.36 | $784.86 | $86.33 | 000 | N | $863.35 |
| **75625** | Aortography, abdominal, by serialography, radiological supervision and interpretation | 12.29 | $780.42 | $85.85 | 000 | N | $858.46 |
| **75630** | Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation | 13.65 | $866.78 | $130.02 | 000 | N | $953.46 |
| **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 | 18.22 | $1,156.97 | $196.68 | 000 | N | $1272.67 |
| **75650** | Angiography, cervicocerebral, catheter, including vessel origin, radiological supervision and interpretation | 12.72 | $807.72 | $105.00 | 000 | N | $888.49 |
| **75658** | Angiography, brachial, retrograde, radiological supervision and interpretation | 12.64 | $802.64 | $96.32 | 000 | N | $882.90 |
| **75660** | Angiography, external carotid, unilateral, selective, radiological supervision and interpretation | 12.62 | $801.37 | $96.16 | 000 | N | $881.51 |
| **75662** | Angiography, external carotid, bilateral, selective, radiological supervision and interpretation | 13.34 | $847.09 | $127.06 | 000 | N | $931.80 |
| **75665** | Angiography, carotid, cerebral, unilateral, radiological supervision and interpretation | 12.68 | $805.18 | $96.62 | 000 | N | $885.70 |
| **75671** | Angiography, carotid, cerebral, bilateral, radiological supervision and interpretation | 13.29 | $843.92 | $126.59 | 000 | N | $928.31 |
| **75676** | Angiography, carotid, cervical, unilateral, radiological supervision and interpretation | 12.61 | $800.74 | $96.09 | 000 | N | $880.81 |
| **75680** | Angiography, carotid, cervical, bilateral, radiological supervision and interpretation | 13.17 | $836.30 | $125.45 | 000 | N | $919.93 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|---|
| | **75685** | Angiography, vertebral, cervical, and/or intracranial, radiological supervision and interpretation | 12.59 | $799.47 | $95.94 | 000 | N | $879.42 |
| | **75705** | Angiography, spinal, selective, radiological supervision and interpretation | 13.69 | $869.32 | $165.17 | 000 | N | $956.25 |
| | **75710** | Angiography, extremity, unilateral, radiological supervision and interpretation | 12.47 | $791.85 | $87.10 | 000 | N | $871.04 |
| | **75716** | Angiography, extremity, bilateral, radiological supervision and interpretation | 12.86 | $816.61 | $97.99 | 000 | N | $898.27 |
| | **75722** | Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation | 12.43 | $789.31 | $86.82 | 000 | N | $868.24 |
| | **75724** | Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation | 13.19 | $837.57 | $117.26 | 000 | N | $921.33 |
| | **75726** | Angiography, visceral, selective or supraselective, (with or without flush aortogram), radiological supervision and interpretation | 12.34 | $783.59 | $86.19 | 000 | N | $861.95 |
| | **75731** | Angiography, adrenal, unilateral, selective, radiological supervision and interpretation | 12.40 | $787.40 | $86.61 | 000 | N | $866.14 |
| | **75733** | Angiography, adrenal, bilateral, selective, radiological supervision and interpretation | 12.95 | $822.33 | $98.68 | 000 | N | $904.56 |
| | **75736** | Angiography, pelvic, selective or supraselective, radiological supervision and interpretation | 12.40 | $787.40 | $86.61 | 000 | N | $866.14 |
| | **75741** | Angiography, pulmonary, unilateral, selective, radiological supervision and interpretation | 12.41 | $788.04 | $94.56 | 000 | N | $866.84 |
| | **75743** | Angiography, pulmonary, bilateral, selective, radiological supervision and interpretation | 12.89 | $818.52 | $122.78 | 000 | N | $900.37 |
| | **75746** | Angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation | 12.29 | $780.42 | $85.85 | 000 | N | $858.46 |
| | **75756** | Angiography, internal mammary, radiological supervision and interpretation | 12.60 | $800.10 | $88.01 | 000 | N | $880.11 |
| + | **75774** | Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure) | 11.14 | $707.39 | $28.30 | 000 | N | $778.13 |
| | **75790** | Angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation | 4.02 | $255.27 | $163.37 | 000 | N | $280.80 |
| | **75801** | Lymphangiography, extremity only, unilateral, radiological supervision and interpretation | 7.15 | $454.03 | $77.19 | 000 | N | $499.43 |
| | **75803** | Lymphangiography, extremity only, bilateral, radiological supervision and interpretation | 7.69 | $488.51 | $107.47 | 000 | N | $537.36 |
| | **75805** | Lymphangiography, pelvic/abdominal, unilateral, radiological supervision and interpretation | 9.05 | $574.68 | $86.20 | 000 | N | $632.15 |
| | **75807** | Lymphangiography, pelvic/abdominal, bilateral, radiological supervision and interpretation | 9.96 | $632.14 | $126.43 | 000 | N | $695.35 |
| | **75809** | Shuntogram for investigation of previously placed indwelling nonvascular shunt (eg, LeVeen shunt, ventriculoperitoneal shunt, indwelling infusion pump), radiological supervision and interpretation | 1.71 | $108.59 | $47.78 | 000 | N | $119.45 |
| | **75810** | Splenoportography, radiological supervision and interpretation | 12.99 | $824.67 | $90.71 | 000 | N | $907.14 |
| | **75820** | Venography, extremity, unilateral, radiological supervision and interpretation | 2.34 | $148.59 | $72.81 | 000 | N | $163.45 |
| | **75822** | Venography, extremity, bilateral, radiological supervision and interpretation | 3.20 | $203.20 | $97.54 | 000 | N | $223.52 |
| | **75825** | Venography, caval, inferior, with serialography, radiological supervision and interpretation | 12.17 | $772.80 | $85.01 | 000 | N | $850.08 |
| | **75827** | Venography, caval, superior, with serialography, radiological supervision and interpretation | 12.16 | $772.16 | $84.94 | 000 | N | $849.38 |
| | **75831** | Venography, renal, unilateral, selective, radiological supervision and interpretation | 12.19 | $774.07 | $85.15 | 000 | N | $851.48 |
| | **75833** | Venography, renal, bilateral, selective, radiological supervision and interpretation | 12.78 | $811.53 | $105.50 | 000 | N | $892.68 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|---|
| | **75840** | Venography, adrenal, unilateral, selective, radiological supervision and interpretation | 12.28 | $779.78 | $85.78 | 000 | N | $857.76 |
| | **75842** | Venography, adrenal, bilateral, selective, radiological supervision and interpretation | 12.73 | $808.36 | $105.09 | 000 | N | $889.20 |
| | **75860** | Venography, venous sinus (eg, petrosal and inferior sagittal) or jugular, catheter, radiological supervision and interpretation | 12.31 | $781.69 | $85.99 | 000 | N | $859.86 |
| | **75870** | Venography, superior sagittal sinus, radiological supervision and interpretation | 12.25 | $777.88 | $85.57 | 000 | N | $855.67 |
| | **75872** | Venography, epidural, radiological supervision and interpretation | 12.52 | $795.02 | $87.45 | 000 | N | $874.52 |
| | **75880** | Venography, orbital, radiological supervision and interpretation | 2.33 | $147.96 | $72.50 | 000 | N | $162.76 |
| | **75885** | Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation | 12.55 | $796.93 | $103.60 | 000 | N | $876.62 |
| | **75887** | Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation | 12.61 | $800.74 | $104.10 | 000 | N | $880.81 |
| | **75889** | Hepatic venography, wedged or free, with hemodynamic evaluation, radiological supervision and interpretation | 12.17 | $772.80 | $85.01 | 000 | N | $850.08 |
| | **75891** | Hepatic venography, wedged or free, without hemodynamic evaluation, radiological supervision and interpretation | 12.17 | $772.80 | $85.01 | 000 | N | $850.08 |
| | **75893** | Venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation | 11.43 | $725.81 | $36.29 | 000 | N | $798.39 |
| | **75894** | Transcatheter therapy, embolization, any method, radiological supervision and interpretation | 27.51 | $1,747.01 | $122.29 | 000 | N | $1921.71 |
| | **75896** | Transcatheter therapy, infusion, any method (eg, thrombolysis other than coronary), radiological supervision and interpretation | 26.79 | $1,701.04 | $136.08 | 000 | N | $1871.14 |
| | **75898** | Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion | 4.98 | $316.10 | $211.79 | 000 | N | $347.71 |
| | **75900** | Exchange of a previously placed intravascular catheter during thrombolytic therapy with contrast monitoring, radiological supervision and interpretation | 10.14 | $643.64 | $96.55 | 000 | N | $708.00 |
| | **75901** | Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation | 3.38 | $214.63 | $51.51 | 000 | N | $236.09 |
| | **75902** | Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation | 2.67 | $169.55 | $33.91 | 000 | N | $186.51 |
| | **75940** | Percutaneous placement of IVC filter, radiological supervision and interpretation | 14.75 | $936.75 | $46.84 | 000 | N | $1030.43 |
| | **75945** | Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel | 8.15 | $517.21 | $56.89 | 000 | N | $568.93 |
| + | **75946** | Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure) | 4.44 | $281.62 | $30.98 | 000 | N | $309.78 |
| | **75952** | Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation | 8.87 | $563.18 | | 000 | N | $619.50 |
| | **75953** | Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiological supervision and interpretation | 2.17 | $137.92 | | 000 | N | $151.71 |
| | **75954** | Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, radiological supervision and interpretation | 3.98 | $252.86 | | 000 | N | $278.15 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|---|
| | **75956** | Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation | 15.75 | $999.93 | | 000 | N | $1099.92 |
| | **75957** | Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation | 14.66 | $930.97 | | 000 | N | $1024.07 |
| | **75958** | Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological supervision and interpretation | 9.96 | $632.14 | | 000 | N | $695.35 |
| | **75959** | Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation | 8.60 | $545.97 | | 000 | N | $600.57 |
| | **75960** | Transcatheter introduction of intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel | 21.45 | $1,362.01 | $95.34 | 000 | N | $1498.21 |
| | **75961** | Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation | 14.53 | $922.66 | $313.70 | 000 | N | $1014.93 |
| | **75962** | Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation | 14.15 | $898.53 | $35.94 | 000 | N | $988.38 |
| + | **75964** | Transluminal balloon angioplasty, each additional peripheral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure) | 7.74 | $491.49 | $24.57 | 000 | N | $540.64 |
| | **75966** | Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation | 15.25 | $968.38 | $96.84 | 000 | N | $1065.22 |
| + | **75968** | Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure) | 7.76 | $492.76 | $24.64 | 000 | N | $542.04 |
| | **75970** | Transcatheter biopsy, radiological supervision and interpretation | 14.66 | $930.97 | $83.79 | 000 | N | $1024.07 |
| | **75978** | Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation | 14.06 | $892.81 | $35.71 | 000 | N | $982.09 |
| | **75980** | Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation | 9.41 | $597.66 | $155.39 | 000 | N | $657.43 |
| | **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 | 9.96 | $632.14 | $145.39 | 000 | N | $695.35 |
| | **75984** | Change of percutaneous tube or drainage catheter with contrast monitoring (eg, gastrointestinal system, genitourinary system, abscess), radiological supervision and interpretation | 2.97 | $188.60 | $60.35 | 000 | N | $207.46 |
| | **75989** | Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation | 4.47 | $283.85 | $93.67 | 000 | N | $312.24 |
| | **75992** | Transluminal atherectomy, peripheral artery, radiological supervision and interpretation | 29.03 | $1,843.53 | $73.74 | 000 | N | $2027.88 |
| + | **75993** | Transluminal atherectomy, each additional peripheral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure) | 19.46 | $1,235.58 | $49.42 | 000 | N | $1359.14 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|---|
| | **75994** | Transluminal atherectomy, renal, radiological supervision and interpretation | 27.15 | $1,724.03 | $172.40 | 000 | N | $1896.43 |
| | **75995** | Transluminal atherectomy, visceral, radiological supervision and interpretation | 26.97 | $1,712.53 | $171.25 | 000 | N | $1883.78 |
| + | **75996** | Transluminal atherectomy, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure) | 10.86 | $689.61 | $68.96 | 000 | N | $758.57 |
| | **76000** | Fluoroscopy (separate procedure), up to 1 hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy) | 1.91 | $121.29 | $16.98 | 000 | N | $133.42 |
| | **76001** | Fluoroscopy, physician time more than 1 hour, assisting a nonradiologic physician (eg, nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy) | 0.00 | BR | $0.00 | 000 | N | BR |
| | **76010** | Radiologic examination from nose to rectum for foreign body, single view, child | 0.76 | $48.26 | $15.44 | 000 | N | $53.09 |
| | **76080** | Radiologic examination, abscess, fistula or sinus tract study, radiological supervision and interpretation | 1.75 | $111.13 | $44.45 | 000 | N | $122.24 |
| | **76098** | Radiological examination, surgical specimen | 0.60 | $38.10 | $12.57 | 000 | N | $41.91 |
| | **76100** | Radiologic examination, single plane body section (eg, tomography), other than with urography | 2.55 | $161.93 | $61.53 | 000 | N | $178.12 |
| | **76101** | Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral | 3.13 | $198.76 | $69.57 | 000 | N | $218.64 |
| | **76102** | Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; bilateral | 4.01 | $254.64 | $76.39 | 000 | N | $280.10 |
| | **76120** | Cineradiography/videoradiography, except where specifically included | 1.76 | $111.76 | $35.76 | 000 | N | $122.94 |
| + | **76125** | Cineradiography/videoradiography to complement routine examination (List separately in addition to code for primary procedure) | 1.36 | $86.23 | $26.73 | 000 | N | $94.85 |
| | **76140** | Consultation on X-ray examination made elsewhere, written report | 0.00 | BR | | 000 | N | BR |
| | **76150** | Xeroradiography | 0.50 | $31.75 | $0.00 | 000 | N | $34.93 |
| | **76350** | Subtraction in conjunction with contrast studies | 1.05 | $66.68 | $13.34 | 000 | N | $73.35 |
| | **76376** | 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation | 3.23 | $205.11 | $16.41 | 000 | N | $225.62 |
| | **76377** | 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation | 4.19 | $266.07 | $61.20 | 000 | N | $292.68 |
| | **76380** | Computed tomography, limited or localized follow-up study | 5.08 | $322.58 | $87.10 | 000 | N | $354.84 |
| | **76390** | Magnetic resonance spectroscopy | 12.86 | $816.61 | $114.33 | 000 | N | $898.27 |
| | **76496** | Unlisted fluoroscopic procedure (eg, diagnostic, interventional) | 0.00 | BR | $0.00 | 000 | N | BR |
| | **76497** | Unlisted computed tomography procedure (eg, diagnostic, interventional) | 0.00 | BR | $0.00 | 000 | N | BR |
| | **76498** | Unlisted magnetic resonance procedure (eg, diagnostic, interventional) | 0.00 | BR | $0.00 | 000 | N | BR |
| | **76499** | Unlisted diagnostic radiographic procedure | 0.00 | BR | | 000 | N | BR |
| | **76506** | Echoencephalography, 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 | 2.63 | $167.01 | $63.46 | 000 | N | $183.71 |
| | **76510** | Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter | 4.22 | $267.97 | $133.99 | 000 | N | $294.77 |
| | **76511** | Ophthalmic ultrasound, diagnostic; quantitative A-scan only | 3.12 | $198.12 | $77.27 | 000 | N | $217.93 |

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|---|---|---|---|---|---|---|---|---|
| | **76512** | Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan) | 2.94 | $186.69 | $78.41 | 000 | N | $205.36 |
| | **76513** | Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy | 2.46 | $156.21 | $57.80 | 000 | N | $171.83 |
| | **76514** | Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness) | 0.32 | $20.32 | $16.46 | 000 | N | $22.35 |
| | **76516** | Ophthalmic biometry by ultrasound echography, A-scan; | 1.96 | $124.46 | $47.29 | 000 | N | $136.91 |
| | **76519** | Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation | 2.06 | $130.81 | $47.09 | 000 | N | $143.89 |
| | **76529** | Ophthalmic ultrasonic foreign body localization | 1.93 | $122.56 | $50.25 | 000 | N | $134.82 |
| | **76536** | Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation | 2.43 | $154.31 | $52.47 | 000 | N | $169.74 |
| | **76604** | Ultrasound, chest (includes mediastinum), real time with image documentation | 2.12 | $134.62 | $47.12 | 000 | N | $148.08 |
| | **76645** | Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation | 1.98 | $125.73 | $50.29 | 000 | N | $138.30 |
| | **76700** | Ultrasound, abdominal, real time with image documentation; complete | 3.27 | $207.65 | $72.68 | 000 | N | $228.42 |
| | **76705** | Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up) | 2.41 | $153.04 | $53.56 | 000 | N | $168.34 |
| | **76770** | Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete | 3.17 | $201.30 | $66.43 | 000 | N | $221.43 |
| | **76775** | Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited | 2.44 | $154.94 | $54.23 | 000 | N | $170.43 |
| | **76776** | Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation | 3.27 | $207.65 | $62.30 | 000 | N | $228.42 |
| | **76800** | Ultrasound, spinal canal and contents | 3.04 | $193.04 | $96.52 | 000 | N | $212.34 |
| | **76801** | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation | 3.48 | $220.98 | $83.97 | 000 | N | $243.08 |
| + | **76802** | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure) | 2.15 | $136.53 | $68.27 | 000 | N | $150.18 |
| | **76805** | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation | 3.61 | $229.24 | $87.11 | 000 | N | $252.16 |
| + | **76810** | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure) | 2.58 | $163.83 | $85.19 | 000 | N | $180.21 |
| | **76811** | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation | 6.16 | $391.16 | $156.46 | 000 | N | $430.28 |
| + | **76812** | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure) | 4.34 | $275.59 | $173.62 | 000 | N | $303.15 |
| | **76813** | Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation | 3.31 | $210.19 | $94.59 | 000 | N | $231.21 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|---|
| + | **76814** | Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation (List separately in addition to code for primary procedure) | 2.19 | $139.07 | $79.27 | 000 | N | $152.98 |
| | **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 | 2.36 | $149.86 | $56.95 | 000 | N | $164.85 |
| | **76816** | Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus | 2.52 | $160.02 | $73.61 | 000 | N | $176.02 |
| | **76817** | Ultrasound, pregnant uterus, real time with image documentation, transvaginal | 2.58 | $163.83 | $65.53 | 000 | N | $180.21 |
| | **76818** | Fetal biophysical profile; with non-stress testing | 3.13 | $198.76 | $89.44 | 000 | N | $218.64 |
| | **76819** | Fetal biophysical profile; without non-stress testing | 2.63 | $167.01 | $65.13 | 000 | N | $183.71 |
| | **76820** | Doppler velocimetry, fetal; umbilical artery | 2.09 | $132.72 | $38.49 | 000 | N | $145.99 |
| | **76821** | Doppler velocimetry, fetal; middle cerebral artery | 2.65 | $168.28 | $62.26 | 000 | N | $185.11 |
| | **76825** | Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; | 4.68 | $297.18 | $157.51 | 000 | N | $326.90 |
| | **76826** | Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study | 2.26 | $143.51 | $86.11 | 000 | N | $157.86 |
| | **76827** | Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete | 2.37 | $150.50 | $46.66 | 000 | N | $165.55 |
| | **76828** | Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study | 1.77 | $112.40 | $44.96 | 000 | N | $123.64 |
| | **76830** | Ultrasound, transvaginal | 2.72 | $172.72 | $63.91 | 000 | N | $189.99 |
| | **76831** | Saline infusion sonohysterography (SIS), including color flow Doppler, when performed | 2.78 | $176.53 | $67.08 | 000 | N | $194.18 |
| | **76856** | Ultrasound, pelvic (nonobstetric), real time with image documentation; complete | 2.74 | $173.99 | $64.38 | 000 | N | $191.39 |
| | **76857** | Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles) | 2.41 | $153.04 | $35.20 | 000 | N | $168.34 |
| | **76870** | Ultrasound, scrotum and contents | 2.68 | $170.18 | $59.56 | 000 | N | $187.20 |
| | **76872** | Ultrasound, transrectal; | 3.28 | $208.28 | $64.57 | 000 | N | $229.11 |
| | **76873** | Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure) | 4.45 | $282.58 | $138.46 | 000 | N | $310.84 |
| | **76880** | Ultrasound, extremity, nonvascular, real time with image documentation | 2.61 | $165.74 | $58.01 | 000 | N | $182.31 |
| | **76885** | Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician manipulation) | 2.88 | $182.88 | $69.49 | 000 | N | $201.17 |
| | **76886** | Ultrasound, infant hips, real time with imaging documentation; limited, static (not requiring physician manipulation) | 2.43 | $154.31 | $55.55 | 000 | N | $169.74 |
| | **76930** | Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation | 2.57 | $163.20 | $60.38 | 000 | N | $179.52 |
| | **76932** | Ultrasonic guidance for endomyocardial biopsy, imaging supervision and interpretation | 2.57 | $163.20 | $60.38 | 000 | N | $179.52 |
| | **76936** | Ultrasound guided compression repair of arterial pseudoaneurysm or arteriovenous fistulae (includes diagnostic ultrasound evaluation, compression of lesion and imaging) | 8.93 | $567.06 | $164.45 | 000 | N | $623.77 |

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|---|---|---|---|---|---|---|---|---|
| + | **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 code for primary procedure) | 0.91 | $57.79 | $27.16 | 000 | N | $63.57 |
| | **76940** | Ultrasound guidance for, and monitoring of, parenchymal tissue ablation | 4.71 | $298.83 | $185.27 | 000 | N | $328.71 |
| | **76941** | Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation | 2.63 | $166.69 | $90.01 | 000 | N | $183.36 |
| | **76942** | Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation | 4.16 | $264.16 | $63.40 | 000 | N | $290.58 |
| | **76945** | Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation | 2.53 | $160.91 | $57.93 | 000 | N | $177.00 |
| | **76946** | Ultrasonic guidance for amniocentesis, imaging supervision and interpretation | 1.81 | $114.94 | $28.74 | 000 | N | $126.43 |
| | **76948** | Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation | 1.80 | $114.30 | $28.58 | 000 | N | $125.73 |
| | **76950** | Ultrasonic guidance for placement of radiation therapy fields | 2.05 | $130.18 | $48.17 | 000 | N | $143.20 |
| | **76965** | Ultrasonic guidance for interstitial radioelement application | 6.38 | $405.13 | $97.23 | 000 | N | $445.64 |
| | **76970** | Ultrasound study follow-up (specify) | 1.85 | $117.48 | $38.77 | 000 | N | $129.23 |
| | **76975** | Gastrointestinal endoscopic ultrasound, supervision and interpretation | 4.25 | $270.13 | $110.75 | 000 | N | $297.14 |
| | **76977** | Ultrasound bone density measurement and interpretation, peripheral site(s), any method | 0.76 | $48.26 | $3.86 | 000 | N | $53.09 |
| | **76998** | Ultrasonic guidance, intraoperative | 0.00 | BR | | 000 | N | BR |
| | **76999** | Unlisted ultrasound procedure (eg, diagnostic, interventional) | 0.00 | BR | | 000 | N | BR |
| + | **77001** | 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) | 2.18 | $138.43 | | 000 | N | $152.27 |
| | **77002** | Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) | 1.98 | $125.73 | | 000 | N | $138.30 |
| | **77003** | 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 | 1.92 | $121.92 | | 000 | N | $134.11 |
| | **77011** | Computed tomography guidance for stereotactic localization | 12.94 | $821.69 | $131.47 | 000 | N | $903.86 |
| | **77012** | Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation | 8.53 | $541.66 | $81.25 | 000 | N | $595.83 |
| | **77013** | Computerized tomography guidance for, and monitoring of, parenchymal tissue ablation | 16.07 | $1,020.64 | $367.43 | 000 | N | $1122.70 |
| | **77014** | Computed tomography guidance for placement of radiation therapy fields | 4.49 | $285.12 | $76.98 | 000 | N | $313.63 |
| | **77021** | Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation | 13.07 | $829.95 | $132.79 | 000 | N | $912.95 |
| | **77022** | Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation | 19.46 | $1,235.58 | $383.03 | 000 | N | $1359.14 |

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|---|---|---|---|---|---|---|---|---|
| | **77031** | Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation | 8.08 | $513.08 | $118.01 | 000 | N | $564.39 |
| | **77032** | Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation | 1.85 | $117.48 | $42.29 | 000 | N | $129.23 |
| + | **77051** | Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure) | 0.45 | $28.58 | $4.86 | 000 | N | $31.44 |
| + | **77052** | Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure) | 0.45 | $28.58 | $4.86 | 000 | N | $31.44 |
| | **77053** | Mammary ductogram or galactogram, single duct, radiological supervision and interpretation | 2.69 | $170.82 | $25.62 | 000 | N | $187.90 |
| | **77054** | Mammary ductogram or galactogram, multiple ducts, radiological supervision and interpretation | 3.86 | $245.11 | $34.32 | 000 | N | $269.62 |
| | **77055** | Mammography; unilateral | 2.06 | $130.81 | $60.17 | 000 | N | $143.89 |
| | **77056** | Mammography; bilateral | 2.57 | $163.20 | $75.07 | 000 | N | $179.52 |
| | **77057** | Screening mammography, bilateral (2-view film study of each breast) | 2.16 | $137.16 | $57.61 | 000 | N | $150.88 |
| | **77058** | Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral | 21.22 | $1,347.47 | $148.22 | 000 | N | $1482.22 |
| | **77059** | Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral | 26.24 | $1,666.24 | $133.30 | 000 | N | $1832.86 |
| | **77071** | Manual application of stress performed by physician for joint radiography, including contralateral joint if indicated | 0.76 | $48.26 | | 000 | N | $53.09 |
| | **77072** | Bone age studies | 0.59 | $37.47 | $11.99 | 000 | N | $41.22 |
| | **77073** | Bone length studies (orthoroentgenogram, scanogram) | 1.11 | $70.49 | $21.85 | 000 | N | $77.54 |
| | **77074** | Radiologic examination, osseous survey; limited (eg, for metastases) | 1.68 | $106.68 | $39.47 | 000 | N | $117.35 |
| | **77075** | Radiologic examination, osseous survey; complete (axial and appendicular skeleton) | 2.35 | $149.23 | $49.25 | 000 | N | $164.15 |
| | **77076** | Radiologic examination, osseous survey, infant | 1.91 | $121.29 | $66.71 | 000 | N | $133.42 |
| | **77077** | Joint survey, single view, 2 or more joints (specify) | 1.43 | $90.81 | $24.52 | 000 | N | $99.89 |
| | **77078** | Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine) | 3.80 | $241.30 | $24.13 | 000 | N | $265.43 |
| | **77079** | Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel) | 2.71 | $172.09 | $17.21 | 000 | N | $189.30 |
| | **77080** | Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine) | 2.95 | $187.33 | $20.61 | 000 | N | $206.06 |
| | **77081** | Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel) | 1.06 | $67.31 | $18.85 | 000 | N | $74.04 |
| | **77082** | Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment | 0.92 | $58.42 | $13.44 | 000 | N | $64.26 |
| | **77083** | Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites | 0.95 | $60.33 | $15.69 | 000 | N | $66.36 |
| | **77084** | Magnetic resonance (eg, proton) imaging, bone marrow blood supply | 14.34 | $910.59 | $364.24 | 000 | N | $1001.65 |
| | **77261** | Therapeutic radiology treatment planning; simple | 1.83 | $116.21 | | 000 | N | $127.83 |
| | **77262** | Therapeutic radiology treatment planning; intermediate | 2.75 | $174.63 | | 000 | N | $192.09 |
| | **77263** | Therapeutic radiology treatment planning; complex | 4.08 | $259.08 | | 000 | N | $284.99 |
| | **77280** | Therapeutic radiology simulation-aided field setting; simple | 4.74 | $300.99 | $63.21 | 000 | N | $331.09 |

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|---|---|---|---|---|---|---|---|
| **77285** | Therapeutic radiology simulation-aided field setting; intermediate | 7.74 | $491.49 | $98.30 | 000 | N | $540.64 |
| **77290** | Therapeutic radiology simulation-aided field setting; complex | 10.46 | $664.21 | $159.41 | 000 | N | $730.63 |
| **77295** | Therapeutic radiology simulation-aided field setting; 3-dimensional | 29.73 | $1,887.86 | $320.94 | 000 | N | $2076.65 |
| **77299** | Unlisted procedure, therapeutic radiology clinical treatment planning | 0.00 | BR | | 000 | N | BR |
| **77300** | Basic radiation dosimetry calculation, central axis depth dose calculation, 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 | 2.11 | $133.99 | $50.92 | 000 | N | $147.39 |
| **77301** | Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications | 46.32 | $2,941.32 | $794.16 | 000 | N | $3235.45 |
| **77305** | Teletherapy, isodose plan (whether hand or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest) | 2.57 | $163.20 | $53.86 | 000 | N | $179.52 |
| **77310** | Teletherapy, isodose plan (whether hand or computer calculated); intermediate (three or more treatment ports directed to a single area of interest) | 3.44 | $218.44 | $80.82 | 000 | N | $240.28 |
| **77315** | Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations) | 4.52 | $287.02 | $123.42 | 000 | N | $315.72 |
| **77321** | Special teletherapy port plan, particles, hemibody, total body | 4.75 | $301.63 | $69.37 | 000 | N | $331.79 |
| **77326** | Brachytherapy isodose plan; simple (calculation made from single plane, one to four sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources) | 3.77 | $239.40 | $81.40 | 000 | N | $263.34 |
| **77327** | Brachytherapy isodose plan; intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources) | 5.47 | $347.35 | $118.10 | 000 | N | $382.09 |
| **77328** | Brachytherapy isodose plan; complex (multiplane isodose plan, volume implant calculations, over 10 sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources) | 7.78 | $494.03 | $172.91 | 000 | N | $543.43 |
| **77331** | Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician | 1.63 | $103.51 | $72.46 | 000 | N | $113.86 |
| **77332** | Treatment devices, design and construction; simple (simple block, simple bolus) | 2.12 | $134.62 | $45.77 | 000 | N | $148.08 |
| **77333** | Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus) | 2.66 | $168.91 | $60.81 | 000 | N | $185.80 |
| **77334** | Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts) | 4.78 | $303.53 | $100.16 | 000 | N | $333.88 |
| **77336** | Continuing medical 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 | 2.68 | $170.18 | | 000 | N | $187.20 |
| **77370** | Special medical radiation physics consultation | 3.56 | $226.06 | | 000 | N | $248.67 |
| **77371** | Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesion(s) consisting of 1 session; multi-source Cobalt 60 based | 30.38 | $1,929.13 | $0.00 | 000 | N | $2122.04 |
| **77372** | Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesion(s) consisting of 1 session; linear accelerator based | 23.06 | $1,464.31 | $0.00 | 000 | N | $1610.74 |

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|---|---|---|---|---|---|---|---|
| **77373** | Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions | 43.00 | $2,730.50 | $0.00 | 000 | N | $3003.55 |
| **77399** | Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services | 0.00 | BR | | 000 | N | BR |
| **77401** | Radiation treatment delivery, superficial and/or ortho voltage | 1.56 | $99.06 | $0.00 | 000 | N | $108.97 |
| **77402** | Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV | 2.48 | $157.48 | $0.00 | 000 | N | $173.23 |
| **77403** | Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV | 2.38 | $151.13 | $0.00 | 000 | N | $166.24 |
| **77404** | Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19 MeV | 2.49 | $158.12 | $0.00 | 000 | N | $173.93 |
| **77406** | Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater | 2.49 | $158.12 | $0.00 | 000 | N | $173.93 |
| **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 | 3.05 | $193.68 | $0.00 | 000 | N | $213.05 |
| **77408** | Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; 6-10 MeV | 2.99 | $189.87 | $0.00 | 000 | N | $208.86 |
| **77409** | Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; 11-19 MeV | 3.14 | $199.39 | $0.00 | 000 | N | $219.33 |
| **77411** | Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater | 3.13 | $198.76 | $0.00 | 000 | N | $218.64 |
| **77412** | Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV | 3.59 | $227.97 | $0.00 | 000 | N | $250.77 |
| **77413** | Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 MeV | 3.59 | $227.97 | $0.00 | 000 | N | $250.77 |
| **77414** | Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 MeV | 3.81 | $241.94 | $0.00 | 000 | N | $266.13 |
| **77416** | Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 MeV or greater | 3.81 | $241.94 | $0.00 | 000 | N | $266.13 |
| **77417** | Therapeutic radiology port film(s) | 0.57 | $36.20 | $0.00 | 000 | N | $39.82 |
| **77418** | Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session | 16.93 | $1,075.06 | $0.00 | 000 | N | $1182.57 |
| **77421** | Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy | 3.58 | $227.33 | $34.10 | 000 | N | $250.06 |
| **77422** | High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking | 4.71 | $299.09 | $0.00 | 000 | N | $329.00 |
| **77423** | High energy neutron radiation treatment delivery; 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s) | 3.97 | $252.10 | $0.00 | 000 | N | $277.31 |
| **77427** | Radiation treatment management, five treatments | 4.65 | $295.28 | | 000 | N | $324.81 |
| **77431** | Radiation therapy management with complete course of therapy consisting of one or two fractions only | 2.43 | $154.31 | | 000 | N | $169.74 |

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|---|---|---|---|---|---|---|---|
| **77432** | Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session) | 10.38 | $659.13 | | 000 | N | $725.04 |
| **77435** | Stereotactic body radiation therapy, treatment management, per treatment course, to one or more lesions, including image guidance, entire course not to exceed 5 fractions | 16.99 | $1,078.87 | | 000 | N | $1186.76 |
| **77470** | Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation) | 11.93 | $757.56 | $181.81 | 000 | N | $833.32 |
| **77499** | Unlisted procedure, therapeutic radiology treatment management | 0.00 | BR | | 000 | N | BR |
| **77520** | Proton treatment delivery; simple, without compensation | 0.00 | BR | $0.00 | 000 | N | BR |
| **77522** | Proton treatment delivery; simple, with compensation | 0.00 | BR | $0.00 | 000 | N | BR |
| **77523** | Proton treatment delivery; intermediate | 0.00 | BR | $0.00 | 000 | N | BR |
| **77525** | Proton treatment delivery; complex | 0.00 | BR | $0.00 | 000 | N | BR |
| ⊙ **77600** | Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less) | 6.73 | $427.36 | $170.94 | 000 | N | $470.10 |
| ⊙ **77605** | Hyperthermia, externally generated; deep (ie, heating to depths greater than 4 cm) | 10.13 | $643.26 | $257.30 | 000 | N | $707.59 |
| ⊙ **77610** | Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators | 8.57 | $544.20 | $217.68 | 000 | N | $598.62 |
| ⊙ **77615** | Hyperthermia generated by interstitial probe(s); more than 5 interstitial applicators | 12.23 | $776.61 | $310.64 | 000 | N | $854.27 |
| **77620** | Hyperthermia generated by intracavitary probe(s) | 6.81 | $432.44 | $177.30 | 000 | N | $475.68 |
| **77750** | Infusion or instillation of radioelement solution (includes 3 months follow-up care) | 8.09 | $513.72 | $426.39 | 090 | N | $565.09 |
| **77761** | Intracavitary radiation source application; simple | 8.04 | $510.54 | $336.96 | 090 | N | $561.59 |
| **77762** | Intracavitary radiation source application; intermediate | 11.64 | $739.14 | $495.22 | 090 | N | $813.05 |
| **77763** | Intracavitary radiation source application; complex | 16.42 | $1,042.67 | $740.30 | 090 | N | $1146.94 |
| **77776** | Interstitial radiation source application; simple | 9.00 | $571.50 | $411.48 | 090 | N | $628.65 |
| **77777** | Interstitial radiation source application; intermediate | 14.27 | $906.15 | $634.31 | 090 | N | $996.77 |
| **77778** | Interstitial radiation source application; complex | 20.32 | $1,290.32 | $954.84 | 090 | N | $1419.35 |
| **77781** | Remote afterloading high intensity brachytherapy; 1-4 source positions or catheters | 18.96 | $1,203.96 | $120.40 | 000 | N | $1324.36 |
| **77782** | Remote afterloading high intensity brachytherapy; 5-8 source positions or catheters | 21.96 | $1,394.46 | $195.22 | 000 | N | $1533.91 |
| **77783** | Remote afterloading high intensity brachytherapy; 9-12 source positions or catheters | 26.39 | $1,675.77 | $318.40 | 000 | N | $1843.35 |
| **77784** | Remote afterloading high intensity brachytherapy; over 12 source positions or catheters | 34.02 | $2,160.27 | $561.67 | 000 | N | $2376.30 |
| **77789** | Surface application of radiation source | 2.25 | $142.88 | $110.02 | 000 | N | $157.17 |
| **77790** | Supervision, handling, loading of radiation source | 2.01 | $127.64 | $93.18 | 000 | N | $140.40 |
| **77799** | Unlisted procedure, clinical brachytherapy | 0.00 | BR | | 000 | N | BR |
| **78000** | Thyroid uptake; single determination | 1.45 | $92.08 | $18.42 | 000 | N | $101.29 |
| **78001** | Thyroid uptake; multiple determinations | 1.90 | $120.65 | $25.34 | 000 | N | $132.72 |
| **78003** | Thyroid uptake; stimulation, suppression or discharge (not including initial uptake studies) | 1.63 | $103.51 | $31.05 | 000 | N | $113.86 |
| **78006** | Thyroid imaging, with uptake; single determination | 3.97 | $252.10 | $52.94 | 000 | N | $277.31 |
| **78007** | Thyroid imaging, with uptake; multiple determinations | 3.37 | $214.00 | $42.80 | 000 | N | $235.40 |
| **78010** | Thyroid imaging; only | 2.93 | $186.06 | $40.93 | 000 | N | $204.67 |
| **78011** | Thyroid imaging; with vascular flow | 3.54 | $224.79 | $44.96 | 000 | N | $247.27 |
| **78015** | Thyroid carcinoma metastases imaging; limited area (eg, neck and chest only) | 4.15 | $263.53 | $65.88 | 000 | N | $289.88 |
| **78016** | Thyroid carcinoma metastases imaging; with additional studies (eg, urinary recovery) | 5.80 | $368.30 | $88.39 | 000 | N | $405.13 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|---|
| | **78018** | Thyroid carcinoma metastases imaging; whole body | 7.26 | $461.01 | $78.37 | 000 | N | $507.11 |
| + | **78020** | Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure) | 2.26 | $143.51 | $51.66 | 000 | N | $157.86 |
| | **78070** | Parathyroid imaging | 5.10 | $323.85 | $68.01 | 000 | N | $356.24 |
| | **78075** | Adrenal imaging, cortex and/or medulla | 8.01 | $508.64 | $76.30 | 000 | N | $559.50 |
| | **78099** | Unlisted endocrine procedure, diagnostic nuclear medicine | 0.00 | BR | | 000 | N | BR |
| | **78102** | Bone marrow imaging; limited area | 3.28 | $208.28 | $54.15 | 000 | N | $229.11 |
| | **78103** | Bone marrow imaging; multiple areas | 4.72 | $299.72 | $71.93 | 000 | N | $329.69 |
| | **78104** | Bone marrow imaging; whole body | 5.72 | $363.22 | $72.64 | 000 | N | $399.54 |
| | **78110** | Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling | 1.52 | $96.52 | $20.27 | 000 | N | $106.17 |
| | **78111** | Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); multiple samplings | 2.85 | $180.98 | $18.10 | 000 | N | $199.08 |
| | **78120** | Red cell volume determination (separate procedure); single sampling | 2.18 | $138.43 | $20.76 | 000 | N | $152.27 |
| | **78121** | Red cell volume determination (separate procedure); multiple samplings | 3.23 | $205.11 | $26.66 | 000 | N | $225.62 |
| | **78122** | Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique) | 4.75 | $301.63 | $33.18 | 000 | N | $331.79 |
| | **78130** | Red cell survival study; | 3.84 | $243.84 | $53.64 | 000 | N | $268.22 |
| | **78135** | Red cell survival study; differential organ/tissue kinetics, (eg, splenic and/or hepatic sequestration) | 6.70 | $425.45 | $63.82 | 000 | N | $468.00 |
| | **78140** | Labeled red cell sequestration, differential organ/tissue, (eg, splenic and/or hepatic) | 4.56 | $289.56 | $49.23 | 000 | N | $318.52 |
| | **78185** | Spleen imaging only, with or without vascular flow | 3.61 | $229.24 | $41.26 | 000 | N | $252.16 |
| | **78190** | Kinetics, study of platelet survival, with or without differential organ/tissue localization | 8.13 | $516.26 | $108.41 | 000 | N | $567.89 |
| | **78191** | Platelet survival study | 7.41 | $470.54 | $47.05 | 000 | N | $517.59 |
| | **78195** | Lymphatics and lymph nodes imaging | 6.76 | $429.26 | $120.19 | 000 | N | $472.19 |
| | **78199** | Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine | 0.00 | BR | | 000 | N | BR |
| | **78201** | Liver imaging; static only | 3.55 | $225.43 | $45.09 | 000 | N | $247.97 |
| | **78202** | Liver imaging; with vascular flow | 4.17 | $264.80 | $50.31 | 000 | N | $291.28 |
| | **78205** | Liver imaging (SPECT); | 6.83 | $433.71 | $60.72 | 000 | N | $477.08 |
| | **78206** | Liver imaging (SPECT); with vascular flow | 9.13 | $579.76 | $104.36 | 000 | N | $637.74 |
| | **78215** | Liver and spleen imaging; static only | 4.06 | $257.81 | $46.41 | 000 | N | $283.59 |
| | **78216** | Liver and spleen imaging; with vascular flow | 4.12 | $261.62 | $47.09 | 000 | N | $287.78 |
| | **78220** | Liver function study with hepatobiliary agents, with serial images | 4.28 | $271.78 | $40.77 | 000 | N | $298.96 |
| | **78223** | Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function | 5.94 | $377.19 | $86.75 | 000 | N | $414.91 |
| | **78230** | Salivary gland imaging; | 3.27 | $207.65 | $43.61 | 000 | N | $228.42 |
| | **78231** | Salivary gland imaging; with serial images | 3.83 | $243.21 | $43.78 | 000 | N | $267.53 |
| | **78232** | Salivary gland function study | 4.04 | $256.54 | $38.48 | 000 | N | $282.19 |
| | **78258** | Esophageal motility | 4.58 | $290.83 | $72.71 | 000 | N | $319.91 |
| | **78261** | Gastric mucosa imaging | 5.55 | $352.43 | $63.44 | 000 | N | $387.67 |
| | **78262** | Gastroesophageal reflux study | 5.63 | $357.51 | $60.78 | 000 | N | $393.26 |
| | **78264** | Gastric emptying study | 5.93 | $376.56 | $75.31 | 000 | N | $414.22 |
| | **78267** | Urea breath test, C-14 (isotopic); acquisition for analysis | 0.00 | BR | $0.00 | 000 | N | BR |
| | **78268** | Urea breath test, C-14 (isotopic); analysis | 0.00 | BR | $0.00 | 000 | N | BR |
| | **78270** | Vitamin B-12 absorption study (eg, Schilling test); without intrinsic factor | 1.96 | $124.46 | $18.67 | 000 | N | $136.91 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **78271** | Vitamin B-12 absorption study (eg, Schilling test); with intrinsic factor | 2.04 | $129.54 | $18.14 | 000 | N | $142.49 |
| **78272** | Vitamin B-12 absorption studies combined, with and without intrinsic factor | 2.68 | $170.18 | $22.12 | 000 | N | $187.20 |
| **78278** | Acute gastrointestinal blood loss imaging | 7.10 | $450.85 | $94.68 | 000 | N | $495.94 |
| **78282** | Gastrointestinal protein loss | 3.04 | $193.10 | $48.28 | 000 | N | $212.41 |
| **78290** | Intestine imaging (eg, ectopic gastric mucosa, Meckel's localization, volvulus) | 5.25 | $333.38 | $76.68 | 000 | N | $366.72 |
| **78291** | Peritoneal-venous shunt patency test (eg, for LeVeen, Denver shunt) | 4.97 | $315.60 | $85.21 | 000 | N | $347.16 |
| **78299** | Unlisted gastrointestinal procedure, diagnostic nuclear medicine | 0.00 | BR | | 000 | N | BR |
| **78300** | Bone and/or joint imaging; limited area | 3.73 | $236.86 | $59.22 | 000 | N | $260.55 |
| **78305** | Bone and/or joint imaging; multiple areas | 5.22 | $331.47 | $76.24 | 000 | N | $364.62 |
| **78306** | Bone and/or joint imaging; whole body | 5.87 | $372.75 | $78.28 | 000 | N | $410.03 |
| **78315** | Bone and/or joint imaging; three phase study | 7.07 | $448.95 | $98.77 | 000 | N | $493.85 |
| **78320** | Bone and/or joint imaging; tomographic (SPECT) | 7.24 | $459.74 | $87.35 | 000 | N | $505.71 |
| **78350** | Bone density (bone mineral content) study, one or more sites; single photon absorptiometry | 1.08 | $68.58 | $18.52 | 000 | N | $75.44 |
| **78351** | Bone density (bone mineral content) study, one or more sites; dual photon absorptiometry, one or more sites | 0.39 | $24.77 | $7.43 | 000 | N | $27.25 |
| **78399** | Unlisted musculoskeletal procedure, diagnostic nuclear medicine | 0.00 | BR | | 000 | N | BR |
| **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 | 2.05 | $129.86 | $38.96 | 000 | N | $142.85 |
| **78428** | Cardiac shunt detection | 4.08 | $259.08 | $82.91 | 000 | N | $284.99 |
| **78445** | Non-cardiac vascular flow imaging (ie, angiography, venography) | 3.18 | $201.93 | $52.50 | 000 | N | $222.12 |
| **78456** | Acute venous thrombosis imaging, peptide | 6.94 | $440.69 | $105.77 | 000 | N | $484.76 |
| **78457** | Venous thrombosis imaging, venogram; unilateral | 4.18 | $265.43 | $71.67 | 000 | N | $291.97 |
| **78458** | Venous thrombosis imaging, venogram; bilateral | 5.39 | $342.27 | $78.72 | 000 | N | $376.50 |
| **78459** | Myocardial imaging, positron emission tomography (PET), metabolic evaluation | 6.99 | $443.67 | $133.10 | 000 | N | $488.04 |
| **78460** | Myocardial perfusion imaging; (planar) single study, at rest or stress (exercise and/or pharmacologic), with or without quantification | 4.04 | $256.54 | $82.09 | 000 | N | $282.19 |
| **78461** | Myocardial perfusion imaging; multiple studies, (planar) at rest and/or stress (exercise and/or pharmacologic), and redistribution and/or rest injection, with or without quantification | 6.22 | $394.97 | $102.69 | 000 | N | $434.47 |
| **78464** | Myocardial perfusion imaging; tomographic (SPECT), single study (including attenuation correction when performed), at rest or stress (exercise and/or pharmacologic), with or without quantification | 8.42 | $534.67 | $90.89 | 000 | N | $588.14 |
| **78465** | Myocardial perfusion imaging; 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 | 14.06 | $892.81 | $124.99 | 000 | N | $982.09 |
| **78466** | Myocardial imaging, infarct avid, planar; qualitative or quantitative | 4.02 | $255.27 | $66.37 | 000 | N | $280.80 |
| **78468** | Myocardial imaging, infarct avid, planar; with ejection fraction by first pass technique | 5.39 | $342.27 | $75.30 | 000 | N | $376.50 |
| **78469** | Myocardial imaging, infarct avid, planar; tomographic SPECT with or without quantification | 6.84 | $434.34 | $82.52 | 000 | N | $477.77 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|---|
| | **78472** | Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing | 7.09 | $450.22 | $85.54 | 000 | N | $495.24 |
| | **78473** | Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification | 10.26 | $651.51 | $123.79 | 000 | N | $716.66 |
| + | **78478** | Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure) | 2.11 | $133.99 | $45.56 | 000 | N | $147.39 |
| + | **78480** | Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure) | 1.90 | $120.65 | $41.02 | 000 | N | $132.72 |
| | **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 | 6.65 | $422.28 | $84.46 | 000 | N | $464.51 |
| | **78483** | Cardiac blood pool imaging, (planar), first pass technique; multiple studies, at rest and with stress (exercise and/ or pharmacologic), wall motion study plus ejection fraction, with or without quantification | 9.80 | $622.30 | $124.46 | 000 | N | $684.53 |
| | **78491** | Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress | 7.11 | $451.68 | $135.50 | 000 | N | $496.85 |
| | **78492** | Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress | 8.87 | $563.18 | $168.95 | 000 | N | $619.50 |
| | **78494** | Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing | 8.59 | $545.47 | $98.18 | 000 | N | $600.02 |
| + | **78496** | Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (List separately in addition to code for primary procedure) | 6.44 | $408.94 | $36.80 | 000 | N | $449.83 |
| | **78499** | Unlisted cardiovascular procedure, diagnostic nuclear medicine | 0.00 | BR | | 000 | N | BR |
| | **78580** | Pulmonary perfusion imaging, particulate | 4.85 | $307.98 | $67.76 | 000 | N | $338.78 |
| | **78584** | Pulmonary perfusion imaging, particulate, with ventilation; single breath | 4.44 | $281.94 | $81.76 | 000 | N | $310.13 |
| | **78585** | Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath | 7.86 | $499.11 | $99.82 | 000 | N | $549.02 |
| | **78586** | Pulmonary ventilation imaging, aerosol; single projection | 3.54 | $224.79 | $38.21 | 000 | N | $247.27 |
| | **78587** | Pulmonary ventilation imaging, aerosol; multiple projections (eg, anterior, posterior, lateral views) | 4.11 | $260.99 | $49.59 | 000 | N | $287.09 |
| | **78588** | Pulmonary perfusion imaging, particulate, with ventilation imaging, aerosol, one or multiple projections | 5.91 | $375.29 | $116.34 | 000 | N | $412.82 |
| | **78591** | Pulmonary ventilation imaging, gaseous, single breath, single projection | 3.73 | $236.86 | $35.53 | 000 | N | $260.55 |
| | **78593** | Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; single projection | 4.48 | $284.48 | $45.52 | 000 | N | $312.93 |
| | **78594** | Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; multiple projections (eg, anterior, posterior, lateral views) | 5.87 | $372.75 | $44.73 | 000 | N | $410.03 |
| | **78596** | Pulmonary quantitative differential function (ventilation/perfusion) study | 9.26 | $588.01 | $111.72 | 000 | N | $646.81 |
| | **78599** | Unlisted respiratory procedure, diagnostic nuclear medicine | 0.00 | BR | $0.00 | 000 | N | BR |
| | **78600** | Brain imaging, limited procedure; static | 4.54 | $288.29 | $49.01 | 000 | N | $317.12 |
| | **78601** | Brain imaging, limited procedure; with vascular flow | 4.59 | $291.47 | $46.64 | 000 | N | $320.62 |
| | **78605** | Brain imaging, complete study; static | 4.48 | $284.48 | $48.36 | 000 | N | $312.93 |
| | **78606** | Brain imaging, complete study; with vascular flow | 5.90 | $374.65 | $67.44 | 000 | N | $412.12 |
| | **78607** | Brain imaging, complete study; tomographic (SPECT) | 10.34 | $656.59 | $131.32 | 000 | N | $722.25 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|---|
| | **78608** | Brain imaging, positron emission tomography (PET); metabolic evaluation | 8.25 | $524.13 | $131.03 | 000 | N | $576.54 |
| | **78609** | Brain imaging, positron emission tomography (PET); perfusion evaluation | 8.25 | $524.13 | $131.03 | 000 | N | $576.54 |
| | **78610** | Brain imaging, vascular flow only | 2.70 | $171.45 | $34.29 | 000 | N | $188.60 |
| | **78615** | Cerebral vascular flow | 4.87 | $309.25 | $40.20 | 000 | N | $340.18 |
| | **78630** | Cerebrospinal fluid flow, imaging (not including introduction of material); cisternography | 6.89 | $437.52 | $65.63 | 000 | N | $481.27 |
| | **78635** | Cerebrospinal fluid flow, imaging (not including introduction of material); ventriculography | 4.81 | $305.44 | $73.31 | 000 | N | $335.98 |
| | **78645** | Cerebrospinal fluid flow, imaging (not including introduction of material); shunt evaluation | 5.42 | $344.17 | $61.95 | 000 | N | $378.59 |
| | **78647** | Cerebrospinal fluid flow, imaging (not including introduction of material); tomographic (SPECT) | 9.22 | $585.47 | $99.53 | 000 | N | $644.02 |
| | **78650** | Cerebrospinal fluid leakage detection and localization | 6.50 | $412.75 | $61.91 | 000 | N | $454.03 |
| | **78660** | Radiopharmaceutical dacryocystography | 3.36 | $213.36 | $51.21 | 000 | N | $234.70 |
| | **78699** | Unlisted nervous system procedure, diagnostic nuclear medicine | 0.00 | BR | | 000 | N | BR |
| | **78700** | Kidney imaging morphology; | 4.05 | $257.18 | $41.15 | 000 | N | $282.90 |
| | **78701** | Kidney imaging morphology; with vascular flow | 4.70 | $298.45 | $44.77 | 000 | N | $328.30 |
| | **78707** | Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention | 6.01 | $381.64 | $83.96 | 000 | N | $419.80 |
| | **78708** | Kidney imaging morphology; with vascular flow and function, single study, with pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic) | 5.82 | $369.57 | $96.09 | 000 | N | $406.53 |
| | **78709** | Kidney imaging morphology; with vascular flow and function, multiple studies, with and without pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic) | 7.35 | $466.73 | $135.35 | 000 | N | $513.40 |
| | **78710** | Kidney imaging morphology; tomographic (SPECT) | 6.78 | $430.53 | $55.97 | 000 | N | $473.58 |
| | **78725** | Kidney function study, non-imaging radioisotopic study | 2.47 | $156.85 | $34.51 | 000 | N | $172.54 |
| + | **78730** | Urinary bladder residual study (List separately in addition to code for primary procedure) | 1.91 | $121.29 | $30.32 | 000 | N | $133.42 |
| | **78740** | Ureteral reflux study (radiopharmaceutical voiding cystogram) | 3.68 | $233.68 | $60.76 | 000 | N | $257.05 |
| | **78761** | Testicular imaging with vascular flow | 4.57 | $290.20 | $63.84 | 000 | N | $319.22 |
| | **78799** | Unlisted genitourinary procedure, diagnostic nuclear medicine | 0.00 | BR | | 000 | N | BR |
| | **78800** | Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area | 4.54 | $288.29 | $57.66 | 000 | N | $317.12 |
| | **78801** | Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); multiple areas | 5.79 | $367.67 | $73.53 | 000 | N | $404.44 |
| | **78802** | Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging | 7.40 | $469.90 | $79.88 | 000 | N | $516.89 |
| | **78803** | Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT) | 10.11 | $641.99 | $115.56 | 000 | N | $706.19 |
| | **78804** | Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging | 13.38 | $849.63 | $93.46 | 000 | N | $934.59 |
| | **78805** | Radiopharmaceutical localization of inflammatory process; limited area | 4.60 | $292.10 | $64.26 | 000 | N | $321.31 |
| | **78806** | Radiopharmaceutical localization of inflammatory process; whole body | 8.17 | $518.80 | $77.82 | 000 | N | $570.68 |
| | **78807** | Radiopharmaceutical localization of inflammatory process; tomographic (SPECT) | 9.93 | $630.56 | $113.50 | 000 | N | $693.62 |
| | **78811** | Tumor imaging, positron emission tomography (PET); limited area (eg, chest, head/neck) | 6.86 | $435.61 | $108.90 | 000 | N | $479.17 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **78812** | Tumor imaging, positron emission tomography (PET); skull base to mid-thigh | 8.47 | $537.91 | $134.48 | 000 | N | $591.70 |
| **78813** | Tumor imaging, positron emission tomography (PET); whole body | 8.82 | $559.75 | $139.94 | 000 | N | $615.73 |
| **78814** | Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (eg, chest, head/neck) | 9.63 | $611.44 | $152.86 | 000 | N | $672.58 |
| **78815** | Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid-thigh | 10.64 | $675.83 | $168.96 | 000 | N | $743.41 |
| **78816** | Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body | 10.93 | $694.18 | $173.55 | 000 | N | $763.60 |
| **78890** | Generation of automated data: interactive process involving nuclear physician and/or allied health professional personnel; simple manipulations and interpretation, not to exceed 30 minutes | 1.21 | $76.84 | $7.68 | 000 | N | $84.52 |
| **78891** | Generation of automated data: interactive process involving nuclear physician and/or allied health professional personnel; complex manipulations and interpretation, exceeding 30 minutes | 2.45 | $155.58 | $7.78 | 000 | N | $171.14 |
| **78999** | Unlisted miscellaneous procedure, diagnostic nuclear medicine | 0.00 | BR | | 000 | N | BR |
| **79005** | Radiopharmaceutical therapy, by oral administration | 4.69 | $297.82 | $139.98 | 000 | N | $327.60 |
| **79101** | Radiopharmaceutical therapy, by intravenous administration | 4.96 | $314.96 | $154.33 | 000 | N | $346.46 |
| **79200** | Radiopharmaceutical therapy, by intracavitary administration | 5.03 | $319.41 | $159.71 | 000 | N | $351.35 |
| **79300** | Radiopharmaceutical therapy, by interstitial radioactive colloid administration | 3.73 | $236.79 | $142.07 | 000 | N | $260.47 |
| **79403** | Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion | 6.83 | $433.71 | $182.16 | 000 | N | $477.08 |
| **79440** | Radiopharmaceutical therapy, by intra-articular administration | 4.93 | $313.06 | $156.53 | 000 | N | $344.37 |
| **79445** | Radiopharmaceutical therapy, by intra-arterial particulate administration | 6.12 | $388.49 | $213.67 | 000 | N | $427.34 |
| **79999** | Radiopharmaceutical therapy, unlisted procedure | 0.00 | BR | | 000 | N | BR |

# Pathology and Laboratory

## I. Guidelines

A. **Pathology Services**
Services in pathology and laboratory are provided by the pathologist, or by the technologist, under responsible supervision of a physician.

B. **Separate or Multiple Procedures**
It is appropriate to designate multiple procedures rendered on the same date by separate entries.

C. **Unlisted Service or Procedures**
A service or procedure may be provided that is not listed in this fee schedule. When reporting such a service or procedure, the appropriate unlisted procedure code may be used to indicate the service, identifying it by special report as discussed below. The unlisted procedures and accompanying codes for Pathology and Laboratory are as follows:

81099 Unlisted urinalysis procedure

84999 Unlisted chemistry procedure

85999 Unlisted hematology and coagulation procedure

86586 Unlisted antigen, each

86849 Unlisted immunology procedure

86999 Unlisted transfusion medicine procedure

87999 Unlisted microbiology procedure

88099 Unlisted necropsy (autopsy) procedure

88199 Unlisted cytopathology procedure

88299 Unlisted cytogenetic study

88399 Unlisted surgical pathology procedure

89240 Unlisted miscellaneous pathology test

D. **Special 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 that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care. This report does not command a separate fee for completion.

E. **By Report (BR)**
"BR" in the Amount column indicates services that are too new, unusual, or variable in the nature of their performance to permit the assignment of a definable fee. Such services should be substantiated by documentation submitted with the bill. Sufficient information should be included to permit proper identification and a sound evaluation. If the service is justified by the report, the actual charge shall be paid in full, unless the payer has evidence that the actual charge exceeds the usual and customary charge for such service.

F. **Facility Fee**
The facility fee is the Amount increased by ten percent (10%).

## II. General Information and Instructions

A. **Panel Tests**
The billing for panel tests must include documentation listing the tests in the panel. When billing for panel tests (80048–80076), use the code number corresponding to the appropriate panel test. These tests will not be reimbursed separately.

The panel components do not preclude the performance of other tests not listed in the panel. If other laboratory tests are performed in conjunction with a particular panel, the additional tests may be reported separately in addition to the panel.

B. **Handling and Collection Process**
1. In collecting a specimen, the cost for collection is covered by the technical component when the lab test is conducted at that site. No separate collection or handling fee for this purpose will be reimbursed.
2. When a specimen must be sent to a reference laboratory, the cost of specimen collection is

covered in a collection fee. This charge is only allowed when a reference laboratory is used, and modifier 90 must be used.

C. **Global, Professional, and Technical Components**
Some procedures in the Pathology and Laboratory section are considered global fees and do not qualify for a separate technical (TC) or professional (PC) component. Some procedures are listed with a PC fee in addition to the global fee. For procedures listed with a PC fee, the TC reimbursement rate is calculated by subtracting the PC amount from the total amount.

Whereas these guidelines are written to be all-inclusive, there are instances when the reviewer must make an informed decision regarding the PC/TC reimbursements. Request for PC reimbursement will only be considered if:

- The physician performs the procedure or reviews the results
- A written report, not a computer generated report, is submitted with the request for payment

## III. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier code. The modifier may be reported by a two-digit number placed after the usual procedure number and separated by a hyphen. If more than one modifier is used, place the multiple modifiers code 99 immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in pathology and laboratory are as follows:

### *22 Unusual Procedural Services*

When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

*Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.*

### *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 modifier 26 to the usual procedure number.

### *TC Technical Component (HCPCS Level II Modifier)*

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

*Mississippi's note: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.*

### *32 Mandated Services*

Services related to mandated consultation and/or related services (eg, PRO, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

### *52 Reduced Services*

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

### *53 Discontinued Procedure*

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

### *59 Distinct Procedural Service*

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day.

Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

### *90 Reference (Outside) Laboratory*

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

### *91 Repeat Clinical Diagnostic Laboratory Test*

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when another code(s) describes a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for a laboratory test(s) performed more than once on the same day on the same patient.

### *99 Multiple Modifiers*

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

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **80048** | Basic metabolic panel This panel must include the following: Calcium (82310) Carbon dioxide (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520) | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **80050** | General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Thyroid stimulating hormone (TSH) (84443) | 1.68 | $100.14 | $0.00 | 000 | N | $110.15 |
| **80051** | Electrolyte panel This panel must include the following: Carbon dioxide (82374) Chloride (82435) Potassium (84132) Sodium (84295) | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **80053** | Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520) | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| **80055** | Obstetric panel This panel must include the following: Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Hepatitis B surface antigen (HBsAg) (87340) Antibody, rubella (86762) Syphilis test, qualitative (eg, VDRL, RPR, ART) (86592) Antibody screen, RBC, each serum technique (86850) Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901) | 2.14 | $127.45 | $0.00 | 000 | N | $140.20 |
| **80061** | Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478) | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **80069** | Renal function panel This panel must include the following: Albumin (82040) Calcium (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphorus inorganic (phosphate) (84100) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520) | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| **80074** | Acute hepatitis panel This panel must include the following: Hepatitis A antibody (HAAb), IgM antibody (86709) Hepatitis B core antibody (HBcAb), IgM antibody (86705) Hepatitis B surface antigen (HBsAg) (87340) Hepatitis C antibody (86803) | 3.03 | $180.23 | $0.00 | 000 | N | $198.25 |
| **80076** | Hepatic function panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Bilirubin, direct (82248) Phosphatase, alkaline (84075) Protein, total (84155) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) | 0.67 | $40.04 | $0.00 | 000 | N | $44.04 |
| **80100** | Drug screen, qualitative; multiple drug classes chromatographic method, each procedure | 1.29 | $76.46 | $0.00 | 000 | N | $84.11 |
| **80101** | Drug screen, qualitative; single drug class method (eg, immunoassay, enzyme assay), each drug class | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **80102** | Drug confirmation, each procedure | 1.65 | $98.29 | $0.00 | 000 | N | $108.12 |
| **80103** | Tissue preparation for drug analysis | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **80150** | Amikacin | 1.29 | $76.46 | $0.00 | 000 | N | $84.11 |
| **80152** | Amitriptyline | 1.71 | $101.98 | $0.00 | 000 | N | $112.18 |
| **80154** | Benzodiazepines | 1.70 | $101.03 | $0.00 | 000 | N | $111.13 |
| **80156** | Carbamazepine; total | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **80157** | Carbamazepine; free | 1.26 | $74.67 | $0.00 | 000 | N | $82.14 |
| **80158** | Cyclosporine | 1.74 | $103.77 | $0.00 | 000 | N | $114.15 |
| **80160** | Desipramine | 1.68 | $100.14 | $0.00 | 000 | N | $110.15 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **80162** | Digoxin | 1.29 | $76.46 | $0.00 | 000 | N | $84.11 |
| **80164** | Dipropylacetic acid (valproic acid) | 1.32 | $78.30 | $0.00 | 000 | N | $86.13 |
| **80166** | Doxepin | 1.47 | $87.41 | $0.00 | 000 | N | $96.15 |
| **80168** | Ethosuximide | 1.50 | $89.19 | $0.00 | 000 | N | $98.11 |
| **80170** | Gentamicin | 1.44 | $85.56 | $0.00 | 000 | N | $94.12 |
| **80172** | Gold | 1.41 | $83.78 | $0.00 | 000 | N | $92.16 |
| **80173** | Haloperidol | 1.26 | $74.67 | $0.00 | 000 | N | $82.14 |
| **80174** | Imipramine | 1.62 | $96.51 | $0.00 | 000 | N | $106.16 |
| **80176** | Lidocaine | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **80178** | Lithium | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **80182** | Nortriptyline | 1.35 | $80.09 | $0.00 | 000 | N | $88.10 |
| **80184** | Phenobarbital | 1.13 | $67.35 | $0.00 | 000 | N | $74.09 |
| **80185** | Phenytoin; total | 1.29 | $76.46 | $0.00 | 000 | N | $84.11 |
| **80186** | Phenytoin; free | 1.35 | $80.09 | $0.00 | 000 | N | $88.10 |
| **80188** | Primidone | 1.62 | $96.51 | $0.00 | 000 | N | $106.16 |
| **80190** | Procainamide; | 1.41 | $83.78 | $0.00 | 000 | N | $92.16 |
| **80192** | Procainamide; with metabolites (eg, n-acetyl procainamide) | 1.56 | $92.88 | $0.00 | 000 | N | $102.17 |
| **80194** | Quinidine | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **80195** | Sirolimus | 1.78 | $105.61 | $0.00 | 000 | N | $116.17 |
| **80196** | Salicylate | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **80197** | Tacrolimus | 1.74 | $103.77 | $0.00 | 000 | N | $114.15 |
| **80198** | Theophylline | 1.35 | $80.09 | $0.00 | 000 | N | $88.10 |
| **80200** | Tobramycin | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **80201** | Topiramate | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **80202** | Vancomycin | 1.26 | $74.67 | $0.00 | 000 | N | $82.14 |
| **80299** | Quantitation of drug, not elsewhere specified | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **80400** | ACTH stimulation panel; for adrenal insufficiency | 2.88 | $171.12 | $0.00 | 000 | N | $188.23 |
| **80402** | ACTH stimulation panel; for 21 hydroxylase deficiency | 4.68 | $278.58 | $0.00 | 000 | N | $306.44 |
| **80406** | ACTH stimulation panel; for 3 beta-hydroxydehydrogenase deficiency | 4.93 | $293.16 | $0.00 | 000 | N | $322.48 |
| **80408** | Aldosterone suppression evaluation panel (eg, saline infusion) | 5.36 | $318.62 | $0.00 | 000 | N | $350.48 |
| **80410** | Calcitonin stimulation panel (eg, calcium, pentagastrin) | 4.44 | $264.00 | $0.00 | 000 | N | $290.40 |
| **80412** | Corticotropic releasing hormone (CRH) stimulation panel | 13.77 | $819.32 | $0.00 | 000 | N | $901.25 |
| **80414** | Chorionic gonadotropin stimulation panel; testosterone response | 2.30 | $136.55 | $0.00 | 000 | N | $150.21 |
| **80415** | Chorionic gonadotropin stimulation panel; estradiol response | 2.30 | $136.55 | $0.00 | 000 | N | $150.21 |
| **80416** | Renal vein renin stimulation panel (eg, captopril) | 6.85 | $407.81 | $0.00 | 000 | N | $448.59 |
| **80417** | Peripheral vein renin stimulation panel (eg, captopril) | 2.94 | $174.81 | $0.00 | 000 | N | $192.29 |
| **80418** | Combined rapid anterior pituitary evaluation panel | 30.60 | $1,820.70 | $0.00 | 000 | N | $2002.77 |
| **80420** | Dexamethasone suppression panel, 48 hour | 3.83 | $227.59 | $0.00 | 000 | N | $250.35 |
| **80422** | Glucagon tolerance panel; for insulinoma | 2.60 | $154.76 | $0.00 | 000 | N | $170.24 |
| **80424** | Glucagon tolerance panel; for pheochromocytoma | 2.60 | $154.76 | $0.00 | 000 | N | $170.24 |
| **80426** | Gonadotropin releasing hormone stimulation panel | 7.19 | $427.86 | $0.00 | 000 | N | $470.65 |
| **80428** | Growth hormone stimulation panel (eg, arginine infusion, l-dopa administration) | 3.98 | $236.69 | $0.00 | 000 | N | $260.36 |
| **80430** | Growth hormone suppression panel (glucose administration) | 3.98 | $236.69 | $0.00 | 000 | N | $260.36 |
| **80432** | Insulin-induced C-peptide suppression panel | 7.80 | $464.28 | $0.00 | 000 | N | $510.71 |
| **80434** | Insulin tolerance panel; for ACTH insufficiency | 4.90 | $291.31 | $0.00 | 000 | N | $320.44 |
| **80435** | Insulin tolerance panel; for growth hormone deficiency | 5.20 | $309.52 | $0.00 | 000 | N | $340.47 |
| **80436** | Metyrapone panel | 5.05 | $300.42 | $0.00 | 000 | N | $330.46 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **80438** | Thyrotropin releasing hormone (TRH) stimulation panel; one hour | 2.91 | $172.97 | $0.00 | 000 | N | $190.27 |
| **80439** | Thyrotropin releasing hormone (TRH) stimulation panel; two hour | 3.06 | $182.07 | $0.00 | 000 | N | $200.28 |
| **80440** | Thyrotropin releasing hormone (TRH) stimulation panel; for hyperprolactinemia | 3.06 | $182.07 | $0.00 | 000 | N | $200.28 |
| **80500** | Clinical pathology consultation; limited, without review of patient's history and medical records | 0.55 | $32.73 | | 000 | N | $36.00 |
| **80502** | Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records | 1.72 | $102.34 | | 000 | N | $112.57 |
| **81000** | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy | 0.35 | $20.94 | $0.00 | 000 | N | $23.03 |
| **81001** | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy | 0.35 | $20.94 | $0.00 | 000 | N | $23.03 |
| **81002** | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy | 0.28 | $16.36 | $0.00 | 000 | N | $18.00 |
| **81003** | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy | 0.29 | $17.31 | $0.00 | 000 | N | $19.04 |
| **81005** | Urinalysis; qualitative or semiquantitative, except immunoassays | 0.28 | $16.36 | $0.00 | 000 | N | $18.00 |
| **81007** | Urinalysis; bacteriuria screen, except by culture or dipstick | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **81015** | Urinalysis; microscopic only | 0.28 | $16.36 | $0.00 | 000 | N | $18.00 |
| **81020** | Urinalysis; two or three glass test | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **81025** | Urine pregnancy test, by visual color comparison methods | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **81050** | Volume measurement for timed collection, each | 0.28 | $16.36 | $0.00 | 000 | N | $18.00 |
| **81099** | Unlisted urinalysis procedure | 0.00 | BR | | 000 | N | BR |
| **82000** | Acetaldehyde, blood | 1.41 | $83.78 | $0.00 | 000 | N | $92.16 |
| **82003** | Acetaminophen | 1.26 | $74.67 | $0.00 | 000 | N | $82.14 |
| **82009** | Acetone or other ketone bodies, serum; qualitative | 0.46 | $27.31 | $0.00 | 000 | N | $30.04 |
| **82010** | Acetone or other ketone bodies, serum; quantitative | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **82013** | Acetylcholinesterase | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **82016** | Acylcarnitines; qualitative, each specimen | 1.50 | $89.19 | $0.00 | 000 | N | $98.11 |
| **82017** | Acylcarnitines; quantitative, each specimen | 1.50 | $89.19 | $0.00 | 000 | N | $98.11 |
| **82024** | Adrenocorticotropic hormone (ACTH) | 0.28 | $16.36 | $0.00 | 000 | N | $18.00 |
| **82030** | Adenosine, 5-monophosphate, cyclic (cyclic AMP) | 2.14 | $127.45 | $0.00 | 000 | N | $140.20 |
| **82040** | Albumin; serum | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **82042** | Albumin; urine or other source, quantitative, each specimen | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| **82043** | Albumin; urine, microalbumin, quantitative | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **82044** | Albumin; urine, microalbumin, semiquantitative (eg, reagent strip assay) | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **82045** | Albumin; ischemia modified | 0.00 | BR | $0.00 | 000 | N | BR |
| **82055** | Alcohol (ethanol); any specimen except breath | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **82075** | Alcohol (ethanol); breath | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **82085** | Aldolase | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| **82088** | Aldosterone | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **82101** | Alkaloids, urine, quantitative | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **82103** | Alpha-1-antitrypsin; total | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **82104** | Alpha-1-antitrypsin; phenotype | 1.74 | $103.77 | $0.00 | 000 | N | $114.15 |
| **82105** | Alpha-fetoprotein (AFP); serum | 1.44 | $85.56 | $0.00 | 000 | N | $94.12 |
| **82106** | Alpha-fetoprotein (AFP); amniotic fluid | 1.44 | $85.56 | $0.00 | 000 | N | $94.12 |
| **82107** | Alpha-fetoprotein (AFP); AFP-L3 fraction isoform and total AFP (including ratio) | 1.68 | $100.14 | $0.00 | 000 | N | $110.15 |
| **82108** | Aluminum | 1.78 | $105.61 | $0.00 | 000 | N | $116.17 |
| **82120** | Amines, vaginal fluid, qualitative | 0.00 | BR | $0.00 | 000 | N | BR |
| **82127** | Amino acids; single, qualitative, each specimen | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **82128** | Amino acids; multiple, qualitative, each specimen | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| **82131** | Amino acids; single, quantitative, each specimen | 3.92 | $233.06 | $0.00 | 000 | N | $256.37 |
| **82135** | Aminolevulinic acid, delta (ALA) | 1.32 | $78.30 | $0.00 | 000 | N | $86.13 |
| **82136** | Amino acids, 2 to 5 amino acids, quantitative, each specimen | 3.92 | $233.06 | $0.00 | 000 | N | $256.37 |
| **82139** | Amino acids, 6 or more amino acids, quantitative, each specimen | 3.92 | $233.06 | $0.00 | 000 | N | $256.37 |
| **82140** | Ammonia | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| **82143** | Amniotic fluid scan (spectrophotometric) | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **82145** | Amphetamine or methamphetamine | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **82150** | Amylase | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **82154** | Androstanediol glucuronide | 2.05 | $121.98 | $0.00 | 000 | N | $134.18 |
| **82157** | Androstenedione | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| **82160** | Androsterone | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **82163** | Angiotensin II | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **82164** | Angiotensin I - converting enzyme (ACE) | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **82172** | Apolipoprotein, each | 1.01 | $60.10 | $0.00 | 000 | N | $66.11 |
| **82175** | Arsenic | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **82180** | Ascorbic acid (Vitamin C), blood | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **82190** | Atomic absorption spectroscopy, each analyte | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **82205** | Barbiturates, not elsewhere specified | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **82232** | Beta-2 microglobulin | 1.68 | $100.14 | $0.00 | 000 | N | $110.15 |
| **82239** | Bile acids; total | 1.04 | $61.88 | $0.00 | 000 | N | $68.07 |
| **82240** | Bile acids; cholylglycine | 2.08 | $123.82 | $0.00 | 000 | N | $136.20 |
| **82247** | Bilirubin; total | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **82248** | Bilirubin; direct | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **82252** | Bilirubin; feces, qualitative | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **82261** | Biotinidase, each specimen | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **82270** | Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided three cards or single triple card for consecutive collection) | 0.31 | $18.21 | $0.00 | 000 | N | $20.03 |
| **82271** | Blood, occult, by peroxidase activity (eg, guaiac), qualitative; other sources | 0.31 | $18.21 | $0.00 | 000 | N | $20.03 |
| **82272** | Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, single specimen (eg, from digital rectal exam) | 0.28 | $16.36 | $0.00 | 000 | N | $18.00 |
| **82274** | Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **82286** | Bradykinin | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **82300** | Cadmium | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **82306** | Calcifediol (25-OH Vitamin D-3) | 2.30 | $136.55 | $0.00 | 000 | N | $150.21 |
| **82307** | Calciferol (Vitamin D) | 2.30 | $136.55 | $0.00 | 000 | N | $150.21 |
| **82308** | Calcitonin | 2.30 | $136.55 | $0.00 | 000 | N | $150.21 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **82310** | Calcium; total | 0.37 | $21.84 | $0.00 | 000 | N | $24.02 |
| **82330** | Calcium; ionized | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **82331** | Calcium; after calcium infusion test | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| **82340** | Calcium; urine quantitative, timed specimen | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| **82355** | Calculus; qualitative analysis | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **82360** | Calculus; quantitative analysis, chemical | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **82365** | Calculus; infrared spectroscopy | 1.10 | $65.57 | $0.00 | 000 | N | $72.13 |
| **82370** | Calculus; x-ray diffraction | 1.13 | $67.35 | $0.00 | 000 | N | $74.09 |
| **82373** | Carbohydrate deficient transferrin | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **82374** | Carbon dioxide (bicarbonate) | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **82375** | Carbon monoxide, (carboxyhemoglobin); quantitative | 0.95 | $56.47 | $0.00 | 000 | N | $62.12 |
| **82376** | Carbon monoxide, (carboxyhemoglobin); qualitative | 0.40 | $23.68 | $0.00 | 000 | N | $26.05 |
| **82378** | Carcinoembryonic antigen (CEA) | 1.59 | $94.66 | $0.00 | 000 | N | $104.13 |
| **82379** | Carnitine (total and free), quantitative, each specimen | 1.59 | $94.66 | $0.00 | 000 | N | $104.13 |
| **82380** | Carotene | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| **82382** | Catecholamines; total urine | 1.47 | $87.41 | $0.00 | 000 | N | $96.15 |
| **82383** | Catecholamines; blood | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **82384** | Catecholamines; fractionated | 2.23 | $132.92 | $0.00 | 000 | N | $146.21 |
| **82387** | Cathepsin-D | 2.14 | $127.45 | $0.00 | 000 | N | $140.20 |
| **82390** | Ceruloplasmin | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **82397** | Chemiluminescent assay | 0.95 | $56.47 | $0.00 | 000 | N | $62.12 |
| **82415** | Chloramphenicol | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **82435** | Chloride; blood | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **82436** | Chloride; urine | 0.40 | $23.68 | $0.00 | 000 | N | $26.05 |
| **82438** | Chloride; other source | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| **82441** | Chlorinated hydrocarbons, screen | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **82465** | Cholesterol, serum or whole blood, total | 0.37 | $21.84 | $0.00 | 000 | N | $24.02 |
| **82480** | Cholinesterase; serum | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **82482** | Cholinesterase; RBC | 1.04 | $61.88 | $0.00 | 000 | N | $68.07 |
| **82485** | Chondroitin B sulfate, quantitative | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **82486** | Chromatography, qualitative; column (eg, gas liquid or HPLC), analyte not elsewhere specified | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **82487** | Chromatography, qualitative; paper, 1-dimensional, analyte not elsewhere specified | 1.35 | $80.09 | $0.00 | 000 | N | $88.10 |
| **82488** | Chromatography, qualitative; paper, 2-dimensional, analyte not elsewhere specified | 1.81 | $107.40 | $0.00 | 000 | N | $118.14 |
| **82489** | Chromatography, qualitative; thin layer, analyte not elsewhere specified | 1.35 | $80.09 | $0.00 | 000 | N | $88.10 |
| **82491** | Chromatography, quantitative, column (eg, gas liquid or HPLC); single analyte not elsewhere specified, single stationary and mobile phase | 1.29 | $76.46 | $0.00 | 000 | N | $84.11 |
| **82492** | Chromatography, quantitative, column (eg, gas liquid or HPLC); multiple analytes, single stationary and mobile phase | 1.47 | $87.41 | $0.00 | 000 | N | $96.15 |
| **82495** | Chromium | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **82507** | Citrate | 2.23 | $132.92 | $0.00 | 000 | N | $146.21 |
| **82520** | Cocaine or metabolite | 1.47 | $87.41 | $0.00 | 000 | N | $96.15 |
| **82523** | Collagen cross links, any method | 0.00 | BR | $0.00 | 000 | N | BR |
| **82525** | Copper | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **82528** | Corticosterone | 1.74 | $103.77 | $0.00 | 000 | N | $114.15 |
| **82530** | Cortisol; free | 1.62 | $96.51 | $0.00 | 000 | N | $106.16 |
| **82533** | Cortisol; total | 1.44 | $85.56 | $0.00 | 000 | N | $94.12 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **82540** | Creatine | 0.47 | $28.20 | $0.00 | 000 | N | $31.02 |
| **82541** | Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), analyte not elsewhere specified; qualitative, single stationary and mobile phase | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **82542** | Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), analyte not elsewhere specified; quantitative, single stationary and mobile phase | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **82543** | Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), analyte not elsewhere specified; stable isotope dilution, single analyte, quantitative, single stationary and mobile phase | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **82544** | Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), analyte not elsewhere specified; stable isotope dilution, multiple analytes, quantitative, single stationary and mobile phase | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **82550** | Creatine kinase (CK), (CPK); total | 0.40 | $23.68 | $0.00 | 000 | N | $26.05 |
| **82552** | Creatine kinase (CK), (CPK); isoenzymes | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **82553** | Creatine kinase (CK), (CPK); MB fraction only | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **82554** | Creatine kinase (CK), (CPK); isoforms | 1.04 | $61.88 | $0.00 | 000 | N | $68.07 |
| **82565** | Creatinine; blood | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **82570** | Creatinine; other source | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| **82575** | Creatinine; clearance | 0.89 | $52.78 | $0.00 | 000 | N | $58.06 |
| **82585** | Cryofibrinogen | 0.70 | $41.89 | $0.00 | 000 | N | $46.08 |
| **82595** | Cryoglobulin, qualitative or semi-quantitative (eg, cryocrit) | 0.64 | $38.26 | $0.00 | 000 | N | $42.09 |
| **82600** | Cyanide | 1.35 | $80.09 | $0.00 | 000 | N | $88.10 |
| **82607** | Cyanocobalamin (Vitamin B-12); | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **82608** | Cyanocobalamin (Vitamin B-12); unsaturated binding capacity | 1.29 | $76.46 | $0.00 | 000 | N | $84.11 |
| **82615** | Cystine and homocystine, urine, qualitative | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **82626** | Dehydroepiandrosterone (DHEA) | 2.08 | $123.82 | $0.00 | 000 | N | $136.20 |
| **82627** | Dehydroepiandrosterone-sulfate (DHEA-S) | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **82633** | Desoxycorticosterone, 11- | 1.99 | $118.35 | $0.00 | 000 | N | $130.19 |
| **82634** | Deoxycortisol, 11- | 1.99 | $118.35 | $0.00 | 000 | N | $130.19 |
| **82638** | Dibucaine number | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| **82646** | Dihydrocodeinone | 1.65 | $98.29 | $0.00 | 000 | N | $108.12 |
| **82649** | Dihydromorphinone | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **82651** | Dihydrotestosterone (DHT) | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **82652** | Dihydroxyvitamin D, 1,25- | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **82654** | Dimethadione | 1.65 | $98.29 | $0.00 | 000 | N | $108.12 |
| **82656** | Elastase, pancreatic (EL-1), fecal, qualitative or semi-quantitative | 0.00 | BR | $0.00 | 000 | N | BR |
| **82657** | Enzyme activity in blood cells, cultured cells, or tissue, not elsewhere specified; nonradioactive substrate, each specimen | 0.00 | BR | $0.00 | 000 | N | BR |
| **82658** | Enzyme activity in blood cells, cultured cells, or tissue, not elsewhere specified; radioactive substrate, each specimen | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **82664** | Electrophoretic technique, not elsewhere specified | 1.41 | $83.78 | $0.00 | 000 | N | $92.16 |
| **82666** | Epiandrosterone | 1.59 | $94.66 | $0.00 | 000 | N | $104.13 |
| **82668** | Erythropoietin | 1.99 | $118.35 | $0.00 | 000 | N | $130.19 |
| **82670** | Estradiol | 1.44 | $85.56 | $0.00 | 000 | N | $94.12 |
| **82671** | Estrogens; fractionated | 2.69 | $160.23 | $0.00 | 000 | N | $176.25 |
| **82672** | Estrogens; total | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **82677** | Estriol | 1.32 | $78.30 | $0.00 | 000 | N | $86.13 |
| **82679** | Estrone | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **82690** | Ethchlorvynol | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **82693** | Ethylene glycol | 1.44 | $85.56 | $0.00 | 000 | N | $94.12 |
| **82696** | Etiocholanolone | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **82705** | Fat or lipids, feces; qualitative | 0.67 | $40.04 | $0.00 | 000 | N | $44.04 |
| **82710** | Fat or lipids, feces; quantitative | 1.50 | $89.19 | $0.00 | 000 | N | $98.11 |
| **82715** | Fat differential, feces, quantitative | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **82725** | Fatty acids, nonesterified | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **82726** | Very long chain fatty acids | 0.00 | BR | $0.00 | 000 | N | BR |
| **82728** | Ferritin | 1.13 | $67.35 | $0.00 | 000 | N | $74.09 |
| **82731** | Fetal fibronectin, cervicovaginal secretions, semi-quantitative | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **82735** | Fluoride | 1.26 | $74.67 | $0.00 | 000 | N | $82.14 |
| **82742** | Flurazepam | 1.50 | $89.19 | $0.00 | 000 | N | $98.11 |
| **82746** | Folic acid; serum | 1.26 | $74.67 | $0.00 | 000 | N | $82.14 |
| **82747** | Folic acid; RBC | 1.50 | $89.19 | $0.00 | 000 | N | $98.11 |
| **82757** | Fructose, semen | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **82759** | Galactokinase, RBC | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **82760** | Galactose | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **82775** | Galactose-1-phosphate uridyl transferase; quantitative | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **82776** | Galactose-1-phosphate uridyl transferase; screen | 0.40 | $23.68 | $0.00 | 000 | N | $26.05 |
| **82784** | Gammaglobulin; IgA, IgD, IgG, IgM, each | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **82785** | Gammaglobulin; IgE | 1.26 | $74.67 | $0.00 | 000 | N | $82.14 |
| **82787** | Gammaglobulin; immunoglobulin subclasses, (IgG1, 2, 3, or 4), each | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **82800** | Gases, blood, pH only | 0.70 | $41.89 | $0.00 | 000 | N | $46.08 |
| **82803** | Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation); | 1.41 | $83.78 | $0.00 | 000 | N | $92.16 |
| **82805** | Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation); with O2 saturation, by direct measurement, except pulse oximetry | 1.44 | $85.56 | $0.00 | 000 | N | $94.12 |
| **82810** | Gases, blood, O2 saturation only, by direct measurement, except pulse oximetry | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| **82820** | Hemoglobin-oxygen affinity (pO2 for 50% hemoglobin saturation with oxygen) | 1.04 | $61.88 | $0.00 | 000 | N | $68.07 |
| **82926** | Gastric acid, free and total, each specimen | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| **82928** | Gastric acid, free or total, each specimen | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **82938** | Gastrin after secretin stimulation | 1.62 | $96.51 | $0.00 | 000 | N | $106.16 |
| **82941** | Gastrin | 1.44 | $85.56 | $0.00 | 000 | N | $94.12 |
| **82943** | Glucagon | 1.74 | $103.77 | $0.00 | 000 | N | $114.15 |
| **82945** | Glucose, body fluid, other than blood | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **82946** | Glucagon tolerance test | 0.95 | $56.47 | $0.00 | 000 | N | $62.12 |
| **82947** | Glucose; quantitative, blood (except reagent strip) | 0.40 | $23.68 | $0.00 | 000 | N | $26.05 |
| **82948** | Glucose; blood, reagent strip | 0.31 | $18.21 | $0.00 | 000 | N | $20.03 |
| **82950** | Glucose; post glucose dose (includes glucose) | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **82951** | Glucose; tolerance test (GTT), three specimens (includes glucose) | 1.10 | $65.57 | $0.00 | 000 | N | $72.13 |
| **82952** | Glucose; tolerance test, each additional beyond three specimens | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **82953** | Glucose; tolbutamide tolerance test | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **82955** | Glucose-6-phosphate dehydrogenase (G6PD); quantitative | 1.10 | $65.57 | $0.00 | 000 | N | $72.13 |
| **82960** | Glucose-6-phosphate dehydrogenase (G6PD); screen | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| **82962** | Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use | 0.31 | $18.21 | $0.00 | 000 | N | $20.03 |
| **82963** | Glucosidase, beta | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **82965** | Glutamate dehydrogenase | 0.43 | $25.47 | $0.00 | 000 | N | $28.02 |
| **82975** | Glutamine (glutamic acid amide) | 1.04 | $61.88 | $0.00 | 000 | N | $68.07 |
| **82977** | Glutamyltransferase, gamma (GGT) | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **82978** | Glutathione | 1.01 | $60.10 | $0.00 | 000 | N | $66.11 |
| **82979** | Glutathione reductase, RBC | 0.89 | $52.78 | $0.00 | 000 | N | $58.06 |
| **82980** | Glutethimide | 1.47 | $87.41 | $0.00 | 000 | N | $96.15 |
| **82985** | Glycated protein | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **83001** | Gonadotropin; follicle stimulating hormone (FSH) | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **83002** | Gonadotropin; luteinizing hormone (LH) | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **83003** | Growth hormone, human (HGH) (somatotropin) | 1.47 | $87.41 | $0.00 | 000 | N | $96.15 |
| **83008** | Guanosine monophosphate (GMP), cyclic | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **83009** | Helicobacter pylori, blood test analysis for urease activity, non-radioactive isotope (eg, C-13) | 0.00 | BR | $0.00 | 000 | N | BR |
| **83010** | Haptoglobin; quantitative | 1.13 | $67.35 | $0.00 | 000 | N | $74.09 |
| **83012** | Haptoglobin; phenotypes | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **83013** | Helicobacter pylori; breath test analysis for urease activity, non-radioactive isotope (eg, C-13) | 0.00 | BR | $0.00 | 000 | N | BR |
| **83014** | Helicobacter pylori; drug administration | 0.00 | BR | $0.00 | 000 | N | BR |
| **83015** | Heavy metal (eg, arsenic, barium, beryllium, bismuth, antimony, mercury); screen | 1.78 | $105.61 | $0.00 | 000 | N | $116.17 |
| **83018** | Heavy metal (eg, arsenic, barium, beryllium, bismuth, antimony, mercury); quantitative, each | 1.78 | $105.61 | $0.00 | 000 | N | $116.17 |
| **83020** | Hemoglobin fractionation and quantitation; electrophoresis (eg, A2, S, C, and/or F) | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **83021** | Hemoglobin fractionation and quantitation; chromatography (eg, A2, S, C, and/or F) | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **83026** | Hemoglobin; by copper sulfate method, non-automated | 0.21 | $12.73 | $0.00 | 000 | N | $14.00 |
| **83030** | Hemoglobin; F (fetal), chemical | 0.67 | $40.04 | $0.00 | 000 | N | $44.04 |
| **83033** | Hemoglobin; F (fetal), qualitative | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| **83036** | Hemoglobin; glycosylated (A1C) | 0.83 | $49.15 | $0.00 | 000 | N | $54.07 |
| **83037** | Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **83045** | Hemoglobin; methemoglobin, qualitative | 0.40 | $23.68 | $0.00 | 000 | N | $26.05 |
| **83050** | Hemoglobin; methemoglobin, quantitative | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **83051** | Hemoglobin; plasma | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **83055** | Hemoglobin; sulfhemoglobin, qualitative | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **83060** | Hemoglobin; sulfhemoglobin, quantitative | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| **83065** | Hemoglobin; thermolabile | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **83068** | Hemoglobin; unstable, screen | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **83069** | Hemoglobin; urine | 0.37 | $21.84 | $0.00 | 000 | N | $24.02 |
| **83070** | Hemosiderin; qualitative | 0.43 | $25.47 | $0.00 | 000 | N | $28.02 |
| **83071** | Hemosiderin; quantitative | 0.43 | $25.47 | $0.00 | 000 | N | $28.02 |
| **83080** | b-Hexosaminidase, each assay | 1.04 | $61.88 | $0.00 | 000 | N | $68.07 |
| **83088** | Histamine | 2.08 | $123.82 | $0.00 | 000 | N | $136.20 |
| **83090** | Homocysteine | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **83150** | Homovanillic acid (HVA) | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **83491** | Hydroxycorticosteroids, 17- (17-OHCS) | 1.68 | $100.14 | $0.00 | 000 | N | $110.15 |
| **83497** | Hydroxyindolacetic acid, 5-(HIAA) | 1.35 | $80.09 | $0.00 | 000 | N | $88.10 |
| **83498** | Hydroxyprogesterone, 17-d | 1.96 | $116.50 | $0.00 | 000 | N | $128.15 |
| **83499** | Hydroxyprogesterone, 20- | 1.64 | $97.40 | $0.00 | 000 | N | $107.14 |
| **83500** | Hydroxyproline; free | 1.50 | $89.19 | $0.00 | 000 | N | $98.11 |
| **83505** | Hydroxyproline; total | 1.99 | $118.35 | $0.00 | 000 | N | $130.19 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **83516** | Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; multiple step method | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **83518** | Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; single step method (eg, reagent strip) | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **83519** | Immunoassay, analyte, quantitative; by radiopharmaceutical technique (eg, RIA) | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **83520** | Immunoassay, analyte, quantitative; not otherwise specified | 1.04 | $61.88 | $0.00 | 000 | N | $68.07 |
| **83525** | Insulin; total | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **83527** | Insulin; free | 1.32 | $78.30 | $0.00 | 000 | N | $86.13 |
| **83528** | Intrinsic factor | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **83540** | Iron | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **83550** | Iron binding capacity | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **83570** | Isocitric dehydrogenase (IDH) | 0.80 | $47.36 | $0.00 | 000 | N | $52.10 |
| **83582** | Ketogenic steroids, fractionation | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **83586** | Ketosteroids, 17- (17-KS); total | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **83593** | Ketosteroids, 17- (17-KS); fractionation | 2.39 | $142.03 | $0.00 | 000 | N | $156.23 |
| **83605** | Lactate (lactic acid) | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **83615** | Lactate dehydrogenase (LD), (LDH); | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **83625** | Lactate dehydrogenase (LD), (LDH); isoenzymes, separation and quantitation | 1.13 | $67.35 | $0.00 | 000 | N | $74.09 |
| **83630** | Lactoferrin, fecal; qualitative | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **83631** | Lactoferrin, fecal; quantitative | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **83632** | Lactogen, human placental (HPL) human chorionic somatomammotropin | 1.96 | $116.50 | $0.00 | 000 | N | $128.15 |
| **83633** | Lactose, urine; qualitative | 0.46 | $27.31 | $0.00 | 000 | N | $30.04 |
| **83634** | Lactose, urine; quantitative | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **83655** | Lead | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| **83661** | Fetal lung maturity assessment; lecithin sphingomyelin (L/S) ratio | 2.63 | $156.60 | $0.00 | 000 | N | $172.26 |
| **83662** | Fetal lung maturity assessment; foam stability test | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| **83663** | Fetal lung maturity assessment; fluorescence polarization | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **83664** | Fetal lung maturity assessment; lamellar body density | 0.80 | $47.36 | $0.00 | 000 | N | $52.10 |
| **83670** | Leucine aminopeptidase (LAP) | 1.19 | $70.98 | $0.00 | 000 | N | $78.08 |
| **83690** | Lipase | 0.67 | $40.04 | $0.00 | 000 | N | $44.04 |
| **83695** | Lipoprotein (a) | 0.70 | $41.89 | $0.00 | 000 | N | $46.08 |
| **83698** | Lipoprotein-associated phospholipase A2, (Lp-PLA2) | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **83700** | Lipoprotein, blood; electrophoretic separation and quantitation | 0.95 | $56.47 | $0.00 | 000 | N | $62.12 |
| **83701** | Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (eg, electrophoresis, ultracentrifugation) | 1.29 | $76.46 | $0.00 | 000 | N | $84.11 |
| **83704** | Lipoprotein, blood; quantitation of lipoprotein particle numbers and lipoprotein particle subclasses (eg, by nuclear magnetic resonance spectroscopy) | 1.44 | $85.56 | $0.00 | 000 | N | $94.12 |
| **83718** | Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol) | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| **83719** | Lipoprotein, direct measurement; VLDL cholesterol | 0.70 | $41.89 | $0.00 | 000 | N | $46.08 |
| **83721** | Lipoprotein, direct measurement; LDL cholesterol | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **83727** | Luteinizing releasing factor (LRH) | 1.68 | $100.14 | $0.00 | 000 | N | $110.15 |
| **83735** | Magnesium | 0.46 | $27.31 | $0.00 | 000 | N | $30.04 |
| **83775** | Malate dehydrogenase | 0.70 | $41.89 | $0.00 | 000 | N | $46.08 |
| **83785** | Manganese | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|---|
| | **83788** | Mass spectrometry and tandem mass spectrometry (MS, MS/MS), analyte not elsewhere specified; qualitative, each specimen | 0.00 | BR | $0.00 | 000 | N | BR |
| | **83789** | Mass spectrometry and tandem mass spectrometry (MS, MS/MS), analyte not elsewhere specified; quantitative, each specimen | 0.00 | BR | $0.00 | 000 | N | BR |
| | **83805** | Meprobamate | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| | **83825** | Mercury, quantitative | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| | **83835** | Metanephrines | 1.78 | $105.61 | $0.00 | 000 | N | $116.17 |
| | **83840** | Methadone | 1.44 | $85.56 | $0.00 | 000 | N | $94.12 |
| | **83857** | Methemalbumin | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| | **83858** | Methsuximide | 1.65 | $98.29 | $0.00 | 000 | N | $108.12 |
| | **83864** | Mucopolysaccharides, acid; quantitative | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| | **83866** | Mucopolysaccharides, acid; screen | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| | **83872** | Mucin, synovial fluid (Ropes test) | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| | **83873** | Myelin basic protein, cerebrospinal fluid | 1.68 | $100.14 | $0.00 | 000 | N | $110.15 |
| | **83874** | Myoglobin | 1.29 | $76.46 | $0.00 | 000 | N | $84.11 |
| | **83880** | Natriuretic peptide | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| | **83883** | Nephelometry, each analyte not elsewhere specified | 1.19 | $70.98 | $0.00 | 000 | N | $78.08 |
| | **83885** | Nickel | 1.29 | $76.46 | $0.00 | 000 | N | $84.11 |
| | **83887** | Nicotine | 1.47 | $87.41 | $0.00 | 000 | N | $96.15 |
| | **83890** | Molecular diagnostics; molecular isolation or extraction | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| | **83891** | Molecular diagnostics; isolation or extraction of highly purified nucleic acid | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| | **83892** | Molecular diagnostics; enzymatic digestion | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| | **83893** | Molecular diagnostics; dot/slot blot production | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| | **83894** | Molecular diagnostics; separation by gel electrophoresis (eg, agarose, polyacrylamide) | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| | **83896** | Molecular diagnostics; nucleic acid probe, each | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| | **83897** | Molecular diagnostics; nucleic acid transfer (eg, Southern, Northern) | 0.70 | $41.89 | $0.00 | 000 | N | $46.08 |
| | **83898** | Molecular diagnostics; amplification of patient nucleic acid, each nucleic acid sequence | 1.99 | $118.35 | $0.00 | 000 | N | $130.19 |
| | **83900** | Molecular diagnostics; amplification of patient nucleic acid, multiplex, first two nucleic acid sequences | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| + | **83901** | Molecular diagnostics; amplification of patient nucleic acid, multiplex, each additional nucleic acid sequence (List separately in addition to code for primary procedure) | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| | **83902** | Molecular diagnostics; reverse transcription | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| | **83903** | Molecular diagnostics; mutation scanning, by physical properties (eg, single strand conformational polymorphisms (SSCP), heteroduplex, denaturing gradient gel electrophoresis (DGGE), RNA'ase A), single segment, each | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| | **83904** | Molecular diagnostics; mutation identification by sequencing, single segment, each segment | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| | **83905** | Molecular diagnostics; mutation identification by allele specific transcription, single segment, each segment | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| | **83906** | Molecular diagnostics; mutation identification by allele specific translation, single segment, each segment | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| | **83907** | Molecular diagnostics; lysis of cells prior to nucleic acid extraction (eg, stool specimens, paraffin embedded tissue) | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| | **83908** | Molecular diagnostics; signal amplification of patient nucleic acid, each nucleic acid sequence | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| | **83909** | Molecular diagnostics; separation and identification by high resolution technique (eg, capillary electrophoresis) | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| | **83912** | Molecular diagnostics; interpretation and report | 0.77 | $45.52 | | 000 | N | $50.07 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **83913** | Molecular diagnostics; RNA stabilization | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| **83914** | Mutation identification by enzymatic ligation or primer extension, single segment, each segment (eg, oligonucleotide ligation assay (OLA), single base chain extension (SBCE), or allele-specific primer extension (ASPE)) | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| **83915** | Nucleotidase 5'- | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **83916** | Oligoclonal immune (oligoclonal bands) | 1.59 | $94.66 | $0.00 | 000 | N | $104.13 |
| **83918** | Organic acids; total, quantitative, each specimen | 2.08 | $123.82 | $0.00 | 000 | N | $136.20 |
| **83919** | Organic acids; qualitative, each specimen | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **83921** | Organic acid, single, quantitative | 1.32 | $78.30 | $0.00 | 000 | N | $86.13 |
| **83925** | Opiates, (eg, morphine, meperidine) | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **83930** | Osmolality; blood | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| **83935** | Osmolality; urine | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| **83937** | Osteocalcin (bone g1a protein) | 2.30 | $136.55 | $0.00 | 000 | N | $150.21 |
| **83945** | Oxalate | 1.10 | $65.57 | $0.00 | 000 | N | $72.13 |
| **83950** | Oncoprotein, HER-2/neu | 1.78 | $105.61 | $0.00 | 000 | N | $116.17 |
| **83970** | Parathormone (parathyroid hormone) | 2.60 | $154.76 | $0.00 | 000 | N | $170.24 |
| **83986** | pH, body fluid, except blood | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **83992** | Phencyclidine (PCP) | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **84022** | Phenothiazine | 1.26 | $74.67 | $0.00 | 000 | N | $82.14 |
| **84030** | Phenylalanine (PKU), blood | 0.43 | $25.47 | $0.00 | 000 | N | $28.02 |
| **84035** | Phenylketones, qualitative | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **84060** | Phosphatase, acid; total | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| **84061** | Phosphatase, acid; forensic examination | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **84066** | Phosphatase, acid; prostatic | 1.01 | $60.10 | $0.00 | 000 | N | $66.11 |
| **84075** | Phosphatase, alkaline; | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **84078** | Phosphatase, alkaline; heat stable (total not included) | 0.80 | $47.36 | $0.00 | 000 | N | $52.10 |
| **84080** | Phosphatase, alkaline; isoenzymes | 1.32 | $78.30 | $0.00 | 000 | N | $86.13 |
| **84081** | Phosphatidylglycerol | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| **84085** | Phosphogluconate, 6-, dehydrogenase, RBC | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| **84087** | Phosphohexose isomerase | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **84100** | Phosphorus inorganic (phosphate); | 0.31 | $18.21 | $0.00 | 000 | N | $20.03 |
| **84105** | Phosphorus inorganic (phosphate); urine | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| **84106** | Porphobilinogen, urine; qualitative | 0.67 | $40.04 | $0.00 | 000 | N | $44.04 |
| **84110** | Porphobilinogen, urine; quantitative | 0.83 | $49.15 | $0.00 | 000 | N | $54.07 |
| **84119** | Porphyrins, urine; qualitative | 0.80 | $47.36 | $0.00 | 000 | N | $52.10 |
| **84120** | Porphyrins, urine; quantitation and fractionation | 1.56 | $92.88 | $0.00 | 000 | N | $102.17 |
| **84126** | Porphyrins, feces; quantitative | 1.56 | $92.88 | $0.00 | 000 | N | $102.17 |
| **84127** | Porphyrins, feces; qualitative | 0.40 | $23.68 | $0.00 | 000 | N | $26.05 |
| **84132** | Potassium; serum | 0.37 | $21.84 | $0.00 | 000 | N | $24.02 |
| **84133** | Potassium; urine | 0.43 | $25.47 | $0.00 | 000 | N | $28.02 |
| **84134** | Prealbumin | 1.04 | $61.88 | $0.00 | 000 | N | $68.07 |
| **84135** | Pregnanediol | 1.29 | $76.46 | $0.00 | 000 | N | $84.11 |
| **84138** | Pregnanetriol | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **84140** | Pregnenolone | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| **84143** | 17-hydroxypregnenolone | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| **84144** | Progesterone | 1.59 | $94.66 | $0.00 | 000 | N | $104.13 |
| **84146** | Prolactin | 1.59 | $94.66 | $0.00 | 000 | N | $104.13 |
| **84150** | Prostaglandin, each | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |

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|---|---|---|---|---|---|---|---|
| **84152** | Prostate specific antigen (PSA); complexed (direct measurement) | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **84153** | Prostate specific antigen (PSA); total | 1.59 | $94.66 | $0.00 | 000 | N | $104.13 |
| **84154** | Prostate specific antigen (PSA); free | 1.47 | $87.41 | $0.00 | 000 | N | $96.15 |
| **84155** | Protein, total, except by refractometry; serum | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **84156** | Protein, total, except by refractometry; urine | 0.43 | $25.47 | $0.00 | 000 | N | $28.02 |
| **84157** | Protein, total, except by refractometry; other source (eg, synovial fluid, cerebrospinal fluid) | 0.40 | $23.68 | $0.00 | 000 | N | $26.05 |
| **84160** | Protein, total, by refractometry, any source | 0.25 | $14.58 | $0.00 | 000 | N | $16.04 |
| **84163** | Pregnancy-associated plasma protein-A (PAPP-A) | 0.00 | BR | $0.00 | 000 | N | BR |
| **84165** | Protein; electrophoretic fractionation and quantitation, serum | 1.10 | $65.57 | $0.00 | 000 | N | $72.13 |
| **84166** | Protein; electrophoretic fractionation and quantitation, other fluids with concentration (eg, urine, CSF) | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **84181** | Protein; Western Blot, with interpretation and report, blood or other body fluid | 1.59 | $94.66 | $0.00 | 000 | N | $104.13 |
| **84182** | Protein; Western Blot, with interpretation and report, blood or other body fluid, immunological probe for band identification, each | 2.57 | $152.92 | $0.00 | 000 | N | $168.21 |
| **84202** | Protoporphyrin, RBC; quantitative | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **84203** | Protoporphyrin, RBC; screen | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| **84206** | Proinsulin | 2.36 | $140.18 | $0.00 | 000 | N | $154.20 |
| **84207** | Pyridoxal phosphate (Vitamin B-6) | 2.30 | $136.55 | $0.00 | 000 | N | $150.21 |
| **84210** | Pyruvate | 1.01 | $60.10 | $0.00 | 000 | N | $66.11 |
| **84220** | Pyruvate kinase | 0.80 | $47.36 | $0.00 | 000 | N | $52.10 |
| **84228** | Quinine | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **84233** | Receptor assay; estrogen | 2.30 | $136.55 | $0.00 | 000 | N | $150.21 |
| **84234** | Receptor assay; progesterone | 2.30 | $136.55 | $0.00 | 000 | N | $150.21 |
| **84235** | Receptor assay; endocrine, other than estrogen or progesterone (specify hormone) | 2.30 | $136.55 | $0.00 | 000 | N | $150.21 |
| **84238** | Receptor assay; non-endocrine (specify receptor) | 3.37 | $200.28 | $0.00 | 000 | N | $220.31 |
| **84244** | Renin | 2.11 | $125.60 | $0.00 | 000 | N | $138.16 |
| **84252** | Riboflavin (Vitamin B-2) | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **84255** | Selenium | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **84260** | Serotonin | 2.60 | $154.76 | $0.00 | 000 | N | $170.24 |
| **84270** | Sex hormone binding globulin (SHBG) | 1.78 | $105.61 | $0.00 | 000 | N | $116.17 |
| **84275** | Sialic acid | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **84285** | Silica | 1.68 | $100.14 | $0.00 | 000 | N | $110.15 |
| **84295** | Sodium; serum | 0.31 | $18.21 | $0.00 | 000 | N | $20.03 |
| **84300** | Sodium; urine | 0.43 | $25.47 | $0.00 | 000 | N | $28.02 |
| **84302** | Sodium; other source | 0.43 | $25.47 | $0.00 | 000 | N | $28.02 |
| **84305** | Somatomedin | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **84307** | Somatostatin | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| **84311** | Spectrophotometry, analyte not elsewhere specified | 0.64 | $38.26 | $0.00 | 000 | N | $42.09 |
| **84315** | Specific gravity (except urine) | 0.28 | $16.36 | $0.00 | 000 | N | $18.00 |
| **84375** | Sugars, chromatographic, TLC or paper chromatography | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **84376** | Sugars (mono-, di-, and oligosaccharides); single qualitative, each specimen | 0.00 | BR | $0.00 | 000 | N | BR |
| **84377** | Sugars (mono-, di-, and oligosaccharides); multiple qualitative, each specimen | 0.00 | BR | $0.00 | 000 | N | BR |
| **84378** | Sugars (mono-, di-, and oligosaccharides); single quantitative, each specimen | 0.00 | BR | $0.00 | 000 | N | BR |
| **84379** | Sugars (mono-, di-, and oligosaccharides); multiple quantitative, each specimen | 0.00 | BR | $0.00 | 000 | N | BR |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **84392** | Sulfate, urine | 0.00 | BR | $0.00 | 000 | N | BR |
| **84402** | Testosterone; free | 1.74 | $103.77 | $0.00 | 000 | N | $114.15 |
| **84403** | Testosterone; total | 1.44 | $85.56 | $0.00 | 000 | N | $94.12 |
| **84425** | Thiamine (Vitamin B-1) | 1.65 | $98.29 | $0.00 | 000 | N | $108.12 |
| **84430** | Thiocyanate | 1.01 | $60.10 | $0.00 | 000 | N | $66.11 |
| **84432** | Thyroglobulin | 1.47 | $87.41 | $0.00 | 000 | N | $96.15 |
| **84436** | Thyroxine; total | 0.55 | $32.78 | $0.00 | 000 | N | $36.06 |
| **84437** | Thyroxine; requiring elution (eg, neonatal) | 0.55 | $32.78 | $0.00 | 000 | N | $36.06 |
| **84439** | Thyroxine; free | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **84442** | Thyroxine binding globulin (TBG) | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **84443** | Thyroid stimulating hormone (TSH) | 1.29 | $76.46 | $0.00 | 000 | N | $84.11 |
| **84445** | Thyroid stimulating immune globulins (TSI) | 3.83 | $227.59 | $0.00 | 000 | N | $250.35 |
| **84446** | Tocopherol alpha (Vitamin E) | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **84449** | Transcortin (cortisol binding globulin) | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **84450** | Transferase; aspartate amino (AST) (SGOT) | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **84460** | Transferase; alanine amino (ALT) (SGPT) | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **84466** | Transferrin | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **84478** | Triglycerides | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **84479** | Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR) | 0.55 | $32.78 | $0.00 | 000 | N | $36.06 |
| **84480** | Triiodothyronine T3; total (TT-3) | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **84481** | Triiodothyronine T3; free | 1.62 | $96.51 | $0.00 | 000 | N | $106.16 |
| **84482** | Triiodothyronine T3; reverse | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **84484** | Troponin, quantitative | 0.00 | BR | $0.00 | 000 | N | BR |
| **84485** | Trypsin; duodenal fluid | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **84488** | Trypsin; feces, qualitative | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **84490** | Trypsin; feces, quantitative, 24-hour collection | 0.55 | $32.78 | $0.00 | 000 | N | $36.06 |
| **84510** | Tyrosine | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **84512** | Troponin, qualitative | 0.00 | BR | $0.00 | 000 | N | BR |
| **84520** | Urea nitrogen; quantitative | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **84525** | Urea nitrogen; semiquantitative (eg, reagent strip test) | 0.37 | $21.84 | $0.00 | 000 | N | $24.02 |
| **84540** | Urea nitrogen, urine | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **84545** | Urea nitrogen, clearance | 0.64 | $38.26 | $0.00 | 000 | N | $42.09 |
| **84550** | Uric acid; blood | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **84560** | Uric acid; other source | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| **84577** | Urobilinogen, feces, quantitative | 0.55 | $32.78 | $0.00 | 000 | N | $36.06 |
| **84578** | Urobilinogen, urine; qualitative | 0.37 | $21.84 | $0.00 | 000 | N | $24.02 |
| **84580** | Urobilinogen, urine; quantitative, timed specimen | 0.55 | $32.78 | $0.00 | 000 | N | $36.06 |
| **84583** | Urobilinogen, urine; semiquantitative | 0.37 | $21.84 | $0.00 | 000 | N | $24.02 |
| **84585** | Vanillylmandelic acid (VMA), urine | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **84586** | Vasoactive intestinal peptide (VIP) | 2.36 | $140.18 | $0.00 | 000 | N | $154.20 |
| **84588** | Vasopressin (antidiuretic hormone, ADH) | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **84590** | Vitamin A | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **84591** | Vitamin, not otherwise specified | 1.32 | $78.30 | $0.00 | 000 | N | $86.13 |
| **84597** | Vitamin K | 1.78 | $105.61 | $0.00 | 000 | N | $116.17 |
| **84600** | Volatiles (eg, acetic anhydride, carbon tetrachloride, dichloroethane, dichloromethane, diethylether, isopropyl alcohol, methanol) | 0.95 | $56.47 | $0.00 | 000 | N | $62.12 |
| **84620** | Xylose absorption test, blood and/or urine | 1.26 | $74.67 | $0.00 | 000 | N | $82.14 |
| **84630** | Zinc | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |

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|---|---|---|---|---|---|---|---|
| **84681** | C-peptide | 1.74 | $103.77 | $0.00 | 000 | N | $114.15 |
| **84702** | Gonadotropin, chorionic (hCG); quantitative | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **84703** | Gonadotropin, chorionic (hCG); qualitative | 0.70 | $41.89 | $0.00 | 000 | N | $46.08 |
| **84830** | Ovulation tests, by visual color comparison methods for human luteinizing hormone | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **84999** | Unlisted chemistry procedure | 0.00 | BR | | 000 | N | BR |
| **85002** | Bleeding time | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **85004** | Blood count; automated differential WBC count | 0.40 | $23.68 | $0.00 | 000 | N | $26.05 |
| **85007** | Blood count; blood smear, microscopic examination with manual differential WBC count | 0.37 | $21.84 | $0.00 | 000 | N | $24.02 |
| **85008** | Blood count; blood smear, microscopic examination without manual differential WBC count | 0.31 | $18.21 | $0.00 | 000 | N | $20.03 |
| **85009** | Blood count; manual differential WBC count, buffy coat | 0.37 | $21.84 | $0.00 | 000 | N | $24.02 |
| **85013** | Blood count; spun microhematocrit | 0.28 | $16.36 | $0.00 | 000 | N | $18.00 |
| **85014** | Blood count; hematocrit (Hct) | 0.28 | $16.36 | $0.00 | 000 | N | $18.00 |
| **85018** | Blood count; hemoglobin (Hgb) | 0.28 | $16.36 | $0.00 | 000 | N | $18.00 |
| **85025** | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 0.57 | $33.68 | $0.00 | 000 | N | $37.05 |
| **85027** | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) | 0.54 | $31.89 | $0.00 | 000 | N | $35.08 |
| **85032** | Blood count; manual cell count (erythrocyte, leukocyte, or platelet) each | 0.43 | $25.47 | $0.00 | 000 | N | $28.02 |
| **85041** | Blood count; red blood cell (RBC), automated | 0.37 | $21.84 | $0.00 | 000 | N | $24.02 |
| **85044** | Blood count; reticulocyte, manual | 0.43 | $25.47 | $0.00 | 000 | N | $28.02 |
| **85045** | Blood count; reticulocyte, automated | 0.46 | $27.31 | $0.00 | 000 | N | $30.04 |
| **85046** | Blood count; reticulocytes, automated, including one or more cellular parameters (eg, reticulocyte hemoglobin content (CHr), immature reticulocyte fraction (IRF), reticulocyte volume (MRV), RNA content), direct measurement | 0.00 | BR | $0.00 | 000 | N | BR |
| **85048** | Blood count; leukocyte (WBC), automated | 0.37 | $21.84 | $0.00 | 000 | N | $24.02 |
| **85049** | Blood count; platelet, automated | 0.37 | $21.84 | $0.00 | 000 | N | $24.02 |
| **85055** | Reticulated platelet assay | 0.00 | BR | | 000 | N | BR |
| **85060** | Blood smear, peripheral, interpretation by physician with written report | 0.59 | $35.11 | | 000 | N | $38.62 |
| **85097** | Bone marrow, smear interpretation | 2.65 | $157.68 | | 000 | N | $173.45 |
| **85130** | Chromogenic substrate assay | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **85170** | Clot retraction | 0.37 | $21.84 | $0.00 | 000 | N | $24.02 |
| **85175** | Clot lysis time, whole blood dilution | 0.67 | $40.04 | $0.00 | 000 | N | $44.04 |
| **85210** | Clotting; factor II, prothrombin, specific | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| **85220** | Clotting; factor V (AcG or proaccelerin), labile factor | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **85230** | Clotting; factor VII (proconvertin, stable factor) | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **85240** | Clotting; factor VIII (AHG), one stage | 1.99 | $118.35 | $0.00 | 000 | N | $130.19 |
| **85244** | Clotting; factor VIII related antigen | 2.30 | $136.55 | $0.00 | 000 | N | $150.21 |
| **85245** | Clotting; factor VIII, VW factor, ristocetin cofactor | 1.65 | $98.29 | $0.00 | 000 | N | $108.12 |
| **85246** | Clotting; factor VIII, VW factor antigen | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **85247** | Clotting; factor VIII, von Willebrand factor, multimetric analysis | 2.51 | $149.29 | $0.00 | 000 | N | $164.22 |
| **85250** | Clotting; factor IX (PTC or Christmas) | 1.99 | $118.35 | $0.00 | 000 | N | $130.19 |
| **85260** | Clotting; factor X (Stuart-Prower) | 1.99 | $118.35 | $0.00 | 000 | N | $130.19 |
| **85270** | Clotting; factor XI (PTA) | 1.96 | $116.50 | $0.00 | 000 | N | $128.15 |
| **85280** | Clotting; factor XII (Hageman) | 1.99 | $118.35 | $0.00 | 000 | N | $130.19 |
| **85290** | Clotting; factor XIII (fibrin stabilizing) | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **85291** | Clotting; factor XIII (fibrin stabilizing), screen solubility | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **85292** | Clotting; prekallikrein assay (Fletcher factor assay) | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |

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|---|---|---|---|---|---|---|---|
| **85293** | Clotting; high molecular weight kininogen assay (Fitzgerald factor assay) | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **85300** | Clotting inhibitors or anticoagulants; antithrombin III, activity | 1.62 | $96.51 | $0.00 | 000 | N | $106.16 |
| **85301** | Clotting inhibitors or anticoagulants; antithrombin III, antigen assay | 1.59 | $94.66 | $0.00 | 000 | N | $104.13 |
| **85302** | Clotting inhibitors or anticoagulants; protein C, antigen | 1.68 | $100.14 | $0.00 | 000 | N | $110.15 |
| **85303** | Clotting inhibitors or anticoagulants; protein C, activity | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| **85305** | Clotting inhibitors or anticoagulants; protein S, total | 1.93 | $114.72 | $0.00 | 000 | N | $126.19 |
| **85306** | Clotting inhibitors or anticoagulants; protein S, free | 1.99 | $118.35 | $0.00 | 000 | N | $130.19 |
| **85307** | Activated Protein C (APC) resistance assay | 1.74 | $103.77 | $0.00 | 000 | N | $114.15 |
| **85335** | Factor inhibitor test | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **85337** | Thrombomodulin | 1.47 | $87.41 | $0.00 | 000 | N | $96.15 |
| **85345** | Coagulation time; Lee and White | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| **85347** | Coagulation time; activated | 0.46 | $27.31 | $0.00 | 000 | N | $30.04 |
| **85348** | Coagulation time; other methods | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| **85360** | Euglobulin lysis | 1.04 | $61.88 | $0.00 | 000 | N | $68.07 |
| **85362** | Fibrin(ogen) degradation (split) products (FDP)(FSP); agglutination slide, semiquantitative | 0.67 | $40.04 | $0.00 | 000 | N | $44.04 |
| **85366** | Fibrin(ogen) degradation (split) products (FDP)(FSP); paracoagulation | 1.01 | $60.10 | $0.00 | 000 | N | $66.11 |
| **85370** | Fibrin(ogen) degradation (split) products (FDP)(FSP); quantitative | 1.04 | $61.88 | $0.00 | 000 | N | $68.07 |
| **85378** | Fibrin degradation products, D-dimer; qualitative or semiquantitative | 0.80 | $47.36 | $0.00 | 000 | N | $52.10 |
| **85379** | Fibrin degradation products, D-dimer; quantitative | 1.01 | $60.10 | $0.00 | 000 | N | $66.11 |
| **85380** | Fibrin degradation products, D-dimer; ultrasensitive (eg, for evaluation for venous thromboembolism), qualitative or semiquantitative | 1.01 | $60.10 | $0.00 | 000 | N | $66.11 |
| **85384** | Fibrinogen; activity | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **85385** | Fibrinogen; antigen | 0.89 | $52.78 | $0.00 | 000 | N | $58.06 |
| **85390** | Fibrinolysins or coagulopathy screen, interpretation and report | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **85396** | Coagulation/fibrinolysis assay, whole blood (eg, viscoelastic clot assessment), including use of any pharmacologic additive(s), as indicated, including interpretation and written report, per day | 0.50 | $29.75 | | 000 | N | $32.73 |
| **85400** | Fibrinolytic factors and inhibitors; plasmin | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **85410** | Fibrinolytic factors and inhibitors; alpha-2 antiplasmin | 1.68 | $100.14 | $0.00 | 000 | N | $110.15 |
| **85415** | Fibrinolytic factors and inhibitors; plasminogen activator | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **85420** | Fibrinolytic factors and inhibitors; plasminogen, except antigenic assay | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **85421** | Fibrinolytic factors and inhibitors; plasminogen, antigenic assay | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **85441** | Heinz bodies; direct | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **85445** | Heinz bodies; induced, acetyl phenylhydrazine | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **85460** | Hemoglobin or RBCs, fetal, for fetomaternal hemorrhage; differential lysis (Kleihauer-Betke) | 0.89 | $52.78 | $0.00 | 000 | N | $58.06 |
| **85461** | Hemoglobin or RBCs, fetal, for fetomaternal hemorrhage; rosette | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **85475** | Hemolysin, acid | 1.10 | $65.57 | $0.00 | 000 | N | $72.13 |
| **85520** | Heparin assay | 1.41 | $83.78 | $0.00 | 000 | N | $92.16 |
| **85525** | Heparin neutralization | 1.13 | $67.35 | $0.00 | 000 | N | $74.09 |
| **85530** | Heparin-protamine tolerance test | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **85536** | Iron stain, peripheral blood | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| **85540** | Leukocyte alkaline phosphatase with count | 0.83 | $49.15 | $0.00 | 000 | N | $54.07 |

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|---|---|---|---|---|---|---|---|
| **85547** | Mechanical fragility, RBC | 0.64 | $38.26 | $0.00 | 000 | N | $42.09 |
| **85549** | Muramidase | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **85555** | Osmotic fragility, RBC; unincubated | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **85557** | Osmotic fragility, RBC; incubated | 1.47 | $87.41 | $0.00 | 000 | N | $96.15 |
| **85576** | Platelet, aggregation (in vitro), each agent | 1.53 | $91.04 | $27.31 | 000 | N | $100.14 |
| **85597** | Platelet neutralization | 1.19 | $70.98 | $0.00 | 000 | N | $78.08 |
| **85610** | Prothrombin time; | 0.40 | $23.68 | $0.00 | 000 | N | $26.05 |
| **85611** | Prothrombin time; substitution, plasma fractions, each | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| **85612** | Russell viper venom time (includes venom); undiluted | 0.83 | $49.15 | $0.00 | 000 | N | $54.07 |
| **85613** | Russell viper venom time (includes venom); diluted | 1.01 | $60.10 | $0.00 | 000 | N | $66.11 |
| **85635** | Reptilase test | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **85651** | Sedimentation rate, erythrocyte; non-automated | 0.38 | $22.79 | $0.00 | 000 | N | $25.07 |
| **85652** | Sedimentation rate, erythrocyte; automated | 0.38 | $22.79 | $0.00 | 000 | N | $25.07 |
| **85660** | Sickling of RBC, reduction | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **85670** | Thrombin time; plasma | 0.64 | $38.26 | $0.00 | 000 | N | $42.09 |
| **85675** | Thrombin time; titer | 0.70 | $41.89 | $0.00 | 000 | N | $46.08 |
| **85705** | Thromboplastin inhibition, tissue | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **85730** | Thromboplastin time, partial (PTT); plasma or whole blood | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **85732** | Thromboplastin time, partial (PTT); substitution, plasma fractions, each | 0.67 | $40.04 | $0.00 | 000 | N | $44.04 |
| **85810** | Viscosity | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| **85999** | Unlisted hematology and coagulation procedure | 0.00 | BR | | 000 | N | BR |
| **86000** | Agglutinins, febrile (eg, Brucella, Francisella, Murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus), each antigen | 0.64 | $38.26 | $0.00 | 000 | N | $42.09 |
| **86001** | Allergen specific IgG quantitative or semiquantitative, each allergen | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **86003** | Allergen specific IgE; quantitative or semiquantitative, each allergen | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **86005** | Allergen specific IgE; qualitative, multiallergen screen (dipstick, paddle or disk) | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **86021** | Antibody identification; leukocyte antibodies | 1.84 | $109.24 | $0.00 | 000 | N | $120.16 |
| **86022** | Antibody identification; platelet antibodies | 2.60 | $154.76 | $0.00 | 000 | N | $170.24 |
| **86023** | Antibody identification; platelet associated immunoglobulin assay | 1.68 | $100.14 | $0.00 | 000 | N | $110.15 |
| **86038** | Antinuclear antibodies (ANA); | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **86039** | Antinuclear antibodies (ANA); titer | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **86060** | Antistreptolysin 0; titer | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **86063** | Antistreptolysin 0; screen | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **86077** | Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report | 1.27 | $75.57 | | 000 | N | $83.13 |
| **86078** | Blood bank physician services; investigation of transfusion reaction including suspicion of transmissible disease, interpretation and written report | 1.32 | $78.54 | | 000 | N | $86.39 |
| **86079** | Blood bank physician services; authorization for deviation from standard blood banking procedures (eg, use of outdated blood, transfusion of Rh incompatible units), with written report | 1.31 | $77.95 | | 000 | N | $85.75 |
| **86140** | C-reactive protein; | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **86141** | C-reactive protein; high sensitivity (hsCRP) | 0.80 | $47.36 | $0.00 | 000 | N | $52.10 |
| **86146** | Beta 2 Glycoprotein I antibody, each | 1.99 | $118.35 | $0.00 | 000 | N | $130.19 |
| **86147** | Cardiolipin (phospholipid) antibody, each Ig class | 1.99 | $118.35 | $0.00 | 000 | N | $130.19 |
| **86148** | Anti-phosphatidylserine (phospholipid) antibody | 0.00 | BR | $0.00 | 000 | N | BR |
| **86155** | Chemotaxis assay, specify method | 0.95 | $56.47 | $0.00 | 000 | N | $62.12 |

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|---|---|---|---|---|---|---|---|
| **86156** | Cold agglutinin; screen | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| **86157** | Cold agglutinin; titer | 0.70 | $41.89 | $0.00 | 000 | N | $46.08 |
| **86160** | Complement; antigen, each component | 1.26 | $74.67 | $0.00 | 000 | N | $82.14 |
| **86161** | Complement; functional activity, each component | 1.41 | $83.78 | $0.00 | 000 | N | $92.16 |
| **86162** | Complement; total hemolytic (CH50) | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| **86171** | Complement fixation tests, each antigen | 0.89 | $52.78 | $0.00 | 000 | N | $58.06 |
| **86185** | Counterimmunoelectrophoresis, each antigen | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| **86200** | Cyclic citrullinated peptide (CCP), antibody | 1.29 | $76.46 | $0.00 | 000 | N | $84.11 |
| **86215** | Deoxyribonuclease, antibody | 1.19 | $70.98 | $0.00 | 000 | N | $78.08 |
| **86225** | Deoxyribonucleic acid (DNA) antibody; native or double stranded | 1.32 | $78.30 | $0.00 | 000 | N | $86.13 |
| **86226** | Deoxyribonucleic acid (DNA) antibody; single stranded | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **86235** | Extractable nuclear antigen, antibody to, any method (eg, nRNP, SS-A, SS-B, Sm, RNP, Sc170, J01), each antibody | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **86243** | Fc receptor | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **86255** | Fluorescent noninfectious agent antibody; screen, each antibody | 1.07 | $63.72 | $35.05 | 000 | N | $70.09 |
| **86256** | Fluorescent noninfectious agent antibody; titer, each antibody | 0.98 | $58.25 | $32.04 | 000 | N | $64.08 |
| **86277** | Growth hormone, human (HGH), antibody | 1.13 | $67.35 | $0.00 | 000 | N | $74.09 |
| **86280** | Hemagglutination inhibition test (HAI) | 0.89 | $52.78 | $0.00 | 000 | N | $58.06 |
| **86294** | Immunoassay for tumor antigen, qualitative or semiquantitative (eg, bladder tumor antigen) | 1.59 | $94.66 | $0.00 | 000 | N | $104.13 |
| **86300** | Immunoassay for tumor antigen, quantitative; CA 15-3 (27.29) | 1.59 | $94.66 | $0.00 | 000 | N | $104.13 |
| **86301** | Immunoassay for tumor antigen, quantitative; CA 19-9 | 1.59 | $94.66 | $0.00 | 000 | N | $104.13 |
| **86304** | Immunoassay for tumor antigen, quantitative; CA 125 | 1.59 | $94.66 | $0.00 | 000 | N | $104.13 |
| **86308** | Heterophile antibodies; screening | 0.55 | $32.78 | $0.00 | 000 | N | $36.06 |
| **86309** | Heterophile antibodies; titer | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| **86310** | Heterophile antibodies; titers after absorption with beef cells and guinea pig kidney | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| **86316** | Immunoassay for tumor antigen, other antigen, quantitative (eg, CA 50, 72-4, 549), each | 1.59 | $94.66 | $0.00 | 000 | N | $104.13 |
| **86317** | Immunoassay for infectious agent antibody, quantitative, not otherwise specified | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **86318** | Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (eg, reagent strip) | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **86320** | Immunoelectrophoresis; serum | 1.87 | $111.09 | $0.00 | 000 | N | $122.20 |
| **86325** | Immunoelectrophoresis; other fluids (eg, urine, cerebrospinal fluid) with concentration | 1.99 | $118.35 | $23.67 | 000 | N | $130.19 |
| **86327** | Immunoelectrophoresis; crossed (2-dimensional assay) | 1.53 | $91.04 | $18.21 | 000 | N | $100.14 |
| **86329** | Immunodiffusion; not elsewhere specified | 1.26 | $74.67 | $0.00 | 000 | N | $82.14 |
| **86331** | Immunodiffusion; gel diffusion, qualitative (Ouchterlony), each antigen or antibody | 1.26 | $74.67 | $0.00 | 000 | N | $82.14 |
| **86332** | Immune complex assay | 1.68 | $100.14 | $0.00 | 000 | N | $110.15 |
| **86334** | Immunofixation electrophoresis; serum | 1.65 | $98.29 | $19.66 | 000 | N | $108.12 |
| **86335** | Immunofixation electrophoresis; other fluids with concentration (eg, urine, CSF) | 1.65 | $98.29 | $19.66 | 000 | N | $108.12 |
| **86336** | Inhibin A | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **86337** | Insulin antibodies | 1.93 | $114.72 | $0.00 | 000 | N | $126.19 |
| **86340** | Intrinsic factor antibodies | 1.35 | $80.09 | $0.00 | 000 | N | $88.10 |
| **86341** | Islet cell antibody | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **86343** | Leukocyte histamine release test (LHR) | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **86344** | Leukocyte phagocytosis | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **86353** | Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis | 3.83 | $227.59 | $0.00 | 000 | N | $250.35 |
| **86355** | B cells, total count | 1.93 | $114.72 | $0.00 | 000 | N | $126.19 |
| **86357** | Natural killer (NK) cells, total count | 1.93 | $114.72 | $0.00 | 000 | N | $126.19 |
| **86359** | T cells; total count | 1.93 | $114.72 | $0.00 | 000 | N | $126.19 |
| **86360** | T cells; absolute CD4 and CD8 count, including ratio | 2.51 | $149.29 | $0.00 | 000 | N | $164.22 |
| **86361** | T cells; absolute CD4 count | 1.93 | $114.72 | $0.00 | 000 | N | $126.19 |
| **86367** | Stem cells (ie, CD34), total count | 1.93 | $114.72 | $0.00 | 000 | N | $126.19 |
| **86376** | Microsomal antibodies (eg, thyroid or liver-kidney), each | 1.29 | $76.46 | $0.00 | 000 | N | $84.11 |
| **86378** | Migration inhibitory factor test (MIF) | 1.29 | $76.46 | $0.00 | 000 | N | $84.11 |
| **86382** | Neutralization test, viral | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **86384** | Nitroblue tetrazolium dye test (NTD) | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **86403** | Particle agglutination; screen, each antibody | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| **86406** | Particle agglutination; titer, each antibody | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **86430** | Rheumatoid factor; qualitative | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| **86431** | Rheumatoid factor; quantitative | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **86480** | Tuberculosis test, cell mediated immunity measurement of gamma interferon antigen response | 0.55 | $32.78 | $0.00 | 000 | N | $36.06 |
| **86485** | Skin test; candida | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| **86490** | Skin test; coccidioidomycosis | 0.27 | $16.07 | $0.00 | 000 | N | $17.68 |
| **86510** | Skin test; histoplasmosis | 0.30 | $17.85 | $0.00 | 000 | N | $19.64 |
| **86580** | Skin test; tuberculosis, intradermal | 0.25 | $14.88 | $0.00 | 000 | N | $16.37 |
| **86586** | Unlisted antigen, each | 0.46 | $27.31 | $0.00 | 000 | N | $30.04 |
| **86590** | Streptokinase, antibody | 0.55 | $32.78 | $0.00 | 000 | N | $36.06 |
| **86592** | Syphilis test; qualitative (eg, VDRL, RPR, ART) | 0.40 | $23.68 | $0.00 | 000 | N | $26.05 |
| **86593** | Syphilis test; quantitative | 0.43 | $25.47 | $0.00 | 000 | N | $28.02 |
| **86602** | Antibody; actinomyces | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **86603** | Antibody; adenovirus | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **86606** | Antibody; Aspergillus | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **86609** | Antibody; bacterium, not elsewhere specified | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **86611** | Antibody; Bartonella | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **86612** | Antibody; Blastomyces | 1.35 | $80.09 | $0.00 | 000 | N | $88.10 |
| **86615** | Antibody; Bordetella | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **86617** | Antibody; Borrelia burgdorferi (Lyme disease) confirmatory test (eg, Western Blot or immunoblot) | 1.62 | $96.51 | $0.00 | 000 | N | $106.16 |
| **86618** | Antibody; Borrelia burgdorferi (Lyme disease) | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **86619** | Antibody; Borrelia (relapsing fever) | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **86622** | Antibody; Brucella | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **86625** | Antibody; Campylobacter | 1.44 | $85.56 | $0.00 | 000 | N | $94.12 |
| **86628** | Antibody; Candida | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **86631** | Antibody; Chlamydia | 0.95 | $56.47 | $0.00 | 000 | N | $62.12 |
| **86632** | Antibody; Chlamydia, IgM | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **86635** | Antibody; Coccidioides | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **86638** | Antibody; Coxiella burnetii (Q fever) | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **86641** | Antibody; Cryptococcus | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **86644** | Antibody; cytomegalovirus (CMV) | 1.41 | $83.78 | $0.00 | 000 | N | $92.16 |
| **86645** | Antibody; cytomegalovirus (CMV), IgM | 1.47 | $87.41 | $0.00 | 000 | N | $96.15 |
| **86648** | Antibody; Diphtheria | 1.29 | $76.46 | $0.00 | 000 | N | $84.11 |
| **86651** | Antibody; encephalitis, California (La Crosse) | 1.10 | $65.57 | $0.00 | 000 | N | $72.13 |
| **86652** | Antibody; encephalitis, Eastern equine | 1.10 | $65.57 | $0.00 | 000 | N | $72.13 |

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|---|---|---|---|---|---|---|---|
| **86653** | Antibody; encephalitis, St. Louis | 1.10 | $65.57 | $0.00 | 000 | N | $72.13 |
| **86654** | Antibody; encephalitis, Western equine | 1.10 | $65.57 | $0.00 | 000 | N | $72.13 |
| **86658** | Antibody; enterovirus (eg, coxsackie, echo, polio) | 1.10 | $65.57 | $0.00 | 000 | N | $72.13 |
| **86663** | Antibody; Epstein-Barr (EB) virus, early antigen (EA) | 1.41 | $83.78 | $0.00 | 000 | N | $92.16 |
| **86664** | Antibody; Epstein-Barr (EB) virus, nuclear antigen (EBNA) | 1.41 | $83.78 | $0.00 | 000 | N | $92.16 |
| **86665** | Antibody; Epstein-Barr (EB) virus, viral capsid (VCA) | 1.59 | $94.66 | $0.00 | 000 | N | $104.13 |
| **86666** | Antibody; Ehrlichia | 1.41 | $83.78 | $0.00 | 000 | N | $92.16 |
| **86668** | Antibody; Francisella tularensis | 1.10 | $65.57 | $0.00 | 000 | N | $72.13 |
| **86671** | Antibody; fungus, not elsewhere specified | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **86674** | Antibody; Giardia lamblia | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **86677** | Antibody; Helicobacter pylori | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **86682** | Antibody; helminth, not elsewhere specified | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **86684** | Antibody; Haemophilus influenza | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **86687** | Antibody; HTLV-I | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **86688** | Antibody; HTLV-II | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **86689** | Antibody; HTLV or HIV antibody, confirmatory test (eg, Western Blot) | 1.62 | $96.51 | $0.00 | 000 | N | $106.16 |
| **86692** | Antibody; hepatitis, delta agent | 1.62 | $96.51 | $0.00 | 000 | N | $106.16 |
| **86694** | Antibody; herpes simplex, non-specific type test | 1.35 | $80.09 | $0.00 | 000 | N | $88.10 |
| **86695** | Antibody; herpes simplex, type 1 | 1.35 | $80.09 | $0.00 | 000 | N | $88.10 |
| **86696** | Antibody; herpes simplex, type 2 | 1.35 | $80.09 | $0.00 | 000 | N | $88.10 |
| **86698** | Antibody; histoplasma | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **86701** | Antibody; HIV-1 | 1.04 | $61.88 | $0.00 | 000 | N | $68.07 |
| **86702** | Antibody; HIV-2 | 1.41 | $83.78 | $0.00 | 000 | N | $92.16 |
| **86703** | Antibody; HIV-1 and HIV-2, single assay | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **86704** | Hepatitis B core antibody (HBcAb); total | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **86705** | Hepatitis B core antibody (HBcAb); IgM antibody | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| **86706** | Hepatitis B surface antibody (HBsAb) | 0.95 | $56.47 | $0.00 | 000 | N | $62.12 |
| **86707** | Hepatitis Be antibody (HBeAb) | 1.04 | $61.88 | $0.00 | 000 | N | $68.07 |
| **86708** | Hepatitis A antibody (HAAb); total | 1.13 | $67.35 | $0.00 | 000 | N | $74.09 |
| **86709** | Hepatitis A antibody (HAAb); IgM antibody | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **86710** | Antibody; influenza virus | 1.01 | $60.10 | $0.00 | 000 | N | $66.11 |
| **86713** | Antibody; Legionella | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **86717** | Antibody; Leishmania | 1.01 | $60.10 | $0.00 | 000 | N | $66.11 |
| **86720** | Antibody; Leptospira | 1.01 | $60.10 | $0.00 | 000 | N | $66.11 |
| **86723** | Antibody; Listeria monocytogenes | 1.01 | $60.10 | $0.00 | 000 | N | $66.11 |
| **86727** | Antibody; lymphocytic choriomeningitis | 1.01 | $60.10 | $0.00 | 000 | N | $66.11 |
| **86729** | Antibody; lymphogranuloma venereum | 1.01 | $60.10 | $0.00 | 000 | N | $66.11 |
| **86732** | Antibody; mucormycosis | 1.35 | $80.09 | $0.00 | 000 | N | $88.10 |
| **86735** | Antibody; mumps | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **86738** | Antibody; mycoplasma | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **86741** | Antibody; Neisseria meningitidis | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **86744** | Antibody; Nocardia | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **86747** | Antibody; parvovirus | 1.44 | $85.56 | $0.00 | 000 | N | $94.12 |
| **86750** | Antibody; Plasmodium (malaria) | 1.35 | $80.09 | $0.00 | 000 | N | $88.10 |
| **86753** | Antibody; protozoa, not elsewhere specified | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **86756** | Antibody; respiratory syncytial virus | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **86757** | Antibody; Rickettsia | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **86759** | Antibody; rotavirus | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |

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|---|---|---|---|---|---|---|---|
| **86762** | Antibody; rubella | 0.83 | $49.15 | $0.00 | 000 | N | $54.07 |
| **86765** | Antibody; rubeola | 1.47 | $87.41 | $0.00 | 000 | N | $96.15 |
| **86768** | Antibody; Salmonella | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **86771** | Antibody; Shigella | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **86774** | Antibody; tetanus | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **86777** | Antibody; Toxoplasma | 1.10 | $65.57 | $0.00 | 000 | N | $72.13 |
| **86778** | Antibody; Toxoplasma, IgM | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **86781** | Antibody; Treponema pallidum, confirmatory test (eg, FTA-abs) | 1.04 | $61.88 | $0.00 | 000 | N | $68.07 |
| **86784** | Antibody; Trichinella | 1.04 | $61.88 | $0.00 | 000 | N | $68.07 |
| **86787** | Antibody; varicella-zoster | 1.35 | $80.09 | $0.00 | 000 | N | $88.10 |
| **86788** | Antibody; West Nile virus, IgM | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **86789** | Antibody; West Nile virus | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **86790** | Antibody; virus, not elsewhere specified | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **86793** | Antibody; Yersinia | 1.10 | $65.57 | $0.00 | 000 | N | $72.13 |
| **86800** | Thyroglobulin antibody | 1.32 | $78.30 | $0.00 | 000 | N | $86.13 |
| **86803** | Hepatitis C antibody; | 1.50 | $89.19 | $0.00 | 000 | N | $98.11 |
| **86804** | Hepatitis C antibody; confirmatory test (eg, immunoblot) | 2.39 | $142.03 | $0.00 | 000 | N | $156.23 |
| **86805** | Lymphocytotoxicity assay, visual crossmatch; with titration | 3.67 | $218.48 | $0.00 | 000 | N | $240.33 |
| **86806** | Lymphocytotoxicity assay, visual crossmatch; without titration | 3.67 | $218.48 | $0.00 | 000 | N | $240.33 |
| **86807** | Serum screening for cytotoxic percent reactive antibody (PRA); standard method | 1.78 | $105.61 | $0.00 | 000 | N | $116.17 |
| **86808** | Serum screening for cytotoxic percent reactive antibody (PRA); quick method | 1.68 | $100.14 | $0.00 | 000 | N | $110.15 |
| **86812** | HLA typing; A, B, or C (eg, A10, B7, B27), single antigen | 2.14 | $127.45 | $0.00 | 000 | N | $140.20 |
| **86813** | HLA typing; A, B, or C, multiple antigens | 2.91 | $172.97 | $0.00 | 000 | N | $190.27 |
| **86816** | HLA typing; DR/DQ, single antigen | 2.91 | $172.97 | $0.00 | 000 | N | $190.27 |
| **86817** | HLA typing; DR/DQ, multiple antigens | 7.65 | $455.18 | $0.00 | 000 | N | $500.70 |
| **86821** | HLA typing; lymphocyte culture, mixed (MLC) | 5.81 | $345.93 | $0.00 | 000 | N | $380.52 |
| **86822** | HLA typing; lymphocyte culture, primed (PLC) | 2.14 | $127.45 | $0.00 | 000 | N | $140.20 |
| **86849** | Unlisted immunology procedure | 0.00 | BR | $0.00 | 000 | N | BR |
| **86850** | Antibody screen, RBC, each serum technique | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **86860** | Antibody elution (RBC), each elution | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **86870** | Antibody identification, RBC antibodies, each panel for each serum technique | 1.13 | $67.35 | $0.00 | 000 | N | $74.09 |
| **86880** | Antihuman globulin test (Coombs test); direct, each antiserum | 0.43 | $25.47 | $0.00 | 000 | N | $28.02 |
| **86885** | Antihuman globulin test (Coombs test); indirect, qualitative, each antiserum | 0.43 | $25.47 | $0.00 | 000 | N | $28.02 |
| **86886** | Antihuman globulin test (Coombs test); indirect, titer, each antiserum | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **86890** | Autologous blood or component, collection processing and storage; predeposited | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **86891** | Autologous blood or component, collection processing and storage; intra- or postoperative salvage | 3.83 | $227.59 | $0.00 | 000 | N | $250.35 |
| **86900** | Blood typing; ABO | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **86901** | Blood typing; Rh (D) | 0.34 | $20.05 | $0.00 | 000 | N | $22.06 |
| **86903** | Blood typing; antigen screening for compatible blood unit using reagent serum, per unit screened | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| **86904** | Blood typing; antigen screening for compatible unit using patient serum, per unit screened | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| **86905** | Blood typing; RBC antigens, other than ABO or Rh (D), each | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| **86906** | Blood typing; Rh phenotyping, complete | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| **86910** | Blood typing, for paternity testing, per individual; ABO, Rh and MN | 0.67 | $40.04 | $0.00 | 000 | N | $44.04 |

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|---|---|---|---|---|---|---|---|
| **86911** | Blood typing, for paternity testing, per individual; each additional antigen system | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| **86920** | Compatibility test each unit; immediate spin technique | 1.01 | $60.10 | $0.00 | 000 | N | $66.11 |
| **86921** | Compatibility test each unit; incubation technique | 0.83 | $49.15 | $0.00 | 000 | N | $54.07 |
| **86922** | Compatibility test each unit; antiglobulin technique | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **86923** | Compatibility test each unit; electronic | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **86927** | Fresh frozen plasma, thawing, each unit | 0.40 | $23.68 | $0.00 | 000 | N | $26.05 |
| **86930** | Frozen blood, each unit; freezing (includes preparation) | 3.06 | $182.07 | $0.00 | 000 | N | $200.28 |
| **86931** | Frozen blood, each unit; thawing | 2.30 | $136.55 | $0.00 | 000 | N | $150.21 |
| **86932** | Frozen blood, each unit; freezing (includes preparation) and thawing | 3.06 | $182.07 | $0.00 | 000 | N | $200.28 |
| **86940** | Hemolysins and agglutinins; auto, screen, each | 0.64 | $38.26 | $0.00 | 000 | N | $42.09 |
| **86941** | Hemolysins and agglutinins; incubated | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **86945** | Irradiation of blood product, each unit | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| **86950** | Leukocyte transfusion | 1.90 | $112.87 | $0.00 | 000 | N | $124.16 |
| **86960** | Volume reduction of blood or blood product (eg, red blood cells or platelets), each unit | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| **86965** | Pooling of platelets or other blood products | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| **86970** | Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing; incubation with chemical agents or drugs, each | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **86971** | Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing; incubation with enzymes, each | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **86972** | Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing; by density gradient separation | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **86975** | Pretreatment of serum for use in RBC antibody identification; incubation with drugs, each | 0.83 | $49.15 | $0.00 | 000 | N | $54.07 |
| **86976** | Pretreatment of serum for use in RBC antibody identification; by dilution | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **86977** | Pretreatment of serum for use in RBC antibody identification; incubation with inhibitors, each | 0.83 | $49.15 | $0.00 | 000 | N | $54.07 |
| **86978** | Pretreatment of serum for use in RBC antibody identification; by differential red cell absorption using patient RBCs or RBCs of known phenotype, each absorption | 0.83 | $49.15 | $0.00 | 000 | N | $54.07 |
| **86985** | Splitting of blood or blood products, each unit | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| **86999** | Unlisted transfusion medicine procedure | 0.00 | BR | | 000 | N | BR |
| **87001** | Animal inoculation, small animal; with observation | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87003** | Animal inoculation, small animal; with observation and dissection | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **87015** | Concentration (any type), for infectious agents | 0.64 | $38.26 | $0.00 | 000 | N | $42.09 |
| **87040** | Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate) | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| **87045** | Culture, bacterial; stool, aerobic, with isolation and preliminary examination (eg, KIA, LIA), Salmonella and Shigella species | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| **87046** | Culture, bacterial; stool, aerobic, additional pathogens, isolation and presumptive identification of isolates, each plate | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| **87070** | Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates | 0.83 | $49.15 | $0.00 | 000 | N | $54.07 |
| **87071** | Culture, bacterial; quantitative, aerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| **87073** | Culture, bacterial; quantitative, anaerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |

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|---|---|---|---|---|---|---|---|---|
| | **87075** | Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| | **87076** | Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| | **87077** | Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| | **87081** | Culture, presumptive, pathogenic organisms, screening only; | 0.55 | $32.78 | $0.00 | 000 | N | $36.06 |
| | **87084** | Culture, presumptive, pathogenic organisms, screening only; with colony estimation from density chart | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| | **87086** | Culture, bacterial; quantitative colony count, urine | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| | **87088** | Culture, bacterial; with isolation and presumptive identification of each isolate, urine | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| | **87101** | Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| | **87102** | Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; other source (except blood) | 0.80 | $47.36 | $0.00 | 000 | N | $52.10 |
| | **87103** | Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; blood | 0.80 | $47.36 | $0.00 | 000 | N | $52.10 |
| | **87106** | Culture, fungi, definitive identification, each organism; yeast | 0.83 | $49.15 | $0.00 | 000 | N | $54.07 |
| | **87107** | Culture, fungi, definitive identification, each organism; mold | 0.83 | $49.15 | $0.00 | 000 | N | $54.07 |
| | **87109** | Culture, mycoplasma, any source | 1.68 | $100.14 | $0.00 | 000 | N | $110.15 |
| | **87110** | Culture, chlamydia, any source | 1.16 | $69.20 | $0.00 | 000 | N | $76.12 |
| | **87116** | Culture, tubercle or other acid-fast bacilli (eg, TB, AFB, mycobacteria) any source, with isolation and presumptive identification of isolates | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| | **87118** | Culture, mycobacterial, definitive identification, each isolate | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| | **87140** | Culture, typing; immunofluorescent method, each antiserum | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| | **87143** | Culture, typing; gas liquid chromatography (GLC) or high pressure liquid chromatography (HPLC) method | 1.13 | $67.35 | $0.00 | 000 | N | $74.09 |
| | **87147** | Culture, typing; immunologic method, other than immunofluoresence (eg, agglutination grouping), per antiserum | 0.43 | $25.47 | $0.00 | 000 | N | $28.02 |
| | **87149** | Culture, typing; identification by nucleic acid probe | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| | **87152** | Culture, typing; identification by pulse field gel typing | 0.00 | BR | $0.00 | 000 | N | BR |
| | **87158** | Culture, typing; other methods | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| | **87164** | Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection | 0.92 | $54.62 | $43.70 | 000 | N | $60.08 |
| | **87166** | Dark field examination, any source (eg, penile, vaginal, oral, skin); without collection | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| | **87168** | Macroscopic examination; arthropod | 0.46 | $27.31 | $0.00 | 000 | N | $30.04 |
| | **87169** | Macroscopic examination; parasite | 0.46 | $27.31 | $0.00 | 000 | N | $30.04 |
| | **87172** | Pinworm exam (eg, cellophane tape prep) | 0.46 | $27.31 | $0.00 | 000 | N | $30.04 |
| | **87176** | Homogenization, tissue, for culture | 0.55 | $32.78 | $0.00 | 000 | N | $36.06 |
| | **87177** | Ova and parasites, direct smears, concentration and identification | 0.83 | $49.15 | $0.00 | 000 | N | $54.07 |
| | **87181** | Susceptibility studies, antimicrobial agent; agar dilution method, per agent (eg, antibiotic gradient strip) | 0.46 | $27.31 | $0.00 | 000 | N | $30.04 |
| | **87184** | Susceptibility studies, antimicrobial agent; disk method, per plate (12 or fewer agents) | 0.61 | $36.41 | $0.00 | 000 | N | $40.05 |
| | **87185** | Susceptibility studies, antimicrobial agent; enzyme detection (eg, beta lactamase), per enzyme | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| | **87186** | Susceptibility studies, antimicrobial agent; microdilution or agar dilution (minimum inhibitory concentration (MIC) or breakpoint), each multi-antimicrobial, per plate | 0.70 | $41.89 | $0.00 | 000 | N | $46.08 |
| + | **87187** | Susceptibility studies, antimicrobial agent; microdilution or agar dilution, minimum lethal concentration (MLC), each plate (List separately in addition to code for primary procedure) | 0.70 | $41.89 | $0.00 | 000 | N | $46.08 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **87188** | Susceptibility studies, antimicrobial agent; macrobroth dilution method, each agent | 0.70 | $41.89 | $0.00 | 000 | N | $46.08 |
| **87190** | Susceptibility studies, antimicrobial agent; mycobacteria, proportion method, each agent | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| **87197** | Serum bactericidal titer (Schlicter test) | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87205** | Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types | 0.46 | $27.31 | $0.00 | 000 | N | $30.04 |
| **87206** | Smear, primary source with interpretation; fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types | 0.55 | $32.78 | $0.00 | 000 | N | $36.06 |
| **87207** | Smear, primary source with interpretation; special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses) | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| **87209** | Smear, primary source with interpretation; complex special stain (eg, trichrome, iron hemotoxylin) for ova and parasites | 0.55 | $32.78 | $0.00 | 000 | N | $36.06 |
| **87210** | Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps) | 0.40 | $23.68 | $0.00 | 000 | N | $26.05 |
| **87220** | Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (eg, scabies) | 0.46 | $27.31 | $0.00 | 000 | N | $30.04 |
| **87230** | Toxin or antitoxin assay, tissue culture (eg, Clostridium difficile toxin) | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **87250** | Virus isolation; inoculation of embryonated eggs, or small animal, includes observation and dissection | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87252** | Virus isolation; tissue culture inoculation, observation, and presumptive identification by cytopathic effect | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87253** | Virus isolation; tissue culture, additional studies or definitive identification (eg, hemabsorption, neutralization, immunofluoresence stain), each isolate | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87254** | Virus isolation; centrifuge enhanced (shell vial) technique, includes identification with immunofluorescence stain, each virus | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87255** | Virus isolation; including identification by non-immunologic method, other than by cytopathic effect (eg, virus specific enzymatic activity) | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87260** | Infectious agent antigen detection by immunofluorescent technique; adenovirus | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87265** | Infectious agent antigen detection by immunofluorescent technique; Bordetella pertussis/parapertussis | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87267** | Infectious agent antigen detection by immunofluorescent technique; Enterovirus, direct fluorescent antibody (DFA) | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87269** | Infectious agent antigen detection by immunofluorescent technique; giardia | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87270** | Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87271** | Infectious agent antigen detection by immunofluorescent technique; Cytomegalovirus, direct fluorescent antibody (DFA) | 1.47 | $87.41 | $0.00 | 000 | N | $96.15 |
| **87272** | Infectious agent antigen detection by immunofluorescent technique; cryptosporidium | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87273** | Infectious agent antigen detection by immunofluorescent technique; Herpes simplex virus type 2 | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87274** | Infectious agent antigen detection by immunofluorescent technique; Herpes simplex virus type 1 | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87275** | Infectious agent antigen detection by immunofluorescent technique; influenza B virus | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87276** | Infectious agent antigen detection by immunofluorescent technique; influenza A virus | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87277** | Infectious agent antigen detection by immunofluorescent technique; Legionella micdadei | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **87278** | Infectious agent antigen detection by immunofluorescent technique; Legionella pneumophila | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **87279** | Infectious agent antigen detection by immunofluorescent technique; Parainfluenza virus, each type | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87280** | Infectious agent antigen detection by immunofluorescent technique; respiratory syncytial virus | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87281** | Infectious agent antigen detection by immunofluorescent technique; Pneumocystis carinii | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87283** | Infectious agent antigen detection by immunofluorescent technique; Rubeola | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87285** | Infectious agent antigen detection by immunofluorescent technique; Treponema pallidum | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **87290** | Infectious agent antigen detection by immunofluorescent technique; Varicella zoster virus | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87299** | Infectious agent antigen detection by immunofluorescent technique; not otherwise specified, each organism | 1.35 | $80.09 | $0.00 | 000 | N | $88.10 |
| **87300** | Infectious agent antigen detection by immunofluorescent technique, polyvalent for multiple organisms, each polyvalent antiserum | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87301** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; adenovirus enteric types 40/41 | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87305** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Aspergillus | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87320** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Chlamydia trachomatis | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87324** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Clostridium difficile toxin(s) | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87327** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Cryptococcus neoformans | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87328** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; cryptosporidium | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87329** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; giardia | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87332** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; cytomegalovirus | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87335** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Escherichia coli 0157 | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87336** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Entamoeba histolytica dispar group | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87337** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Entamoeba histolytica group | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87338** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Helicobacter pylori, stool | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87339** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Helicobacter pylori | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87340** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg) | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87341** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg) neutralization | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **87350** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis Be antigen (HBeAg) | 1.04 | $61.88 | $0.00 | 000 | N | $68.07 |
| **87380** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis, delta agent | 1.38 | $81.93 | $0.00 | 000 | N | $90.12 |
| **87385** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Histoplasma capsulatum | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87390** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-1 | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87391** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-2 | 1.44 | $85.56 | $0.00 | 000 | N | $94.12 |
| **87400** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Influenza, A or B, each | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87420** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; respiratory syncytial virus | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87425** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; rotavirus | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87427** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Shiga-like toxin | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87430** | Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Streptococcus, group A | 0.73 | $43.67 | $0.00 | 000 | N | $48.04 |
| **87449** | Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple step method, not otherwise specified, each organism | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87450** | Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; single step method, not otherwise specified, each organism | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87451** | Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple step method, polyvalent for multiple organisms, each polyvalent antiserum | 0.98 | $58.25 | $0.00 | 000 | N | $64.08 |
| **87470** | Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, direct probe technique | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87471** | Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, amplified probe technique | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87472** | Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, quantification | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **87475** | Infectious agent detection by nucleic acid (DNA or RNA); Borrelia burgdorferi, direct probe technique | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87476** | Infectious agent detection by nucleic acid (DNA or RNA); Borrelia burgdorferi, amplified probe technique | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87477** | Infectious agent detection by nucleic acid (DNA or RNA); Borrelia burgdorferi, quantification | 2.46 | $146.55 | $0.00 | 000 | N | $161.21 |
| **87480** | Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe technique | 1.50 | $89.19 | $0.00 | 000 | N | $98.11 |
| **87481** | Infectious agent detection by nucleic acid (DNA or RNA); Candida species, amplified probe technique | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **87482** | Infectious agent detection by nucleic acid (DNA or RNA); Candida species, quantification | 2.46 | $146.55 | $0.00 | 000 | N | $161.21 |
| **87485** | Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, direct probe technique | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |

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|---|---|---|---|---|---|---|---|
| **87486** | Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, amplified probe technique | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **87487** | Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, quantification | 2.46 | $146.55 | $0.00 | 000 | N | $161.21 |
| **87490** | Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87491** | Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **87492** | Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification | 2.30 | $136.55 | $0.00 | 000 | N | $150.21 |
| **87495** | Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, direct probe technique | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87496** | Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, amplified probe technique | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87497** | Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, quantification | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87498** | Infectious agent detection by nucleic acid (DNA or RNA); enterovirus, amplified probe technique | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87510** | Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, direct probe technique | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87511** | Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, amplified probe technique | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **87512** | Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, quantification | 2.30 | $136.55 | $0.00 | 000 | N | $150.21 |
| **87515** | Infectious agent detection by nucleic acid (DNA or RNA); hepatitis B virus, direct probe technique | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87516** | Infectious agent detection by nucleic acid (DNA or RNA); hepatitis B virus, amplified probe technique | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87517** | Infectious agent detection by nucleic acid (DNA or RNA); hepatitis B virus, quantification | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87520** | Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, direct probe technique | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87521** | Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, amplified probe technique | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87522** | Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, quantification | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87525** | Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, direct probe technique | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87526** | Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, amplified probe technique | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87527** | Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, quantification | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87528** | Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, direct probe technique | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87529** | Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, amplified probe technique | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87530** | Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, quantification | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87531** | Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, direct probe technique | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87532** | Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, amplified probe technique | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87533** | Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, quantification | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87534** | Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87535** | Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87536** | Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **87537** | Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87538** | Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, amplified probe technique | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87539** | Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, quantification | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87540** | Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, direct probe technique | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87541** | Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, amplified probe technique | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **87542** | Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, quantification | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **87550** | Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria species, direct probe technique | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87551** | Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria species, amplified probe technique | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **87552** | Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria species, quantification | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87555** | Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria tuberculosis, direct probe technique | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87556** | Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria tuberculosis, amplified probe technique | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87557** | Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria tuberculosis, quantification | 2.46 | $146.55 | $0.00 | 000 | N | $161.21 |
| **87560** | Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria avium-intracellulare, direct probe technique | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87561** | Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria avium-intracellulare, amplified probe technique | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87562** | Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria avium-intracellulare, quantification | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87580** | Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, direct probe technique | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87581** | Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, amplified probe technique | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| **87582** | Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, quantification | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **87590** | Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87591** | Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **87592** | Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification | 2.46 | $146.55 | $0.00 | 000 | N | $161.21 |
| **87620** | Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, direct probe technique | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **87621** | Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, amplified probe technique | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **87622** | Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, quantification | 2.46 | $146.55 | $0.00 | 000 | N | $161.21 |
| **87640** | Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, amplified probe technique | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **87641** | Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, methicillin resistant, amplified probe technique | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **87650** | Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, direct probe technique | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| **87651** | Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, amplified probe technique | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **87652** | Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, quantification | 2.46 | $146.55 | $0.00 | 000 | N | $161.21 |
| **87653** | Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group B, amplified probe technique | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|---|
| | **87660** | Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| | **87797** | Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism | 1.22 | $72.83 | $0.00 | 000 | N | $80.11 |
| | **87798** | Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| | **87799** | Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| | **87800** | Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique | 0.00 | BR | $0.00 | 000 | N | BR |
| | **87801** | Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique | 0.00 | BR | $0.00 | 000 | N | BR |
| | **87802** | Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group B | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| | **87803** | Infectious agent antigen detection by immunoassay with direct optical observation; Clostridium difficile toxin A | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| | **87804** | Infectious agent antigen detection by immunoassay with direct optical observation; Influenza | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| | **87807** | Infectious agent antigen detection by immunoassay with direct optical observation; respiratory syncytial virus | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| | **87808** | Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| | **87810** | Infectious agent detection by immunoassay with direct optical observation; Chlamydia trachomatis | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| | **87850** | Infectious agent detection by immunoassay with direct optical observation; Neisseria gonorrhoeae | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| | **87880** | Infectious agent detection by immunoassay with direct optical observation; Streptococcus, group A | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| | **87899** | Infectious agent detection by immunoassay with direct optical observation; not otherwise specified | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| | **87900** | Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic bioinformatics | 0.00 | BR | $0.00 | 000 | N | BR |
| | **87901** | Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV 1, reverse transcriptase and protease | 13.59 | $808.37 | $0.00 | 000 | N | $889.21 |
| | **87902** | Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis C virus | 13.59 | $808.37 | $0.00 | 000 | N | $889.21 |
| | **87903** | Infectious agent phenotype analysis by nucleic acid (DNA or RNA) with drug resistance tissue culture analysis, HIV 1; first through 10 drugs tested | 25.77 | $1,533.02 | $0.00 | 000 | N | $1686.32 |
| + | **87904** | Infectious agent phenotype analysis by nucleic acid (DNA or RNA) with drug resistance tissue culture analysis, HIV 1; each additional drug tested (List separately in addition to code for primary procedure) | 6.85 | $407.81 | $0.00 | 000 | N | $448.59 |
| | **87999** | Unlisted microbiology procedure | 0.00 | BR | | 000 | N | BR |
| | **88000** | Necropsy (autopsy), gross examination only; without CNS | 6.12 | $364.14 | | 000 | N | $400.55 |
| | **88005** | Necropsy (autopsy), gross examination only; with brain | 7.04 | $418.76 | | 000 | N | $460.64 |
| | **88007** | Necropsy (autopsy), gross examination only; with brain and spinal cord | 7.65 | $455.18 | | 000 | N | $500.70 |
| | **88012** | Necropsy (autopsy), gross examination only; infant with brain | 5.51 | $327.73 | | 000 | N | $360.50 |
| | **88014** | Necropsy (autopsy), gross examination only; stillborn or newborn with brain | 5.51 | $327.73 | | 000 | N | $360.50 |
| | **88016** | Necropsy (autopsy), gross examination only; macerated stillborn | 7.04 | $418.76 | | 000 | N | $460.64 |
| | **88020** | Necropsy (autopsy), gross and microscopic; without CNS | 9.49 | $564.42 | | 000 | N | $620.86 |
| | **88025** | Necropsy (autopsy), gross and microscopic; with brain | 10.40 | $619.04 | | 000 | N | $680.94 |
| | **88027** | Necropsy (autopsy), gross and microscopic; with brain and spinal cord | 11.32 | $673.66 | | 000 | N | $741.03 |
| | **88028** | Necropsy (autopsy), gross and microscopic; infant with brain | 5.51 | $327.73 | | 000 | N | $360.50 |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
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| | **88029** | Necropsy (autopsy), gross and microscopic; stillborn or newborn with brain | 5.51 | $327.73 | | 000 | N | $360.50 |
| | **88036** | Necropsy (autopsy), limited, gross and/or microscopic; regional | 3.06 | $182.07 | | 000 | N | $200.28 |
| | **88037** | Necropsy (autopsy), limited, gross and/or microscopic; single organ | 2.45 | $145.66 | | 000 | N | $160.23 |
| | **88040** | Necropsy (autopsy); forensic examination | 15.30 | $910.35 | | 000 | N | $1001.39 |
| | **88045** | Necropsy (autopsy); coroner's call | 1.53 | $91.04 | | 000 | N | $100.14 |
| | **88099** | Unlisted necropsy (autopsy) procedure | 0.00 | BR | | 000 | N | BR |
| | **88104** | Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation | 1.47 | $87.47 | $49.86 | 000 | N | $96.22 |
| | **88106** | Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation | 1.93 | $114.84 | $48.23 | 000 | N | $126.32 |
| | **88107** | Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears and simple filter preparation with interpretation | 2.39 | $142.21 | $68.26 | 000 | N | $156.43 |
| | **88108** | Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique) | 1.81 | $107.70 | $48.47 | 000 | N | $118.47 |
| | **88112** | Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal | 2.95 | $175.53 | $94.79 | 000 | N | $193.08 |
| | **88125** | Cytopathology, forensic (eg, sperm) | 0.52 | $30.94 | $21.35 | 000 | N | $34.03 |
| | **88130** | Sex chromatin identification; Barr bodies | 0.77 | $45.52 | $0.00 | 000 | N | $50.07 |
| | **88140** | Sex chromatin identification; peripheral blood smear, polymorphonuclear drumsticks | 0.46 | $27.31 | $0.00 | 000 | N | $30.04 |
| | **88141** | Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician | 0.61 | $36.30 | | 000 | N | $39.93 |
| | **88142** | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| | **88143** | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision | 0.57 | $33.68 | $0.00 | 000 | N | $37.05 |
| | **88147** | Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision | 0.54 | $32.31 | $0.00 | 000 | N | $35.54 |
| | **88148** | Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision | 0.57 | $34.15 | $0.00 | 000 | N | $37.57 |
| | **88150** | Cytopathology, slides, cervical or vaginal; manual screening under physician supervision | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| | **88152** | Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| | **88153** | Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| | **88154** | Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision | 0.60 | $35.52 | $0.00 | 000 | N | $39.07 |
| + | **88155** | Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (eg, maturation index, karyopyknotic index, estrogenic index) (List separately in addition to code(s) for other technical and interpretation services) | 0.37 | $21.84 | $0.00 | 000 | N | $24.02 |
| | **88160** | Cytopathology, smears, any other source; screening and interpretation | 1.34 | $79.73 | $42.26 | 000 | N | $87.70 |
| | **88161** | Cytopathology, smears, any other source; preparation, screening and interpretation | 1.48 | $88.06 | $43.15 | 000 | N | $96.87 |
| | **88162** | Cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains | 1.78 | $105.91 | $64.61 | 000 | N | $116.50 |
| | **88164** | Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |

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| | **88165** | Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision | 0.57 | $34.15 | $0.00 | 000 | N | $37.57 |
| | **88166** | Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision | 0.52 | $30.94 | $0.00 | 000 | N | $34.03 |
| | **88167** | Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision | 0.67 | $40.04 | $0.00 | 000 | N | $44.04 |
| | **88172** | Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s) | 1.34 | $79.73 | $51.03 | 000 | N | $87.70 |
| | **88173** | Cytopathology, evaluation of fine needle aspirate; interpretation and report | 3.50 | $208.25 | $116.62 | 000 | N | $229.08 |
| | **88174** | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| | **88175** | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision | 0.60 | $35.52 | $0.00 | 000 | N | $39.07 |
| | **88182** | Flow cytometry, cell cycle or DNA analysis | 2.73 | $162.44 | $64.98 | 000 | N | $178.68 |
| | **88184** | Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker | 1.62 | $96.39 | $0.00 | 000 | N | $106.03 |
| + | **88185** | Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker) | 0.87 | $51.77 | $0.00 | 000 | N | $56.95 |
| | **88187** | Flow cytometry, interpretation; 2 to 8 markers | 1.67 | $99.37 | | 000 | N | $109.31 |
| | **88188** | Flow cytometry, interpretation; 9 to 15 markers | 2.07 | $123.17 | | 000 | N | $135.49 |
| | **88189** | Flow cytometry, interpretation; 16 or more markers | 2.70 | $160.65 | | 000 | N | $176.72 |
| | **88199** | Unlisted cytopathology procedure | 0.00 | BR | | 000 | N | BR |
| | **88230** | Tissue culture for non-neoplastic disorders; lymphocyte | 3.52 | $209.38 | $0.00 | 000 | N | $230.32 |
| | **88233** | Tissue culture for non-neoplastic disorders; skin or other solid tissue biopsy | 3.52 | $209.38 | $0.00 | 000 | N | $230.32 |
| | **88235** | Tissue culture for non-neoplastic disorders; amniotic fluid or chorionic villus cells | 6.12 | $364.14 | $0.00 | 000 | N | $400.55 |
| | **88237** | Tissue culture for neoplastic disorders; bone marrow, blood cells | 5.51 | $327.73 | $0.00 | 000 | N | $360.50 |
| | **88239** | Tissue culture for neoplastic disorders; solid tumor | 3.52 | $209.38 | $0.00 | 000 | N | $230.32 |
| | **88240** | Cryopreservation, freezing and storage of cells, each cell line | 3.06 | $182.07 | $0.00 | 000 | N | $200.28 |
| | **88241** | Thawing and expansion of frozen cells, each aliquot | 2.30 | $136.55 | $0.00 | 000 | N | $150.21 |
| | **88245** | Chromosome analysis for breakage syndromes; baseline Sister Chromatid Exchange (SCE), 20-25 cells | 4.13 | $245.79 | $0.00 | 000 | N | $270.37 |
| | **88248** | Chromosome analysis for breakage syndromes; baseline breakage, score 50-100 cells, count 20 cells, 2 karyotypes (eg, for ataxia telangiectasia, Fanconi anemia, fragile X) | 7.34 | $436.97 | $0.00 | 000 | N | $480.67 |
| | **88249** | Chromosome analysis for breakage syndromes; score 100 cells, clastogen stress (eg, diepoxybutane, mitomycin C, ionizing radiation, UV radiation) | 8.26 | $491.59 | $0.00 | 000 | N | $540.75 |
| | **88261** | Chromosome analysis; count 5 cells, 1 karyotype, with banding | 7.19 | $427.86 | $0.00 | 000 | N | $470.65 |
| | **88262** | Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding | 9.64 | $573.52 | $0.00 | 000 | N | $630.87 |
| | **88263** | Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes, with banding | 9.91 | $589.88 | $0.00 | 000 | N | $648.87 |
| | **88264** | Chromosome analysis; analyze 20-25 cells | 9.18 | $546.21 | $0.00 | 000 | N | $600.83 |
| | **88267** | Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, 1 karyotype, with banding | 10.86 | $646.35 | $0.00 | 000 | N | $710.99 |
| | **88269** | Chromosome analysis, in situ for amniotic fluid cells, count cells from 6-12 colonies, 1 karyotype, with banding | 9.55 | $568.05 | $0.00 | 000 | N | $624.86 |

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|---|---|---|---|---|---|---|---|---|
| | **88271** | Molecular cytogenetics; DNA probe, each (eg, FISH) | 0.00 | BR | $0.00 | 000 | N | BR |
| | **88272** | Molecular cytogenetics; chromosomal in situ hybridization, analyze 3-5 cells (eg, for derivatives and markers) | 0.00 | BR | $0.00 | 000 | N | BR |
| | **88273** | Molecular cytogenetics; chromosomal in situ hybridization, analyze 10-30 cells (eg, for microdeletions) | 0.00 | BR | $0.00 | 000 | N | BR |
| | **88274** | Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells | 0.00 | BR | $0.00 | 000 | N | BR |
| | **88275** | Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells | 0.00 | BR | $0.00 | 000 | N | BR |
| | **88280** | Chromosome analysis; additional karyotypes, each study | 3.15 | $187.54 | $0.00 | 000 | N | $206.29 |
| | **88283** | Chromosome analysis; additional specialized banding technique (eg, NOR, C-banding) | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| | **88285** | Chromosome analysis; additional cells counted, each study | 2.75 | $163.86 | $0.00 | 000 | N | $180.25 |
| | **88289** | Chromosome analysis; additional high resolution study | 2.30 | $136.55 | $0.00 | 000 | N | $150.21 |
| | **88291** | Cytogenetics and molecular cytogenetics, interpretation and report | 0.69 | $41.06 | | 000 | N | $45.17 |
| | **88299** | Unlisted cytogenetic study | 0.00 | BR | | 000 | N | BR |
| | **88300** | Level I - Surgical pathology, gross examination only | 0.58 | $34.51 | $7.59 | 000 | N | $37.96 |
| | **88302** | Level II - Surgical pathology, gross and microscopic examination | 1.25 | $74.38 | $12.64 | 000 | N | $81.82 |
| | **88304** | Level III - Surgical pathology, gross and microscopic examination | 1.60 | $95.20 | $19.04 | 000 | N | $104.72 |
| | **88305** | Level IV - Surgical pathology, gross and microscopic examination | 2.71 | $161.25 | $66.11 | 000 | N | $177.38 |
| | **88307** | Level V - Surgical pathology, gross and microscopic examination | 5.03 | $299.29 | $143.66 | 000 | N | $329.22 |
| | **88309** | Level VI - Surgical pathology, gross and microscopic examination | 7.52 | $447.44 | $219.25 | 000 | N | $492.18 |
| + | **88311** | Decalcification procedure (List separately in addition to code for surgical pathology examination) | 0.47 | $27.97 | $19.86 | 000 | N | $30.77 |
| + | **88312** | Special stains (List separately in addition to code for primary service); Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), each | 2.28 | $135.66 | $51.55 | 000 | N | $149.23 |
| + | **88313** | Special stains (List separately in addition to code for primary service); Group II, all other, (eg, iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each | 1.66 | $98.77 | $22.72 | 000 | N | $108.65 |
| + | **88314** | Special stains (List separately in addition to code for primary service); histochemical staining with frozen section(s) | 2.48 | $147.56 | $38.37 | 000 | N | $162.32 |
| | **88318** | Determinative histochemistry to identify chemical components (eg, copper, zinc) | 2.39 | $142.21 | $42.66 | 000 | N | $156.43 |
| | **88319** | Determinative histochemistry or cytochemistry to identify enzyme constituents, each | 3.88 | $230.86 | $43.86 | 000 | N | $253.95 |
| | **88321** | Consultation and report on referred slides prepared elsewhere | 2.30 | $136.85 | | 000 | N | $150.54 |
| | **88323** | Consultation and report on referred material requiring preparation of slides | 3.60 | $214.20 | $132.80 | 000 | N | $235.62 |
| | **88325** | Consultation, comprehensive, with review of records and specimens, with report on referred material | 5.08 | $302.26 | | 000 | N | $332.49 |
| | **88329** | Pathology consultation during surgery; | 1.28 | $76.16 | | 000 | N | $83.78 |
| | **88331** | Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen | 2.29 | $136.26 | $99.47 | 000 | N | $149.89 |
| | **88332** | Pathology consultation during surgery; each additional tissue block with frozen section(s) | 1.03 | $61.29 | $48.42 | 000 | N | $67.42 |
| | **88333** | Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site | 2.31 | $137.45 | $103.09 | 000 | N | $151.20 |
| | **88334** | Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site | 1.35 | $80.33 | $57.03 | 000 | N | $88.36 |
| | **88342** | Immunohistochemistry (including tissue immunoperoxidase), each antibody | 2.41 | $143.40 | $76.00 | 000 | N | $157.74 |
| | **88346** | Immunofluorescent study, each antibody; direct method | 2.49 | $148.16 | $74.08 | 000 | N | $162.98 |

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|---|---|---|---|---|---|---|---|
| **88347** | Immunofluorescent study, each antibody; indirect method | 2.10 | $124.95 | $71.22 | 000 | N | $137.45 |
| **88348** | Electron microscopy; diagnostic | 12.97 | $771.72 | $154.34 | 000 | N | $848.89 |
| **88349** | Electron microscopy; scanning | 5.65 | $336.18 | $84.05 | 000 | N | $369.80 |
| **88355** | Morphometric analysis; skeletal muscle | 9.20 | $547.40 | $136.85 | 000 | N | $602.14 |
| **88356** | Morphometric analysis; nerve | 7.70 | $458.15 | $270.31 | 000 | N | $503.97 |
| **88358** | Morphometric analysis; tumor (eg, DNA ploidy) | 1.93 | $114.84 | $84.98 | 000 | N | $126.32 |
| **88360** | Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual | 2.94 | $174.93 | $97.96 | 000 | N | $192.42 |
| **88361** | Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology | 4.17 | $248.12 | $99.25 | 000 | N | $272.93 |
| **88362** | Nerve teasing preparations | 6.93 | $412.34 | $185.55 | 000 | N | $453.57 |
| **88365** | In situ hybridization (eg, FISH), each probe | 3.45 | $205.28 | $104.69 | 000 | N | $225.81 |
| **88367** | Morphometric analysis, in situ hybridization, (quantitative or semi-quantitative) each probe; using computer-assisted technology | 5.60 | $333.20 | $116.62 | 000 | N | $366.52 |
| **88368** | Morphometric analysis, in situ hybridization, (quantitative or semi-quantitative) each probe; manual | 4.34 | $258.23 | $136.86 | 000 | N | $284.05 |
| **88371** | Protein analysis of tissue by Western Blot, with interpretation and report; | 2.66 | $158.39 | $31.68 | 000 | N | $174.23 |
| **88372** | Protein analysis of tissue by Western Blot, with interpretation and report; immunological probe for band identification, each | 2.60 | $154.76 | $30.95 | 000 | N | $170.24 |
| **88380** | Microdissection (eg, mechanical, laser capture) | 0.00 | BR | $0.00 | 000 | N | BR |
| **88384** | Array-based evaluation of multiple molecular probes; 11 through 50 probes | 0.00 | BR | | 000 | N | BR |
| **88385** | Array-based evaluation of multiple molecular probes; 51 through 250 probes | 10.37 | $617.02 | | 000 | N | $678.72 |
| **88386** | Array-based evaluation of multiple molecular probes; 251 through 500 probes | 10.69 | $636.06 | | 000 | N | $699.67 |
| **88399** | Unlisted surgical pathology procedure | 0.00 | BR | | 000 | N | BR |
| **88400** | Bilirubin, total, transcutaneous | 0.00 | BR | $0.00 | 000 | N | BR |
| **89049** | Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report | 4.91 | $292.15 | | 000 | N | $321.37 |
| **89050** | Cell count, miscellaneous body fluids (eg, cerebrospinal fluid, joint fluid), except blood; | 0.55 | $32.78 | $0.00 | 000 | N | $36.06 |
| **89051** | Cell count, miscellaneous body fluids (eg, cerebrospinal fluid, joint fluid), except blood; with differential count | 0.58 | $34.57 | $0.00 | 000 | N | $38.03 |
| **89055** | Leukocyte assessment, fecal, qualitative or semiquantitative | 0.49 | $29.16 | $0.00 | 000 | N | $32.08 |
| **89060** | Crystal identification by light microscopy with or without polarizing lens analysis, tissue or any body fluid (except urine) | 0.61 | $36.41 | $23.67 | 000 | N | $40.05 |
| **89100** | Duodenal intubation and aspiration; single specimen (eg, simple bile study or afferent loop culture) plus appropriate test procedure | 4.15 | $246.93 | | 000 | N | $271.62 |
| **89105** | Duodenal intubation and aspiration; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube | 4.03 | $239.79 | | 000 | N | $263.77 |
| **89125** | Fat stain, feces, urine, or respiratory secretions | 0.55 | $32.78 | $0.00 | 000 | N | $36.06 |
| **89130** | Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology; | 3.44 | $204.68 | | 000 | N | $225.15 |
| **89132** | Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology; after stimulation | 2.96 | $176.12 | | 000 | N | $193.73 |
| **89135** | Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); one hour | 4.38 | $260.61 | | 000 | N | $286.67 |
| **89136** | Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); two hours | 3.25 | $193.38 | | 000 | N | $212.72 |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **89140** | Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); two hours including gastric stimulation (eg, histalog, pentagastrin) | 4.14 | $246.33 | | 000 | N | $270.96 |
| **89141** | Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); three hours, including gastric stimulation | 4.22 | $251.09 | | 000 | N | $276.20 |
| **89160** | Meat fibers, feces | 0.37 | $21.84 | $0.00 | 000 | N | $24.02 |
| **89190** | Nasal smear for eosinophils | 0.43 | $25.47 | $0.00 | 000 | N | $28.02 |
| **89220** | Sputum, obtaining specimen, aerosol induced technique (separate procedure) | 0.43 | $25.59 | $0.00 | 000 | N | $28.15 |
| **89225** | Starch granules, feces | 0.37 | $21.84 | $0.00 | 000 | N | $24.02 |
| **89230** | Sweat collection by iontophoresis | 0.12 | $7.14 | $0.00 | 000 | N | $7.85 |
| **89235** | Water load test | 0.86 | $50.99 | $0.00 | 000 | N | $56.09 |
| **89240** | Unlisted miscellaneous pathology test | 0.00 | BR | $0.00 | 000 | N | BR |
| **89250** | Culture of oocyte(s)/embryo(s), less than 4 days; | 20.59 | $1,225.34 | $0.00 | 000 | N | $1347.87 |
| **89251** | Culture of oocyte(s)/embryo(s), less than 4 days; with co-culture of oocyte(s)/embryos | 21.42 | $1,274.49 | $0.00 | 000 | N | $1401.94 |
| **89253** | Assisted embryo hatching, microtechniques (any method) | 0.00 | BR | $0.00 | 000 | N | BR |
| **89254** | Oocyte identification from follicular fluid | 0.00 | BR | $0.00 | 000 | N | BR |
| **89255** | Preparation of embryo for transfer (any method) | 0.00 | BR | $0.00 | 000 | N | BR |
| **89257** | Sperm identification from aspiration (other than seminal fluid) | 0.00 | BR | $0.00 | 000 | N | BR |
| **89258** | Cryopreservation; embryo(s) | 0.00 | BR | $0.00 | 000 | N | BR |
| **89259** | Cryopreservation; sperm | 0.00 | BR | $0.00 | 000 | N | BR |
| **89260** | Sperm isolation; simple prep (eg, sperm wash and swim-up) for insemination or diagnosis with semen analysis | 0.00 | BR | $0.00 | 000 | N | BR |
| **89261** | Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis | 0.00 | BR | $0.00 | 000 | N | BR |
| **89264** | Sperm identification from testis tissue, fresh or cryopreserved | 0.00 | BR | $0.00 | 000 | N | BR |
| **89268** | Insemination of oocytes | 0.00 | BR | $0.00 | 000 | N | BR |
| **89272** | Extended culture of oocyte(s)/embryo(s), 4-7 days | 0.00 | BR | $0.00 | 000 | N | BR |
| **89280** | Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes | 0.00 | BR | $0.00 | 000 | N | BR |
| **89281** | Assisted oocyte fertilization, microtechnique; greater than 10 oocytes | 0.00 | BR | $0.00 | 000 | N | BR |
| **89290** | Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos | 0.00 | BR | $0.00 | 000 | N | BR |
| **89291** | Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos | 0.00 | BR | $0.00 | 000 | N | BR |
| **89300** | Semen analysis; presence and/or motility of sperm including Huhner test (post coital) | 1.07 | $63.72 | $0.00 | 000 | N | $70.09 |
| **89310** | Semen analysis; motility and count (not including Huhner test) | 1.10 | $65.57 | $0.00 | 000 | N | $72.13 |
| **89320** | Semen analysis; complete (volume, count, motility, and differential) | 1.53 | $91.04 | $0.00 | 000 | N | $100.14 |
| **89321** | Semen analysis, presence and/or motility of sperm | 0.92 | $54.62 | $0.00 | 000 | N | $60.08 |
| **89325** | Sperm antibodies | 2.45 | $145.66 | $0.00 | 000 | N | $160.23 |
| **89329** | Sperm evaluation; hamster penetration test | 6.12 | $364.14 | $0.00 | 000 | N | $400.55 |
| **89330** | Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test | 1.68 | $100.14 | $0.00 | 000 | N | $110.15 |
| **89335** | Cryopreservation, reproductive tissue, testicular | 0.00 | BR | $0.00 | 000 | N | BR |
| **89342** | Storage, (per year); embryo(s) | 0.00 | BR | $0.00 | 000 | N | BR |
| **89343** | Storage, (per year); sperm/semen | 0.00 | BR | $0.00 | 000 | N | BR |
| **89344** | Storage, (per year); reproductive tissue, testicular/ovarian | 0.00 | BR | $0.00 | 000 | N | BR |
| **89346** | Storage, (per year); oocyte(s) | 0.00 | BR | $0.00 | 000 | N | BR |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg | Facility Fee |
|---|---|---|---|---|---|---|---|
| **89352** | Thawing of cryopreserved; embryo(s) | 0.00 | BR | $0.00 | 000 | N | BR |
| **89353** | Thawing of cryopreserved; sperm/semen, each aliquot | 0.00 | BR | $0.00 | 000 | N | BR |
| **89354** | Thawing of cryopreserved; reproductive tissue, testicular/ovarian | 0.00 | BR | $0.00 | 000 | N | BR |
| **89356** | Thawing of cryopreserved; oocytes, each aliquot | 0.00 | BR | $0.00 | 000 | N | |

# Medicine Services

In addition to the general rules, this section applies to unique guidelines for medicine specialties. Physical medicine and rehabilitation guidelines, as well as chiropractic and osteopathic services, are listed in a separate section following Medicine Services.

## I. GUIDELINES

A. **Unlisted Services or Procedures**
When a service or procedure is provided that is not specifically listed in the Fee Schedule, documentation must be submitted to substantiate the charge.

B. **Multiple Procedures**
It is appropriate to designate multiple procedures rendered on the same date by separate entries.

C. **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.

D. **By Report (BR) Procedures**
"BR" in the Amount column indicates services that are too new, unusual, or variable in the nature of their performance to permit the assignment of a definable fee. Such services should be substantiated by documentation submitted with the bill. Sufficient information should be included to permit proper identification and a sound evaluation. If the service is justified by the report, the actual charge shall be paid in full, unless the payer has evidence that the actual charge exceeds the usual and customary charge for such service.

E. **Special 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 that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

F. **Materials Supplied by Physician**
Supplies and materials provided by the physician over and above those usually included with the office visit should be identified with CPT code 99070 or specific HCPCS Level II code. Reimbursement shall be limited to the Fee Schedule maximum reimbursement allowance (MRA) or the usual and customary rate for items not listed in this Fee Schedule.

G. **Audiological Function Tests**
The audiometric tests (92551–92596) require use of calibrated electronic equipment. Other hearing tests (e.g., whisper voice or tuning fork) are considered part of the examination and not paid separately. All descriptors refer to testing of both ears.

H. **Psychological Services**
Payment for a psychiatric diagnostic interview includes history and mental status determination, development of a treatment plan when necessary, and the preparation of a written report that must be submitted with the required billing form.

Psychotherapy codes (90804–90857) must be billed under the CPT code most closely approximating the length of the session. The codes for individual therapy services designate whether the service includes medical evaluation. Only a psychiatrist (M.D. or D.O.) may bill for those codes that include medical evaluation (procedure codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829).

A service level adjustment factor is used to determine payment for psychotherapy when a provider other than a psychiatrist provides the service. In those instances, the reimbursement amount for the CPT code is paid at eighty-five percent (85%) of the maximum

reimbursement allowance. This applies to psychologists, social workers, and counselors.

I. **Electromyography (EMG)**
Payment for EMG services includes the initial set of electrodes and all supplies necessary to perform the service. The physician may be paid for a consultation or new patient visit in addition to the EMG performed on the same day. When an EMG is performed on the same day as a follow up visit, payment may be made for the EMG only unless documentation supports the need for a medical service in addition to the EMG.

J. **Manipulative Services**
Chiropractic manipulative services, which are medicine services, will be discussed in the Physical Medicine section.

## II. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, identify the modifying circumstance by the addition of the appropriate modifier code, which may be reported by a two-digit number placed after the usual procedure number separated by a hyphen. If more than one modifier is used, place the multiple modifiers code 99 immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in Medicine Services are as follows:

### *22 Unusual Procedure Services*

When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

*Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.*

### *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 modifier 26 to the usual procedure number.

### *TC Technical Component (HCPCS Level II Modifier)*

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

*Mississippi's note: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.*

### *32 Mandated Services*

Services related to mandated consultation and/or related services (eg, PRO, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

### *51 Multiple Procedures*

When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see the applicable CPT book).

*Mississippi's note: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the applicable CPT book.*

### *52 Reduced Services*

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

### *53 Discontinued Procedure*

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the wellbeing of the patient prior to or after administration of

anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

### *55 Postoperative Management Only*

When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

### *56 Preoperative Management Only*

When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

### *57 Decision for Surgery*

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

### *58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period*

The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.

### *59 Distinct Procedural Service*

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

### *76 Repeat Procedure by Same Physician*

The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

### *77 Repeat Procedure by Another Physician*

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 procedure/service.

### *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 modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

### *79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period*

The physician 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 modifier 79. (For repeat procedures on the same day, see modifier 76.)

### *90 Reference (Outside) Laboratory*

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

### *99 Multiple Modifiers*

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

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| ⊘ | 90281 | Immune globulin (Ig), human, for intramuscular use | 0.00 | BR | | 000 | N |
| ⊘ | 90283 | Immune globulin (IgIV), human, for intravenous use | 0.00 | BR | | 000 | N |
| ⊘ | 90287 | Botulinum antitoxin, equine, any route | 0.00 | BR | | 000 | N |
| ⊘ | 90288 | Botulism immune globulin, human, for intravenous use | 0.00 | BR | | 000 | N |
| ⊘ | 90291 | Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use | 0.00 | BR | | 000 | N |
| ⊘ | 90296 | Diphtheria antitoxin, equine, any route | 0.00 | BR | | 000 | N |
| ⊘ | 90371 | Hepatitis B immune globulin (HBIg), human, for intramuscular use | 1.79 | $105.55 | | 000 | N |
| ⊘ | 90375 | Rabies immune globulin (RIg), human, for intramuscular and/or subcutaneous use | 2.04 | $120.36 | | 000 | N |
| ⊘ | 90376 | Rabies immune globulin, heat-treated (RIg-HT), human, for intramuscular and/or subcutaneous use | 2.17 | $127.79 | | 000 | N |
| ⊘ | 90378 | Respiratory syncytial virus immune globulin (RSV-IgIM), for intramuscular use, 50 mg, each | 0.00 | BR | | 000 | N |
| ⊘ | 90379 | Respiratory syncytial virus immune globulin (RSV-IgIV), human, for intravenous use | 0.00 | BR | | 000 | N |
| ⊘ | 90384 | Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use | 1.46 | $86.26 | | 000 | N |
| ⊘ | 90385 | Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use | 0.46 | $26.96 | | 000 | N |
| ⊘ | 90386 | Rho(D) immune globulin (RhIgIV), human, for intravenous use | 1.71 | $100.83 | | 000 | N |
| ⊘ | 90389 | Tetanus immune globulin (TIg), human, for intramuscular use | 1.58 | $93.40 | | 000 | N |
| ⊘ | 90393 | Vaccinia immune globulin, human, for intramuscular use | 0.00 | BR | | 000 | N |
| ⊘ | 90396 | Varicella-zoster immune globulin, human, for intramuscular use | 1.91 | $112.69 | | 000 | N |
| ⊘ | 90399 | Unlisted immune globulin | 0.00 | BR | | 000 | N |
| | 90465 | Immunization administration younger than 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day | 0.51 | $30.09 | | 000 | N |
| + | 90466 | Immunization administration younger than 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; each additional injection (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure) | 0.27 | $15.93 | | 000 | N |
| | 90467 | Immunization administration younger than age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid), per day | 0.33 | $19.47 | | 000 | N |
| + | 90468 | Immunization administration younger than age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; each additional administration (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure) | 0.25 | $14.75 | | 000 | N |
| | 90471 | Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid) | 0.51 | $30.09 | | 000 | N |
| + | 90472 | Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure) | 0.27 | $15.93 | | 000 | N |
| | 90473 | Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid) | 0.34 | $20.06 | | 000 | N |
| + | 90474 | Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure) | 0.23 | $13.57 | | 000 | N |
| ⊘ | 90476 | Adenovirus vaccine, type 4, live, for oral use | 0.00 | BR | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| ⊘ | **90477** | Adenovirus vaccine, type 7, live, for oral use | 0.00 | BR | | 000 | N |
| ⊘ | **90581** | Anthrax vaccine, for subcutaneous use | 1.67 | $98.71 | | 000 | N |
| ⊘ | **90585** | Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use | 2.12 | $125.14 | | 000 | N |
| ⊘ | **90586** | Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use | 2.31 | $136.41 | | 000 | N |
| ⊘ | **90632** | Hepatitis A vaccine, adult dosage, for intramuscular use | 0.88 | $52.16 | | 000 | N |
| ⊘ | **90633** | Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use | 0.44 | $25.78 | | 000 | N |
| ⊘ | **90634** | Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use | 0.44 | $25.78 | | 000 | N |
| ⊘ | **90636** | Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use | 1.17 | $68.79 | | 000 | N |
| ⊘ | **90645** | Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use | 0.34 | $20.18 | | 000 | N |
| ⊘ | **90646** | Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use | 0.00 | BR | | 000 | N |
| ⊘ | **90647** | Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use | 0.35 | $20.77 | | 000 | N |
| ⊘ | **90648** | Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use | 0.34 | $20.18 | | 000 | N |
| ⊘ | **90649** | Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use | 0.00 | BR | | 000 | N |
| ⊘ | **90655** | Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use | 0.00 | BR | | 000 | N |
| ⊘ | **90656** | Influenza virus vaccine, split virus, preservative free, when administered to 3 years and older, for intramuscular use | 0.00 | BR | | 000 | N |
| ⊘ | **90657** | Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use | 0.19 | $10.97 | | 000 | N |
| ⊘ | **90658** | Influenza virus vaccine, split virus, when administered to 3 years of age and older, for intramuscular use | 0.19 | $10.97 | | 000 | N |
| ⊘ | **90660** | Influenza virus vaccine, live, for intranasal use | 0.00 | BR | | 000 | N |
| ⊘ | **90665** | Lyme disease vaccine, adult dosage, for intramuscular use | 0.00 | BR | | 000 | N |
| ⊘ | **90669** | Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use | 1.04 | $61.36 | | 000 | N |
| ⊘ | **90675** | Rabies vaccine, for intramuscular use | 2.29 | $135.17 | | 000 | N |
| ⊘ | **90676** | Rabies vaccine, for intradermal use | 0.00 | BR | | 000 | N |
| ⊘ | **90680** | Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use | 0.98 | $57.82 | | 000 | N |
| ⊘ | **90690** | Typhoid vaccine, live, oral | 0.49 | $28.73 | | 000 | N |
| ⊘ | **90691** | Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use | 0.66 | $38.82 | | 000 | N |
| ⊘ | **90692** | Typhoid vaccine, heat- and phenol-inactivated (H-P), for subcutaneous or intradermal use | 0.00 | BR | | 000 | N |
| ⊘ | **90693** | Typhoid vaccine, acetone-killed, dried (AKD), for subcutaneous use (U.S. military) | 0.00 | BR | | 000 | N |
| ⊘ | **90698** | Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP - Hib - IPV), for intramuscular use | 1.09 | $64.02 | | 000 | N |
| ⊘ | **90700** | Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to younger than 7 years, for intramuscular use | 0.32 | $19.00 | | 000 | N |
| ⊘ | **90701** | Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP), for intramuscular use | 0.33 | $19.29 | | 000 | N |
| ⊘ | **90702** | Diphtheria and tetanus toxoids (DT) adsorbed when administered to younger than 7 years, for intramuscular use | 0.25 | $14.51 | | 000 | N |
| ⊘ | **90703** | Tetanus toxoid adsorbed, for intramuscular use | 0.28 | $16.28 | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| ⊘ | **90704** | Mumps virus vaccine, live, for subcutaneous use | 0.29 | $17.17 | | 000 | N |
| ⊘ | **90705** | Measles virus vaccine, live, for subcutaneous use | 0.23 | $13.33 | | 000 | N |
| ⊘ | **90706** | Rubella virus vaccine, live, for subcutaneous use | 0.25 | $14.81 | | 000 | N |
| ⊘ | **90707** | Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use | 0.66 | $38.82 | | 000 | N |
| ⊘ | **90708** | Measles and rubella virus vaccine, live, for subcutaneous use | 0.00 | BR | | 000 | N |
| ⊘ | **90710** | Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use | 1.81 | $106.73 | | 000 | N |
| ⊘ | **90712** | Poliovirus vaccine, (any type(s)) (OPV), live, for oral use | 0.00 | BR | | 000 | N |
| ⊘ | **90713** | Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use | 0.37 | $21.95 | | 000 | N |
| ⊘ | **90714** | Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to 7 years or older, for intramuscular use | 0.00 | BR | | 000 | N |
| ⊘ | **90715** | Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to 7 years or older, for intramuscular use | 0.00 | BR | | 000 | N |
| ⊘ | **90716** | Varicella virus vaccine, live, for subcutaneous use | 1.01 | $59.30 | | 000 | N |
| ⊘ | **90717** | Yellow fever vaccine, live, for subcutaneous use | 1.03 | $60.48 | | 000 | N |
| ⊘ | **90718** | Tetanus and diphtheria toxoids (Td) adsorbed when administered to 7 years or older, for intramuscular use | 0.00 | BR | | 000 | N |
| ⊘ | **90719** | Diphtheria toxoid, for intramuscular use | 0.00 | BR | | 000 | N |
| ⊘ | **90720** | Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use | 0.00 | BR | | 000 | N |
| ⊘ | **90721** | Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use | 0.00 | BR | | 000 | N |
| ⊘ | **90723** | Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use | 0.00 | BR | | 000 | N |
| ⊘ | **90725** | Cholera vaccine for injectable use | 0.00 | BR | | 000 | N |
| ⊘ | **90727** | Plague vaccine, for intramuscular use | 0.00 | BR | | 000 | N |
| ⊘ | **90732** | Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to 2 years or older, for subcutaneous or intramuscular use | 0.38 | $22.24 | | 000 | N |
| ⊘ | **90733** | Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use | 1.29 | $75.87 | | 000 | N |
| ⊘ | **90734** | Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use | 1.24 | $72.92 | | 000 | N |
| ⊘ | **90735** | Japanese encephalitis virus vaccine, for subcutaneous use | 1.37 | $80.65 | | 000 | N |
| ⊘ | **90736** | Zoster (shingles) vaccine, live, for subcutaneous injection | 0.00 | BR | | 000 | N |
| ⊘ | **90740** | Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use | 2.60 | $153.58 | | 000 | N |
| ⊘ | **90743** | Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use | 0.42 | $24.60 | | 000 | N |
| ⊘ | **90744** | Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use | 0.42 | $24.60 | | 000 | N |
| ⊘ | **90746** | Hepatitis B vaccine, adult dosage, for intramuscular use | 0.81 | $48.03 | | 000 | N |
| ⊘ | **90747** | Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use | 2.60 | $153.58 | | 000 | N |
| ⊘ | **90748** | Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use | 0.67 | $39.71 | | 000 | N |
| ⊘ | **90749** | Unlisted vaccine/toxoid | 0.00 | BR | | 000 | N |
| | **90760** | Intravenous infusion, hydration; initial, up to 1 hour | 1.62 | $95.58 | | 000 | N |
| + | **90761** | Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure) | 0.50 | $29.50 | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| | **90765** | Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour | 1.98 | $116.82 | | 000 | N |
| + | **90766** | Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure) | 0.64 | $37.76 | | 000 | N |
| + | **90767** | Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure) | 1.05 | $61.95 | | 000 | N |
| + | **90768** | Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure) | 0.60 | $35.40 | | 000 | N |
| | **90772** | Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular | 0.51 | $30.09 | | 000 | N |
| | **90773** | Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial | 0.48 | $28.32 | | 000 | N |
| | **90774** | Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug | 1.51 | $89.09 | | 000 | N |
| + | **90775** | Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure) | 0.69 | $40.71 | | 000 | N |
| | **90779** | Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion | 0.00 | BR | | 000 | N |
| | **90801** | Psychiatric diagnostic interview examination | 3.83 | $225.97 | | 000 | N |
| | **90802** | Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication | 4.06 | $239.54 | | 000 | N |
| | **90804** | Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; | 1.63 | $96.17 | | 000 | N |
| | **90805** | Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services | 1.79 | $105.61 | | 000 | N |
| | **90806** | Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; | 2.37 | $139.83 | | 000 | N |
| | **90807** | Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services | 2.57 | $151.63 | | 000 | N |
| | **90808** | Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; | 3.51 | $207.09 | | 000 | N |
| | **90809** | Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services | 3.69 | $217.71 | | 000 | N |
| | **90810** | Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; | 1.74 | $102.66 | | 000 | N |
| | **90811** | Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services | 1.98 | $116.82 | | 000 | N |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|
| **90812** | Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; | 2.56 | $151.04 | | 000 | N |
| **90813** | Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services | 2.76 | $162.84 | | 000 | N |
| **90814** | Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; | 3.69 | $217.71 | | 000 | N |
| **90815** | Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services | 3.86 | $227.74 | | 000 | N |
| **90816** | Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; | 1.58 | $93.22 | | 000 | N |
| **90817** | Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services | 1.74 | $102.66 | | 000 | N |
| **90818** | Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; | 2.37 | $139.83 | | 000 | N |
| **90819** | Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services | 2.50 | $147.50 | | 000 | N |
| **90821** | Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; | 3.52 | $207.68 | | 000 | N |
| **90822** | Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services | 3.64 | $214.76 | | 000 | N |
| **90823** | Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; | 1.70 | $100.30 | | 000 | N |
| **90824** | Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services | 1.87 | $110.33 | | 000 | N |
| **90826** | Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; | 2.52 | $148.68 | | 000 | N |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|
| **90827** | Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services | 2.62 | $154.58 | | 000 | N |
| **90828** | Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; | 3.65 | $215.35 | | 000 | N |
| **90829** | Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services | 3.76 | $221.84 | | 000 | N |
| **90845** | Psychoanalysis | 2.18 | $128.62 | | 000 | N |
| **90846** | Family psychotherapy (without the patient present) | 2.31 | $136.29 | | 000 | N |
| **90847** | Family psychotherapy (conjoint psychotherapy) (with patient present) | 2.84 | $167.56 | | 000 | N |
| **90849** | Multiple-family group psychotherapy | 0.83 | $48.97 | | 000 | N |
| **90853** | Group psychotherapy (other than of a multiple-family group) | 0.80 | $47.20 | | 000 | N |
| **90857** | Interactive group psychotherapy | 0.89 | $52.51 | | 000 | N |
| **90862** | Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy | 1.33 | $78.47 | | 000 | N |
| **90865** | Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital (Amytal) interview) | 3.99 | $235.41 | | 000 | N |
| **90870** | Electroconvulsive therapy (includes necessary monitoring) | 3.66 | $215.94 | | 000 | N |
| **90875** | Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes | 1.93 | $113.87 | | 000 | N |
| **90876** | Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 45-50 minutes | 2.80 | $165.20 | | 000 | N |
| **90880** | Hypnotherapy | 2.94 | $173.46 | | 000 | N |
| **90882** | Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions | 1.59 | $93.69 | | 000 | N |
| **90885** | Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes | 1.22 | $71.98 | | 000 | N |
| **90887** | Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient | 2.14 | $126.26 | | 000 | N |
| **90889** | Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers | 1.37 | $80.65 | | 000 | N |
| **90899** | Unlisted psychiatric service or procedure | 0.00 | BR | | 000 | N |
| **90901** | Biofeedback training by any modality | 1.00 | $59.00 | | 000 | N |
| **90911** | Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry | 2.37 | $139.83 | | 000 | N |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|
| **90918** | End-stage renal disease (ESRD) related services per full month; for patients younger than two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents | 16.15 | $952.85 | | 000 | N |
| **90919** | End-stage renal disease (ESRD) related services per full month; for patients between two and eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents | 11.72 | $691.48 | | 000 | N |
| **90920** | End-stage renal disease (ESRD) related services per full month; for patients between twelve and nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents | 10.26 | $605.34 | | 000 | N |
| **90921** | End-stage renal disease (ESRD) related services per full month; for patients twenty years of age and older | 6.41 | $378.19 | | 000 | N |
| **90922** | End-stage renal disease (ESRD) related services (less than full month), per day; for patients younger than two years of age | 0.54 | $31.86 | | 000 | N |
| **90923** | End-stage renal disease (ESRD) related services (less than full month), per day; for patients between two and eleven years of age | 0.38 | $22.42 | | 000 | N |
| **90924** | End-stage renal disease (ESRD) related services (less than full month), per day; for patients between twelve and nineteen years of age | 0.34 | $20.06 | | 000 | N |
| **90925** | End-stage renal disease (ESRD) related services (less than full month), per day; for patients twenty years of age and older | 0.21 | $12.39 | | 000 | N |
| **90935** | Hemodialysis procedure with single physician evaluation | 1.78 | $105.02 | | 000 | N |
| **90937** | Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription | 2.90 | $171.10 | | 000 | N |
| **90940** | Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator method | 1.11 | $65.25 | $26.10 | 000 | N |
| **90945** | Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single physician evaluation | 1.85 | $109.15 | | 000 | N |
| **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 | 2.95 | $174.05 | | 000 | N |
| **90989** | Dialysis training, patient, including helper where applicable, any mode, completed course | 7.54 | $444.74 | | 000 | N |
| **90993** | Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session | 1.31 | $77.11 | | 000 | N |
| **90997** | Hemoperfusion (eg, with activated charcoal or resin) | 2.33 | $137.47 | | 000 | N |
| **90999** | Unlisted dialysis procedure, inpatient or outpatient | 0.00 | BR | | 000 | N |
| **91000** | Esophageal intubation and collection of washings for cytology, including preparation of specimens (separate procedure) | 1.50 | $88.50 | $81.42 | 000 | N |
| **91010** | Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study; | 5.46 | $322.14 | $96.64 | 000 | N |
| **91011** | Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study; with mecholyl or similar stimulant | 6.73 | $397.07 | $123.09 | 000 | N |
| **91012** | Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study; with acid perfusion studies | 7.13 | $420.67 | $117.79 | 000 | N |
| **91020** | Gastric motility (manometric) studies | 6.01 | $354.59 | $117.01 | 000 | N |
| **91022** | Duodenal motility (manometric) study | 5.51 | $325.09 | $110.53 | 000 | N |
| **91030** | Esophagus, acid perfusion (Bernstein) test for esophagitis | 3.43 | $202.37 | $74.88 | 000 | N |
| **91034** | Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation | 5.95 | $351.05 | $77.23 | 000 | N |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|
| **91035** | Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation | 12.47 | $735.73 | $132.43 | 000 | N |
| **91037** | Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; | 4.03 | $237.77 | $80.84 | 000 | N |
| **91038** | Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours) | 3.47 | $204.73 | $92.13 | 000 | N |
| **91040** | Esophageal balloon distension provocation study | 11.66 | $687.94 | $75.67 | 000 | N |
| **91052** | Gastric analysis test with injection of stimulant of gastric secretion (eg, histamine, insulin, pentagastrin, calcium and secretin) | 3.35 | $197.65 | $65.22 | 000 | N |
| **91055** | Gastric intubation, washings, and preparing slides for cytology (separate procedure) | 3.73 | $220.07 | $70.42 | 000 | N |
| **91065** | Breath hydrogen test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit) | 1.63 | $96.17 | $16.35 | 000 | N |
| **91100** | Intestinal bleeding tube, passage, positioning and monitoring | 3.67 | $216.53 | | 000 | N |
| **91105** | Gastric intubation, and aspiration or lavage for treatment (eg, for ingested poisons) | 2.37 | $139.83 | | 000 | N |
| **91110** | Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report | 25.20 | $1,486.80 | $297.36 | 000 | N |
| **91111** | Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with physician interpretation and report | 19.60 | $1,156.40 | $92.51 | 000 | N |
| **91120** | Rectal sensation, tone, and compliance test (ie, response to graded balloon distention) | 11.47 | $676.73 | $81.21 | 000 | N |
| **91122** | Anorectal manometry | 6.56 | $387.04 | $143.20 | 000 | N |
| **91123** | Pulsed irrigation of fecal impaction | 0.00 | BR | | 000 | N |
| **91132** | Electrogastrography, diagnostic, transcutaneous; | 0.60 | $35.58 | $23.13 | 000 | N |
| **91133** | Electrogastrography, diagnostic, transcutaneous; with provocative testing | 0.70 | $41.54 | $27.00 | 000 | N |
| **91299** | Unlisted diagnostic gastroenterology procedure | 0.00 | BR | | 000 | N |
| **92002** | Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient | 1.78 | $105.02 | | 000 | N |
| **92004** | Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits | 3.21 | $189.39 | | 000 | N |
| **92012** | Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient | 1.63 | $96.17 | | 000 | N |
| **92014** | Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits | 2.41 | $142.19 | | 000 | N |
| **92015** | Determination of refractive state | 1.49 | $87.91 | | 000 | N |
| **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 | 3.36 | $198.24 | | 000 | N |
| **92019** | 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; limited | 1.74 | $102.66 | | 000 | N |
| **92020** | Gonioscopy (separate procedure) | 0.66 | $38.94 | | 000 | N |
| **92025** | Computerized corneal topography, unilateral or bilateral, with interpretation and report | 0.77 | $45.43 | $26.80 | 000 | N |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|
| **92060** | Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure) | 1.40 | $82.60 | | 000 | N |
| **92065** | Orthoptic and/or pleoptic training, with continuing medical direction and evaluation | 0.97 | $57.23 | | 000 | N |
| **92070** | Fitting of contact lens for treatment of disease, including supply of lens | 1.69 | $99.71 | | 000 | N |
| **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) | 1.29 | $76.11 | $29.68 | 000 | N |
| **92082** | Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33) | 1.68 | $99.12 | $37.67 | 000 | N |
| **92083** | Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30°, 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) | 1.93 | $113.87 | $42.13 | 000 | N |
| **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) | 2.18 | $128.62 | | 000 | N |
| **92120** | Tonography with interpretation and report, recording indentation tonometer method or perilimbal suction method | 1.80 | $106.20 | | 000 | N |
| **92130** | Tonography with water provocation | 2.01 | $118.59 | | 000 | N |
| **92135** | Scanning computerized ophthalmic diagnostic imaging (eg, scanning laser) with interpretation and report, unilateral | 1.12 | $66.08 | $29.08 | 000 | N |
| **92136** | Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation | 2.17 | $128.03 | $44.81 | 000 | N |
| **92140** | Provocative tests for glaucoma, with interpretation and report, without tonography | 1.43 | $84.37 | | 000 | N |
| **92225** | Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial | 0.58 | $34.22 | | 000 | N |
| **92226** | Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; subsequent | 0.53 | $31.27 | | 000 | N |
| **92230** | Fluorescein angioscopy with interpretation and report | 1.89 | $111.51 | | 000 | N |
| **92235** | Fluorescein angiography (includes multiframe imaging) with interpretation and report | 3.35 | $197.65 | $67.20 | 000 | N |
| **92240** | Indocyanine-green angiography (includes multiframe imaging) with interpretation and report | 6.78 | $400.02 | $88.00 | 000 | N |
| **92250** | Fundus photography with interpretation and report | 1.90 | $112.10 | $35.87 | 000 | N |
| **92260** | Ophthalmodynamometry | 0.44 | $25.96 | | 000 | N |
| **92265** | Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report | 2.16 | $127.44 | $61.17 | 000 | N |
| **92270** | Electro-oculography with interpretation and report | 2.28 | $134.52 | $65.91 | 000 | N |
| **92275** | Electroretinography with interpretation and report | 3.04 | $179.36 | $87.89 | 000 | N |
| **92283** | Color vision examination, extended, eg, anomaloscope or equivalent | 1.06 | $62.54 | | 000 | N |
| **92284** | Dark adaptation examination with interpretation and report | 1.96 | $115.64 | | 000 | N |
| **92285** | External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography) | 1.15 | $67.85 | $16.96 | 000 | N |

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|---|---|---|---|---|---|---|
| **92286** | Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count | 3.46 | $204.14 | $53.08 | 000 | N |
| **92287** | Special anterior segment photography with interpretation and report; with fluorescein angiography | 3.03 | $178.77 | $46.48 | 000 | N |
| **92310** | Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia | 2.19 | $129.21 | | 000 | N |
| **92311** | Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye | 2.14 | $126.26 | | 000 | N |
| **92312** | Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes | 2.35 | $138.65 | | 000 | N |
| **92313** | Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens | 2.02 | $119.18 | | 000 | N |
| **92314** | Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia | 1.62 | $95.58 | | 000 | N |
| **92315** | Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, one eye | 1.38 | $81.42 | | 000 | N |
| **92316** | Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, both eyes | 1.73 | $102.07 | | 000 | N |
| **92317** | Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneoscleral lens | 1.48 | $87.32 | | 000 | N |
| **92325** | Modification of contact lens (separate procedure), with medical supervision of adaptation | 0.52 | $30.68 | | 000 | N |
| **92326** | Replacement of contact lens | 1.47 | $86.73 | | 000 | N |
| **92340** | Fitting of spectacles, except for aphakia; monofocal | 0.98 | $57.82 | | 000 | N |
| **92341** | Fitting of spectacles, except for aphakia; bifocal | 1.10 | $64.90 | | 000 | N |
| **92342** | Fitting of spectacles, except for aphakia; multifocal, other than bifocal | 1.18 | $69.62 | | 000 | N |
| **92352** | Fitting of spectacle prosthesis for aphakia; monofocal | 0.99 | $58.41 | | 000 | N |
| **92353** | Fitting of spectacle prosthesis for aphakia; multifocal | 1.17 | $69.03 | | 000 | N |
| **92354** | Fitting of spectacle mounted low vision aid; single element system | 6.82 | $402.38 | | 000 | N |
| **92355** | Fitting of spectacle mounted low vision aid; telescopic or other compound lens system | 3.37 | $198.83 | | 000 | N |
| **92358** | Prosthesis service for aphakia, temporary (disposable or loan, including materials) | 0.84 | $49.56 | | 000 | N |
| **92370** | Repair and refitting spectacles; except for aphakia | 0.82 | $48.38 | | 000 | N |
| **92371** | Repair and refitting spectacles; spectacle prosthesis for aphakia | 0.55 | $32.45 | | 000 | N |
| **92499** | Unlisted ophthalmological service or procedure | 0.00 | BR | | 000 | N |
| **92502** | Otolaryngologic examination under general anesthesia | 2.44 | $143.96 | | 000 | N |
| **92504** | Binocular microscopy (separate diagnostic procedure) | 0.68 | $40.12 | | 000 | N |
| **92506** | Evaluation of speech, language, voice, communication, and/or auditory processing | 3.56 | $210.04 | | 000 | N |
| **92507** | Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual | 1.62 | $95.58 | | 000 | N |
| **92508** | Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals | 0.75 | $44.25 | | 000 | N |
| **92511** | Nasopharyngoscopy with endoscope (separate procedure) | 4.00 | $236.00 | | 000 | N |
| **92512** | Nasal function studies (eg, rhinomanometry) | 1.60 | $94.40 | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| | **92516** | Facial nerve function studies (eg, electroneuronography) | 1.59 | $93.81 | | 000 | N |
| | **92520** | Laryngeal function studies (ie, aerodynamic testing and acoustic testing) | 1.30 | $76.70 | | 000 | N |
| | **92526** | Treatment of swallowing dysfunction and/or oral function for feeding | 2.16 | $127.44 | | 000 | N |
| | **92531** | Spontaneous nystagmus, including gaze | 0.60 | $35.58 | | 000 | N |
| | **92532** | Positional nystagmus test | 0.54 | $32.04 | | 000 | N |
| | **92533** | Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests) | 0.86 | $50.98 | | 000 | N |
| | **92534** | Optokinetic nystagmus test | 0.46 | $27.26 | | 000 | N |
| | **92541** | Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording | 1.45 | $85.55 | $35.08 | 000 | N |
| | **92542** | Positional nystagmus test, minimum of 4 positions, with recording | 1.49 | $87.91 | $29.01 | 000 | N |
| | **92543** | Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording | 0.70 | $41.30 | $9.50 | 000 | N |
| | **92544** | Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording | 1.19 | $70.21 | $23.17 | 000 | N |
| | **92545** | Oscillating tracking test, with recording | 1.09 | $64.31 | $21.22 | 000 | N |
| | **92546** | Sinusoidal vertical axis rotational testing | 2.23 | $131.57 | $25.00 | 000 | N |
| + | **92547** | Use of vertical electrodes (List separately in addition to code for primary procedure) | 0.15 | $8.85 | $1.77 | 000 | N |
| | **92548** | Computerized dynamic posturography | 2.70 | $159.30 | | 000 | N |
| | **92551** | Screening test, pure tone, air only | 0.26 | $15.34 | | 000 | N |
| | **92552** | Pure tone audiometry (threshold); air only | 0.51 | $30.09 | | 000 | N |
| | **92553** | Pure tone audiometry (threshold); air and bone | 0.73 | $43.07 | | 000 | N |
| | **92555** | Speech audiometry threshold; | 0.42 | $24.78 | | 000 | N |
| | **92556** | Speech audiometry threshold; with speech recognition | 0.62 | $36.58 | | 000 | N |
| | **92557** | Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined) | 1.33 | $78.47 | | 000 | N |
| | **92559** | Audiometric testing of groups | 0.60 | $35.58 | | 000 | N |
| | **92560** | Bekesy audiometry; screening | 0.36 | $21.36 | | 000 | N |
| | **92561** | Bekesy audiometry; diagnostic | 0.77 | $45.43 | | 000 | N |
| | **92562** | Loudness balance test, alternate binaural or monaural | 0.52 | $30.68 | | 000 | N |
| | **92563** | Tone decay test | 0.45 | $26.55 | | 000 | N |
| | **92564** | Short increment sensitivity index (SISI) | 0.51 | $30.09 | | 000 | N |
| | **92565** | Stenger test, pure tone | 0.40 | $23.60 | | 000 | N |
| | **92567** | Tympanometry (impedance testing) | 0.57 | $33.63 | | 000 | N |
| | **92568** | Acoustic reflex testing; threshold | 0.36 | $21.24 | | 000 | N |
| | **92569** | Acoustic reflex testing; decay | 0.39 | $23.01 | | 000 | N |
| | **92571** | Filtered speech test | 0.43 | $25.37 | | 000 | N |
| | **92572** | Staggered spondaic word test | 0.23 | $13.57 | | 000 | N |
| | **92575** | Sensorineural acuity level test | 0.52 | $30.68 | | 000 | N |
| | **92576** | Synthetic sentence identification test | 0.52 | $30.68 | | 000 | N |
| | **92577** | Stenger test, speech | 0.67 | $39.53 | | 000 | N |
| | **92579** | Visual reinforcement audiometry (VRA) | 0.82 | $48.38 | | 000 | N |
| | **92582** | Conditioning play audiometry | 0.88 | $51.92 | | 000 | N |
| | **92583** | Select picture audiometry | 0.92 | $54.28 | | 000 | N |
| | **92584** | Electrocochleography | 2.35 | $138.65 | | 000 | N |
| | **92585** | Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive | 2.64 | $155.76 | $42.06 | 000 | N |
| | **92586** | Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited | 1.88 | $110.92 | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| | **92587** | Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products) | 1.43 | $84.37 | $10.12 | 000 | N |
| | **92588** | Evoked otoacoustic emissions; comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies) | 1.94 | $114.46 | $28.62 | 000 | N |
| | **92590** | Hearing aid examination and selection; monaural | 1.11 | $65.25 | | 000 | N |
| | **92591** | Hearing aid examination and selection; binaural | 1.41 | $83.01 | | 000 | N |
| | **92592** | Hearing aid check; monaural | 0.44 | $26.08 | | 000 | N |
| | **92593** | Hearing aid check; binaural | 0.72 | $42.72 | | 000 | N |
| | **92594** | Electroacoustic evaluation for hearing aid; monaural | 0.42 | $24.90 | | 000 | N |
| | **92595** | Electroacoustic evaluation for hearing aid; binaural | 0.91 | $53.40 | | 000 | N |
| | **92596** | Ear protector attenuation measurements | 0.74 | $43.66 | | 000 | N |
| | **92597** | Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech | 2.49 | $146.91 | | 000 | N |
| | **92601** | Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming | 3.91 | $230.69 | | 000 | N |
| | **92602** | Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming | 2.69 | $158.71 | | 000 | N |
| | **92603** | Diagnostic analysis of cochlear implant, age 7 years or older; with programming | 2.47 | $145.73 | | 000 | N |
| | **92604** | Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming | 1.61 | $94.99 | | 000 | N |
| | **92605** | Evaluation for prescription of non-speech-generating augmentative and alternative communication device | 0.00 | BR | | 000 | N |
| | **92606** | Therapeutic service(s) for the use of non-speech-generating device, including programming and modification | 0.00 | BR | | 000 | N |
| | **92607** | Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour | 3.43 | $202.37 | | 000 | N |
| + | **92608** | Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure) | 0.68 | $40.12 | | 000 | N |
| | **92609** | Therapeutic services for the use of speech-generating device, including programming and modification | 1.81 | $106.79 | | 000 | N |
| | **92610** | Evaluation of oral and pharyngeal swallowing function | 3.06 | $180.54 | | 000 | N |
| | **92611** | Motion fluoroscopic evaluation of swallowing function by cine or video recording | 3.12 | $184.08 | | 000 | N |
| | **92612** | Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording; | 3.92 | $231.28 | | 000 | N |
| | **92613** | Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording; physician interpretation and report only | 1.05 | $61.95 | | 000 | N |
| | **92614** | Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording; | 3.62 | $213.58 | | 000 | N |
| | **92615** | Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording; physician interpretation and report only | 0.93 | $54.87 | | 000 | N |
| | **92616** | Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; | 5.02 | $296.18 | | 000 | N |
| | **92617** | Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; physician interpretation and report only | 1.15 | $67.85 | | 000 | N |
| | **92620** | Evaluation of central auditory function, with report; initial 60 minutes | 1.38 | $81.42 | | 000 | N |
| | **92621** | Evaluation of central auditory function, with report; each additional 15 minutes | 0.35 | $20.65 | | 000 | N |
| | **92625** | Assessment of tinnitus (includes pitch, loudness matching, and masking) | 1.36 | $80.24 | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| | **92626** | Evaluation of auditory rehabilitation status; first hour | 2.17 | $128.03 | | 000 | N |
| + | **92627** | Evaluation of auditory rehabilitation status; each additional 15 minutes (List separately in addition to code for primary procedure) | 0.54 | $31.86 | | 000 | N |
| | **92630** | Auditory rehabilitation; prelingual hearing loss | 0.00 | BR | | 000 | N |
| | **92633** | Auditory rehabilitation; postlingual hearing loss | 0.00 | BR | | 000 | N |
| | **92640** | Diagnostic analysis with programming of auditory brainstem implant, per hour | 1.41 | $83.19 | | 000 | N |
| | **92700** | Unlisted otorhinolaryngological service or procedure | 0.00 | BR | | 000 | N |
| | **92950** | Cardiopulmonary resuscitation (eg, in cardiac arrest) | 7.65 | $451.35 | | 000 | N |
| ⊙ | **92953** | Temporary transcutaneous pacing | 0.30 | $17.70 | | 000 | N |
| ⊙ | **92960** | Cardioversion, elective, electrical conversion of arrhythmia; external | 7.92 | $467.28 | | 000 | N |
| ⊙ | **92961** | Cardioversion, elective, electrical conversion of arrhythmia; internal (separate procedure) | 6.61 | $389.99 | | 000 | N |
| | **92970** | Cardioassist-method of circulatory assist; internal | 4.52 | $266.68 | | 000 | N |
| | **92971** | Cardioassist-method of circulatory assist; external | 2.56 | $151.04 | | 000 | N |
| +⊙ | **92973** | Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure) | 4.60 | $271.40 | | 000 | N |
| +⊙ | **92974** | Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to code for primary procedure) | 4.22 | $248.98 | | 000 | N |
| ⊙ | **92975** | Thrombolysis, coronary; by intracoronary infusion, including selective coronary angiography | 10.10 | $595.90 | | 000 | N |
| | **92977** | Thrombolysis, coronary; by intravenous infusion | 6.92 | $408.28 | | 000 | N |
| +⊙ | **92978** | Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure) | 14.07 | $830.13 | $290.55 | 000 | N |
| +⊙ | **92979** | Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure) | 7.52 | $443.50 | $204.01 | 000 | N |
| ⊙ | **92980** | Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel | 21.01 | $1,239.59 | | 000 | N |
| +⊙ | **92981** | Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure) | 5.83 | $343.97 | | 000 | N |
| ⊙ | **92982** | Percutaneous transluminal coronary balloon angioplasty; single vessel | 15.59 | $919.81 | | 000 | N |
| +⊙ | **92984** | Percutaneous transluminal coronary balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure) | 4.16 | $245.44 | | 000 | N |
| ⊙ | **92986** | Percutaneous balloon valvuloplasty; aortic valve | 34.77 | $2,051.43 | | 090 | N |
| ⊙ | **92987** | Percutaneous balloon valvuloplasty; mitral valve | 35.95 | $2,121.05 | | 090 | N |
| | **92990** | Percutaneous balloon valvuloplasty; pulmonary valve | 27.67 | $1,632.53 | | 090 | N |
| | **92992** | Atrial septectomy or septostomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization) | 46.81 | $2,761.97 | | 090 | Y |
| | **92993** | Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization) | 37.02 | $2,184.42 | | 090 | Y |
| ⊙ | **92995** | Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel | 17.15 | $1,011.85 | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| +⊙ | **92996** | Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure) | 4.44 | $261.96 | | 000 | N |
| | **92997** | Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel | 16.10 | $949.90 | | 000 | N |
| + | **92998** | Percutaneous transluminal pulmonary artery balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure) | 8.02 | $473.18 | | 000 | N |
| | **93000** | Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report | 0.65 | $38.35 | | 000 | N |
| | **93005** | Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report | 0.43 | $25.37 | $0.00 | 000 | N |
| | **93010** | Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only | 0.22 | $12.98 | | 000 | N |
| | **93012** | Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), 24-hour attended monitoring, per 30 day period of time; tracing only | 5.73 | $338.07 | $0.00 | 000 | N |
| | **93014** | Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), 24-hour attended monitoring, per 30 day period of time; physician review with interpretation and report only | 0.69 | $40.71 | | 000 | N |
| | **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 | 2.76 | $162.84 | | 000 | N |
| | **93016** | Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report | 0.61 | $35.99 | | 000 | N |
| | **93017** | Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report | 1.75 | $103.25 | $0.00 | 000 | N |
| | **93018** | Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only | 0.40 | $23.60 | | 000 | N |
| | **93024** | Ergonovine provocation test | 2.96 | $174.64 | $101.29 | 000 | N |
| | **93025** | Microvolt T-wave alternans for assessment of ventricular arrhythmias | 7.48 | $441.32 | $57.37 | 000 | N |
| | **93040** | Rhythm ECG, one to three leads; with interpretation and report | 0.36 | $21.24 | | 000 | N |
| | **93041** | Rhythm ECG, one to three leads; tracing only without interpretation and report | 0.16 | $9.44 | $0.00 | 000 | N |
| | **93042** | Rhythm ECG, one to three leads; interpretation and report only | 0.20 | $11.80 | | 000 | N |
| | **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 | 4.00 | $236.00 | | 000 | N |
| | **93225** | Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; recording (includes hook-up, recording, and disconnection) | 1.28 | $75.52 | $0.00 | 000 | N |
| | **93226** | Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; scanning analysis with report | 2.02 | $119.18 | $0.00 | 000 | N |
| | **93227** | Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; physician review and interpretation | 0.70 | $41.30 | | 000 | N |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|
| **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 | 4.22 | $248.98 | | 000 | N |
| **93231** | 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; recording (includes hook-up, recording, and disconnection) | 1.48 | $87.32 | $0.00 | 000 | N |
| **93232** | 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; microprocessor-based analysis with report | 2.05 | $120.95 | $0.00 | 000 | N |
| **93233** | 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; physician review and interpretation | 0.69 | $40.71 | | 000 | N |
| **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 | 3.62 | $213.46 | | 000 | N |
| **93236** | 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; monitoring and real-time data analysis with report | 2.87 | $169.57 | $0.00 | 000 | N |
| **93237** | 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; physician review and interpretation | 0.60 | $35.40 | | 000 | N |
| **93268** | Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; includes transmission, physician review and interpretation | 7.77 | $458.43 | | 000 | N |
| **93270** | Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; recording (includes hook-up, recording, and disconnection) | 1.08 | $63.72 | $0.00 | 000 | N |
| **93271** | Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; monitoring, receipt of transmissions, and analysis | 6.00 | $354.00 | $0.00 | 000 | N |
| **93272** | Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; physician review and interpretation only | 0.69 | $40.71 | | 000 | N |
| **93278** | Signal-averaged electrocardiography (SAECG), with or without ECG | 1.43 | $84.37 | $18.56 | 000 | N |
| **93303** | Transthoracic echocardiography for congenital cardiac anomalies; complete | 5.85 | $345.15 | $107.00 | 000 | N |
| **93304** | Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study | 3.28 | $193.52 | $65.80 | 000 | N |
| **93307** | Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete | 5.19 | $306.21 | $73.49 | 000 | N |
| **93308** | Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; follow-up or limited study | 2.89 | $170.51 | $46.04 | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| ⊙ | **93312** | Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report | 7.66 | $451.94 | $194.33 | 000 | N |
| ⊙ | **93313** | Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only | 1.10 | $64.90 | | 000 | N |
| ⊙ | **93314** | Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only | 6.44 | $379.96 | $113.99 | 000 | N |
| ⊙ | **93315** | Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report | 8.44 | $498.08 | $249.04 | 000 | N |
| ⊙ | **93316** | Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only | 1.15 | $67.85 | | 000 | N |
| ⊙ | **93317** | Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only | 5.83 | $343.91 | $171.96 | 000 | N |
| ⊙ | **93318** | Echocardiography, transesophageal (TEE) for monitoring 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 | 6.43 | $379.49 | $189.75 | 000 | N |
| + | **93320** | Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete | 2.29 | $135.11 | $31.08 | 000 | N |
| + | **93321** | Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging) | 1.26 | $74.34 | $11.89 | 000 | N |
| + | **93325** | Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography) | 2.64 | $155.76 | $4.67 | 000 | N |
| | **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 | 4.54 | $267.86 | $139.29 | 000 | N |
| ⊘⊙ | **93501** | Right heart catheterization | 11.88 | $700.86 | $140.17 | 000 | N |
| ⊘ | **93503** | Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes | 2.21 | $130.45 | | 000 | N |
| ⊘⊙ | **93505** | Endomyocardial biopsy | 4.52 | $266.86 | $200.15 | 000 | N |
| ⊘⊙ | **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 | 10.25 | $604.81 | $199.59 | 000 | N |
| ⊘⊙ | **93510** | Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous | 24.12 | $1,423.08 | $213.46 | 000 | N |
| ⊘⊙ | **93511** | Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; by cutdown | 24.12 | $1,423.08 | $241.92 | 000 | N |
| ⊘⊙ | **93514** | Left heart catheterization by left ventricular puncture | 25.91 | $1,528.63 | $336.30 | 000 | N |
| ⊘⊙ | **93524** | Combined transseptal and retrograde left heart catheterization | 31.16 | $1,838.15 | $312.49 | 000 | N |
| ⊘⊙ | **93526** | Combined right heart catheterization and retrograde left heart catheterization | 30.15 | $1,778.85 | $266.83 | 000 | N |
| ⊘⊙ | **93527** | Combined right heart catheterization and transseptal left heart catheterization through intact septum (with or without retrograde left heart catheterization) | 31.96 | $1,885.58 | $339.40 | 000 | N |
| ⊘⊙ | **93528** | Combined right heart catheterization with left ventricular puncture (with or without retrograde left heart catheterization) | 32.16 | $1,897.44 | $398.46 | 000 | N |

| Code | | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| ⊘⊙ | **93529** | Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization) | 29.15 | $1,719.56 | $223.54 | 000 | N |
| ⊘⊙ | **93530** | Right heart catheterization, for congenital cardiac anomalies | 12.99 | $766.12 | $199.19 | 000 | N |
| ⊘ | **93531** | Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies | 33.97 | $2,004.17 | $400.83 | 000 | N |
| ⊘ | **93532** | Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies | 36.18 | $2,134.62 | $490.96 | 000 | N |
| ⊘ | **93533** | Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies | 34.17 | $2,016.03 | $322.56 | 000 | N |
| ⊘⊙ | **93539** | Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (eg, internal mammary), whether native or used for bypass | 0.68 | $40.30 | | 000 | N |
| ⊘⊙ | **93540** | Injection procedure during cardiac catheterization; for selective opacification of aortocoronary venous bypass grafts, one or more coronary arteries | 0.70 | $41.54 | | 000 | N |
| ⊘⊙ | **93541** | Injection procedure during cardiac catheterization; for pulmonary angiography | 0.66 | $39.12 | | 000 | N |
| ⊘⊙ | **93542** | Injection procedure during cardiac catheterization; for selective right ventricular or right atrial angiography | 0.66 | $39.12 | | 000 | N |
| ⊘⊙ | **93543** | Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography | 0.66 | $39.12 | | 000 | N |
| ⊘⊙ | **93544** | Injection procedure during cardiac catheterization; for aortography | 0.64 | $37.94 | | 000 | N |
| ⊘⊙ | **93545** | Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand) | 0.68 | $40.30 | | 000 | N |
| ⊘⊙ | **93555** | Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography | 4.22 | $249.04 | $37.36 | 000 | N |
| ⊘⊙ | **93556** | Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass) | 7.04 | $415.07 | $41.51 | 000 | N |
| ⊙ | **93561** | Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure) | 1.01 | $59.30 | $32.02 | 000 | N |
| ⊙ | **93562** | Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output | 0.48 | $28.44 | $10.81 | 000 | N |
| +⊙ | **93571** | Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure) | 3.90 | $230.04 | $80.51 | 000 | N |
| +⊙ | **93572** | Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure) | 2.39 | $141.13 | $66.33 | 000 | N |
| | **93580** | Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant | 25.38 | $1,497.42 | | 000 | N |
| | **93581** | Percutaneous transcatheter closure of a congenital ventricular septal defect with implant | 34.05 | $2,008.95 | | 000 | N |
| ⊘ | **93600** | Bundle of His recording | 7.56 | $445.92 | $267.55 | 000 | N |
| ⊘ | **93602** | Intra-atrial recording | 5.03 | $296.48 | $213.47 | 000 | N |
| ⊘ | **93603** | Right ventricular recording | 4.88 | $288.16 | $181.54 | 000 | N |

| Code | | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| +⊙ | 93609 | Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure) | 16.99 | $1,002.12 | $721.53 | 000 | N |
| ⊘ | 93610 | Intra-atrial pacing | 8.04 | $474.36 | $355.77 | 000 | N |
| ⊘ | 93612 | Intraventricular pacing | 6.37 | $375.95 | $270.68 | 000 | N |
| +⊙ | 93613 | Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure) | 9.81 | $578.79 | $416.73 | 000 | N |
| ⊘⊙ | 93615 | Esophageal recording of atrial electrogram with or without ventricular electrogram(s); | 1.87 | $110.27 | $87.11 | 000 | N |
| ⊘⊙ | 93616 | Esophageal recording of atrial electrogram with or without ventricular electrogram(s); with pacing | 3.22 | $189.74 | $142.31 | 000 | N |
| ⊘⊙ | 93618 | Induction of arrhythmia by electrical pacing | 18.09 | $1,067.31 | $640.39 | 000 | N |
| ⊘⊙ | 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 | 29.47 | $1,738.55 | $990.97 | 000 | N |
| ⊘⊙ | 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 | 34.83 | $2,055.15 | $1,541.36 | 000 | N |
| +⊙ | 93621 | Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure) | 8.56 | $505.22 | $378.92 | 000 | N |
| +⊙ | 93622 | Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left ventricular pacing and recording (List separately in addition to code for primary procedure) | 7.36 | $434.06 | $325.55 | 000 | N |
| + | 93623 | Programmed stimulation and pacing after intravenous drug infusion (List separately in addition to code for primary procedure) | 7.24 | $426.92 | $320.19 | 000 | N |
| ⊘⊙ | 93624 | Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia | 16.08 | $948.72 | $740.00 | 000 | N |
| ⊘ | 93631 | Intra-operative epicardial and endocardial pacing and mapping to localize the site of tachycardia or zone of slow conduction for surgical correction | 25.45 | $1,501.37 | $1,126.03 | 000 | N |
| ⊘⊙ | 93640 | Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement; | 21.41 | $1,263.01 | $505.20 | 000 | N |
| ⊘⊙ | 93641 | Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement; with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator | 24.62 | $1,452.76 | $769.96 | 000 | N |
| ⊘⊙ | 93642 | Electrophysiologic evaluation of single or dual chamber pacing 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) | 13.86 | $817.74 | $400.69 | 000 | N |
| ⊘⊙ | 93650 | Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement | 15.00 | $885.00 | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| ⊘⊙ | **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 | 22.69 | $1,338.71 | | 000 | N |
| ⊘⊙ | **93652** | Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia | 24.68 | $1,456.12 | | 000 | N |
| ⊘ | **93660** | Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention | 4.36 | $257.24 | $156.92 | 000 | N |
| + | **93662** | Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure) | 10.71 | $632.07 | $474.05 | 000 | N |
| | **93668** | Peripheral arterial disease (PAD) rehabilitation, per session | 0.41 | $24.19 | $0.00 | 000 | N |
| | **93701** | Bioimpedance, thoracic, electrical | 1.08 | $63.72 | | 000 | N |
| | **93720** | Plethysmography, total body; with interpretation and report | 1.09 | $64.31 | $25.72 | 000 | N |
| | **93721** | Plethysmography, total body; tracing only, without interpretation and report | 0.88 | $51.92 | $0.00 | 000 | N |
| | **93722** | Plethysmography, total body; interpretation and report only | 0.21 | $12.39 | | 000 | N |
| | **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) | 10.07 | $594.13 | $368.36 | 000 | N |
| | **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) | 0.80 | $47.20 | $33.04 | 000 | N |
| | **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 | 1.15 | $67.85 | $36.64 | 000 | N |
| | **93732** | 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); with reprogramming | 1.84 | $108.56 | $75.99 | 000 | N |
| | **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 | 1.05 | $61.95 | $14.87 | 000 | N |
| | **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 | 0.92 | $54.28 | $32.03 | 000 | N |
| | **93735** | 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); with reprogramming | 1.51 | $89.09 | $60.58 | 000 | N |
| | **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 | 0.94 | $55.46 | $13.31 | 000 | N |
| | **93740** | Temperature gradient studies | 0.31 | $18.29 | $10.43 | 000 | N |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|
| **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 | 1.78 | $105.02 | $65.11 | 000 | N |
| **93742** | 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, with reprogramming | 1.96 | $115.64 | $75.17 | 000 | N |
| **93743** | 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); dual chamber, without reprogramming | 2.15 | $126.85 | $82.45 | 000 | N |
| **93744** | 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); dual chamber, with reprogramming | 2.33 | $137.47 | $96.23 | 000 | N |
| **93745** | Initial set-up and programming by a physician of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problems or events | 0.00 | BR | $0.00 | 000 | N |
| **93760** | Thermogram; cephalic | 2.01 | $118.59 | $23.72 | 000 | N |
| **93762** | Thermogram; peripheral | 2.21 | $130.45 | $26.09 | 000 | N |
| **93770** | Determination of venous pressure | 0.23 | $13.57 | $11.53 | 000 | N |
| **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 | 1.91 | $112.69 | | 000 | N |
| **93786** | Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only | 0.91 | $53.69 | $0.00 | 000 | N |
| **93788** | Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report | 0.52 | $30.68 | $0.00 | 000 | N |
| **93790** | Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report | 0.48 | $28.32 | | 000 | N |
| **93797** | Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session) | 0.48 | $28.32 | | 000 | N |
| **93798** | Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session) | 0.72 | $42.48 | | 000 | N |
| **93799** | Unlisted cardiovascular service or procedure | 0.00 | BR | | 000 | N |
| **93875** | Noninvasive physiologic studies of extracranial arteries, complete bilateral study (eg, periorbital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis) | 2.70 | $159.30 | $19.12 | 000 | N |
| **93880** | Duplex scan of extracranial arteries; complete bilateral study | 6.60 | $389.40 | $50.62 | 000 | N |
| **93882** | Duplex scan of extracranial arteries; unilateral or limited study | 4.25 | $250.75 | $35.11 | 000 | N |
| **93886** | Transcranial Doppler study of the intracranial arteries; complete study | 8.07 | $476.13 | $80.94 | 000 | N |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|
| **93888** | Transcranial Doppler study of the intracranial arteries; limited study | 5.24 | $309.16 | $52.56 | 000 | N |
| **93890** | Transcranial Doppler study of the intracranial arteries; vasoreactivity study | 6.55 | $386.45 | $88.88 | 000 | N |
| **93892** | Transcranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection | 7.00 | $413.00 | $103.25 | 000 | N |
| **93893** | Transcranial Doppler study of the intracranial arteries; emboli detection with intravenous microbubble injection | 6.82 | $402.38 | $100.60 | 000 | N |
| **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) | 3.15 | $185.85 | $20.44 | 000 | N |
| **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 postural provocative tests, measurements with reactive hyperemia) | 4.84 | $285.56 | $37.12 | 000 | N |
| **93924** | Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, complete bilateral study | 5.80 | $342.20 | $44.49 | 000 | N |
| **93925** | Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study | 7.96 | $469.64 | $51.66 | 000 | N |
| **93926** | Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study | 4.93 | $290.87 | $34.90 | 000 | N |
| **93930** | Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study | 6.36 | $375.24 | $41.28 | 000 | N |
| **93931** | Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study | 4.19 | $247.21 | $27.19 | 000 | N |
| **93965** | Noninvasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography) | 3.28 | $193.52 | $29.03 | 000 | N |
| **93970** | Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study | 6.51 | $384.09 | $57.61 | 000 | N |
| **93971** | Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study | 4.37 | $257.83 | $36.10 | 000 | N |
| **93975** | Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study | 9.96 | $587.64 | $146.91 | 000 | N |
| **93976** | Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study | 5.77 | $340.43 | $95.32 | 000 | N |
| **93978** | Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study | 5.86 | $345.74 | $58.78 | 000 | N |
| **93979** | Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study | 4.13 | $243.67 | $38.99 | 000 | N |
| **93980** | Duplex scan of arterial inflow and venous outflow of penile vessels; complete study | 4.56 | $269.04 | $102.24 | 000 | N |
| **93981** | Duplex scan of arterial inflow and venous outflow of penile vessels; follow-up or limited study | 3.58 | $211.22 | $33.80 | 000 | N |
| **93990** | Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow) | 4.76 | $280.84 | $22.47 | 000 | N |
| **94002** | Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day | 2.22 | $130.98 | | 000 | N |
| **94003** | Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day | 1.62 | $95.58 | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| | **94004** | Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day | 1.18 | $69.62 | | 000 | N |
| | **94005** | Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more | 2.10 | $123.90 | | 000 | N |
| | **94010** | Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation | 0.87 | $51.33 | $13.35 | 000 | N |
| | **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 | 1.27 | $74.93 | $29.97 | 000 | N |
| | **94015** | Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration) | 0.62 | $36.58 | $0.00 | 000 | N |
| | **94016** | Patient-initiated spirometric recording per 30-day period of time; physician review and interpretation only | 0.65 | $38.35 | | 000 | N |
| | **94060** | Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration | 1.48 | $87.32 | $24.45 | 000 | N |
| | **94070** | Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010, with administered agents (eg, antigen(s), cold air, methacholine) | 1.53 | $90.27 | $46.94 | 000 | N |
| | **94150** | Vital capacity, total (separate procedure) | 0.56 | $33.04 | $6.61 | 000 | N |
| | **94200** | Maximum breathing capacity, maximal voluntary ventilation | 0.58 | $34.22 | $8.90 | 000 | N |
| | **94240** | Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method | 0.99 | $58.41 | $21.03 | 000 | N |
| | **94250** | Expired gas collection, quantitative, single procedure (separate procedure) | 0.73 | $43.07 | $8.18 | 000 | N |
| | **94260** | Thoracic gas volume | 0.80 | $47.20 | $11.33 | 000 | N |
| | **94350** | Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time | 1.01 | $59.59 | $19.66 | 000 | N |
| | **94360** | Determination of resistance to airflow, oscillatory or plethysmographic methods | 1.07 | $63.13 | $21.46 | 000 | N |
| | **94370** | Determination of airway closing volume, single breath tests | 0.95 | $56.05 | $19.62 | 000 | N |
| | **94375** | Respiratory flow volume loop | 0.94 | $55.46 | $24.40 | 000 | N |
| | **94400** | Breathing response to CO2 (CO2 response curve) | 1.34 | $79.06 | $32.41 | 000 | N |
| | **94450** | Breathing response to hypoxia (hypoxia response curve) | 1.29 | $76.11 | $31.97 | 000 | N |
| | **94452** | High altitude simulation test (HAST), with physician interpretation and report; | 1.37 | $80.83 | $25.06 | 000 | N |
| | **94453** | High altitude simulation test (HAST), with physician interpretation and report; with supplemental oxygen titration | 1.93 | $113.87 | $31.88 | 000 | N |
| ⊘ | **94610** | Intrapulmonary surfactant administration by a physician through endotracheal tube | 1.65 | $97.35 | | 000 | N |
| | **94620** | Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry) | 2.77 | $163.43 | $44.13 | 000 | N |
| | **94621** | Pulmonary stress testing; complex (including measurements of CO<sub>2</sub> production, O<sub>2</sub> uptake, and electrocardiographic recordings) | 3.89 | $229.51 | $117.05 | 000 | N |
| | **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) | 0.34 | $20.06 | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| | **94642** | Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis | 1.41 | $83.01 | | 000 | N |
| | **94644** | Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour | 0.94 | $55.46 | | 000 | N |
| + | **94645** | Continuous inhalation treatment with aerosol medication for acute airway obstruction; each additional hour (List separately in addition to code for primary procedure) | 0.36 | $21.24 | | 000 | N |
| | **94660** | Continuous positive airway pressure ventilation (CPAP), initiation and management | 1.41 | $83.19 | | 000 | N |
| | **94662** | Continuous negative pressure ventilation (CNP), initiation and management | 0.93 | $54.87 | | 000 | N |
| | **94664** | Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device | 0.37 | $21.83 | | 000 | N |
| | **94667** | Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation | 0.58 | $34.22 | | 000 | N |
| | **94668** | Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent | 0.48 | $28.32 | | 000 | N |
| | **94680** | Oxygen uptake, expired gas analysis; rest and exercise, direct, simple | 1.97 | $116.23 | $18.60 | 000 | N |
| | **94681** | Oxygen uptake, expired gas analysis; including CO2 output, percentage oxygen extracted | 2.47 | $145.73 | $13.12 | 000 | N |
| | **94690** | Oxygen uptake, expired gas analysis; rest, indirect (separate procedure) | 1.86 | $109.74 | $5.49 | 000 | N |
| | **94720** | Carbon monoxide diffusing capacity (eg, single breath, steady state) | 1.34 | $79.06 | $20.56 | 000 | N |
| | **94725** | Membrane diffusion capacity | 2.79 | $164.61 | $18.11 | 000 | N |
| | **94750** | Pulmonary compliance study (eg, plethysmography, volume and pressure measurements) | 1.69 | $99.71 | $18.94 | 000 | N |
| | **94760** | Noninvasive ear or pulse oximetry for oxygen saturation; single determination | 0.07 | $4.13 | $0.00 | 000 | N |
| | **94761** | Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise) | 0.14 | $8.26 | $0.00 | 000 | N |
| | **94762** | Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure) | 0.66 | $38.94 | $0.00 | 000 | N |
| | **94770** | Carbon dioxide, expired gas determination by infrared analyzer | 0.97 | $57.23 | $11.45 | 000 | N |
| | **94772** | Circadian respiratory pattern recording (pediatric pneumogram), 12-24 hour continuous recording, infant | 0.00 | BR | $0.00 | 000 | N |
| | **94774** | Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; includes monitor attachment, download of data, physician review, interpretation, and preparation of a report | 0.00 | BR | | 000 | N |
| | **94775** | Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; monitor attachment only (includes hook-up, initiation of recording and disconnection) | 0.00 | BR | | 000 | N |
| | **94776** | Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; monitoring, download of information, receipt of transmission(s) and analyses by computer only | 0.00 | BR | | 000 | N |
| | **94777** | Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; physician review, interpretation and preparation of report only | 0.00 | BR | | 000 | N |
| | **94799** | Unlisted pulmonary service or procedure | 0.00 | BR | | 000 | N |
| | **95004** | Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, specify number of tests | 0.13 | $7.67 | | 000 | N |
| | **95010** | Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, specify number of tests | 0.45 | $26.55 | | 000 | N |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|
| **95012** | Nitric oxide expired gas determination | 0.49 | $28.91 | | 000 | N |
| **95015** | Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, specify number of tests | 0.30 | $17.70 | | 000 | N |
| **95024** | Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, specify number of tests | 0.18 | $10.62 | | 000 | N |
| **95027** | Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, specify number of tests | 0.18 | $10.62 | | 000 | N |
| **95028** | Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests | 0.26 | $15.34 | | 000 | N |
| **95044** | Patch or application test(s) (specify number of tests) | 0.20 | $11.80 | | 000 | N |
| **95052** | Photo patch test(s) (specify number of tests) | 0.24 | $14.16 | | 000 | N |
| **95056** | Photo tests | 0.44 | $25.96 | | 000 | N |
| **95060** | Ophthalmic mucous membrane tests | 0.47 | $27.73 | | 000 | N |
| **95065** | Direct nasal mucous membrane test | 0.33 | $19.47 | | 000 | N |
| **95070** | Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with histamine, methacholine, or similar compounds | 1.93 | $113.87 | | 000 | N |
| **95071** | Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with antigens or gases, specify | 2.43 | $143.37 | | 000 | N |
| **95075** | Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite) | 1.66 | $97.94 | | 000 | N |
| **95115** | Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection | 0.37 | $21.83 | | 000 | N |
| **95117** | Professional services for allergen immunotherapy not including provision of allergenic extracts; two or more injections | 0.46 | $27.14 | | 000 | N |
| **95120** | Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract; single injection | 0.22 | $13.04 | | 000 | N |
| **95125** | Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract; two or more injections | 0.27 | $15.99 | | 000 | N |
| **95130** | Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract; single stinging insect venom | 0.38 | $22.54 | | 000 | N |
| **95131** | Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract; two stinging insect venoms | 0.48 | $28.44 | | 000 | N |
| **95132** | Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract; three stinging insect venoms | 0.58 | $34.40 | | 000 | N |
| **95133** | Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract; four stinging insect venoms | 0.70 | $41.54 | | 000 | N |
| **95134** | Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract; five stinging insect venoms | 0.84 | $49.80 | | 000 | N |
| **95144** | Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials) | 0.27 | $15.93 | | 000 | N |
| **95145** | Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom | 0.39 | $23.01 | | 000 | N |
| **95146** | Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); two single stinging insect venoms | 0.55 | $32.45 | | 000 | N |

| Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|
| **95147** | Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); three single stinging insect venoms | 0.54 | $31.86 | | 000 | N |
| **95148** | Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); four single stinging insect venoms | 0.73 | $43.07 | | 000 | N |
| **95149** | Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); five single stinging insect venoms | 0.97 | $57.23 | | 000 | N |
| **95165** | Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses) | 0.27 | $15.93 | | 000 | N |
| **95170** | Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses) | 0.21 | $12.39 | | 000 | N |
| **95180** | Rapid desensitization procedure, each hour (eg, insulin, penicillin, equine serum) | 3.77 | $222.43 | | 000 | N |
| **95199** | Unlisted allergy/clinical immunologic service or procedure | 0.00 | BR | | 000 | N |
| **95250** | Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording | 3.96 | $233.64 | $0.00 | 000 | N |
| **95251** | Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; physician interpretation and report | 0.99 | $58.41 | | 000 | N |
| **95805** | Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness | 16.82 | $992.38 | $129.01 | 000 | N |
| **95806** | Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist | 5.34 | $315.06 | $132.33 | 000 | N |
| **95807** | Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist | 13.81 | $814.79 | $130.37 | 000 | N |
| **95808** | Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist | 16.72 | $986.48 | $226.89 | 000 | N |
| **95810** | Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist | 21.30 | $1,256.70 | $276.47 | 000 | N |
| **95811** | Polysomnography; 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 | 23.34 | $1,377.06 | $302.95 | 000 | N |
| **95812** | Electroencephalogram (EEG) extended monitoring; 41-60 minutes | 5.63 | $332.17 | $99.65 | 000 | N |
| **95813** | Electroencephalogram (EEG) extended monitoring; greater than one hour | 7.16 | $422.44 | $152.08 | 000 | N |
| **95816** | Electroencephalogram (EEG); including recording awake and drowsy | 5.23 | $308.57 | $98.74 | 000 | N |
| **95819** | Electroencephalogram (EEG); including recording awake and asleep | 4.89 | $288.51 | $109.63 | 000 | N |
| **95822** | Electroencephalogram (EEG); recording in coma or sleep only | 5.98 | $352.82 | $95.26 | 000 | N |
| **95824** | Electroencephalogram (EEG); cerebral death evaluation only | 2.71 | $160.13 | $62.45 | 000 | N |
| **95827** | Electroencephalogram (EEG); all night recording | 6.05 | $356.95 | $139.21 | 000 | N |
| **95829** | Electrocorticogram at surgery (separate procedure) | 35.64 | $2,102.76 | $504.66 | 000 | N |
| **95830** | Insertion by physician of sphenoidal electrodes for electroencephalographic (EEG) recording | 4.85 | $286.15 | | 000 | N |
| **95831** | Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk | 0.70 | $41.30 | | 000 | N |
| **95832** | Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side | 0.62 | $36.58 | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| | **95833** | Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands | 0.99 | $58.41 | | 000 | N |
| | **95834** | Muscle testing, manual (separate procedure) with report; total evaluation of body, including hands | 1.18 | $69.62 | | 000 | N |
| | **95851** | Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine) | 0.49 | $28.91 | | 000 | N |
| | **95852** | Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side | 0.36 | $21.24 | | 000 | N |
| | **95857** | Tensilon test for myasthenia gravis | 1.10 | $64.90 | | 000 | N |
| | **95860** | Needle electromyography; one extremity with or without related paraspinal areas | 2.29 | $135.11 | $78.36 | 000 | N |
| | **95861** | Needle electromyography; two extremities with or without related paraspinal areas | 3.00 | $177.00 | $130.98 | 000 | N |
| | **95863** | Needle electromyography; three extremities with or without related paraspinal areas | 3.62 | $213.58 | $155.91 | 000 | N |
| | **95864** | Needle electromyography; four extremities with or without related paraspinal areas | 4.53 | $267.27 | $163.03 | 000 | N |
| | **95865** | Needle electromyography; larynx | 2.95 | $174.05 | $134.02 | 000 | N |
| | **95866** | Needle electromyography; hemidiaphragm | 2.12 | $125.08 | $111.32 | 000 | N |
| | **95867** | Needle electromyography; cranial nerve supplied muscle(s), unilateral | 1.76 | $103.84 | $67.50 | 000 | N |
| | **95868** | Needle electromyography; cranial nerve supplied muscles, bilateral | 2.42 | $142.78 | $99.95 | 000 | N |
| | **95869** | Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12) | 0.90 | $53.10 | $37.70 | 000 | N |
| | **95870** | Needle electromyography; 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 | 0.90 | $53.10 | $37.70 | 000 | N |
| | **95872** | Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied | 4.07 | $240.13 | $184.90 | 000 | N |
| + | **95873** | Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure) | 0.88 | $51.92 | $36.86 | 000 | N |
| + | **95874** | Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure) | 0.89 | $52.51 | $37.81 | 000 | N |
| | **95875** | Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s) | 2.51 | $148.09 | $90.33 | 000 | N |
| ⊘ | **95900** | Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study | 1.60 | $94.40 | $33.98 | 000 | N |
| ⊘ | **95903** | Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study | 1.74 | $102.66 | $49.28 | 000 | N |
| ⊘ | **95904** | Nerve conduction, amplitude and latency/velocity study, each nerve; sensory | 1.38 | $81.42 | $28.50 | 000 | N |
| + | **95920** | Intraoperative neurophysiology testing, per hour (List separately in addition to code for primary procedure) | 4.26 | $251.34 | $175.94 | 000 | N |
| | **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 | 1.69 | $99.71 | | 000 | N |
| | **95922** | Testing of autonomic nervous system function; 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 | 1.93 | $113.87 | | 000 | N |

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|---|---|---|---|---|---|---|---|
| | **95923** | Testing of autonomic nervous system function; 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 | 2.87 | $169.33 | | 000 | N |
| | **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 | 2.22 | $130.98 | $58.94 | 000 | N |
| | **95926** | Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs | 2.17 | $128.03 | $57.61 | 000 | N |
| | **95927** | Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head | 2.22 | $130.98 | $60.25 | 000 | N |
| | **95928** | Central motor evoked potential study (transcranial motor stimulation); upper limbs | 4.69 | $276.71 | $132.82 | 000 | N |
| | **95929** | Central motor evoked potential study (transcranial motor stimulation); lower limbs | 4.92 | $290.28 | $133.53 | 000 | N |
| | **95930** | Visual evoked potential (VEP) testing central nervous system, checkerboard or flash | 2.68 | $158.12 | $31.62 | 000 | N |
| | **95933** | Orbicularis oculi (blink) reflex, by electrodiagnostic testing | 1.67 | $98.53 | $50.25 | 000 | N |
| | **95934** | H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle | 1.05 | $61.95 | $47.70 | 000 | N |
| | **95936** | H-reflex, amplitude and latency study; record muscle other than gastrocnemius/soleus muscle | 1.03 | $60.77 | $47.40 | 000 | N |
| | **95937** | Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method | 1.36 | $80.24 | $59.38 | 000 | N |
| | **95950** | Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours | 6.05 | $356.95 | $132.07 | 000 | N |
| | **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 | 17.59 | $1,037.69 | $415.08 | 000 | N |
| | **95953** | Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours | 11.09 | $654.31 | $261.72 | 000 | N |
| | **95954** | Pharmacological or physical activation requiring physician attendance during EEG recording of activation phase (eg, thiopental activation test) | 6.77 | $399.43 | $211.70 | 000 | N |
| | **95955** | Electroencephalogram (EEG) during nonintracranial surgery (eg, carotid surgery) | 3.56 | $210.04 | $84.02 | 000 | N |
| | **95956** | Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours | 18.83 | $1,110.97 | $266.63 | 000 | N |
| | **95957** | Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis) | 5.38 | $317.42 | $196.80 | 000 | N |
| | **95958** | Wada activation test for hemispheric function, including electroencephalographic (EEG) monitoring | 8.40 | $495.60 | $381.61 | 000 | N |
| | **95961** | Functional cortical and subcortical mapping by stimulation 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 | 5.97 | $352.23 | $274.74 | 000 | N |
| + | **95962** | Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of physician attendance (List separately in addition to code for primary procedure) | 5.87 | $346.33 | $270.14 | 000 | N |
| | **95965** | Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization) | 0.00 | BR | $0.00 | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| | **95966** | Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization) | 0.00 | BR | $0.00 | 000 | N |
| + | **95967** | Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure) | 0.00 | BR | $0.00 | 000 | N |
| | **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 | 1.29 | $76.11 | | 000 | N |
| | **95971** | 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 spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming | 1.43 | $84.37 | | 000 | N |
| | **95972** | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour | 2.70 | $159.30 | | 000 | N |
| + | **95973** | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure) | 1.51 | $89.09 | | 000 | N |
| | **95974** | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour | 4.51 | $266.09 | | 000 | N |
| + | **95975** | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure) | 2.51 | $148.09 | | 000 | N |
| | **95978** | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour | 5.24 | $309.16 | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| + | **95979** | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; each additional 30 minutes after first hour (List separately in addition to code for primary procedure) | 2.40 | $141.60 | | 000 | N |
| | **95990** | Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); | 1.59 | $93.81 | | 000 | N |
| | **95991** | Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician | 2.28 | $134.52 | | 000 | N |
| | **95999** | Unlisted neurological or neuromuscular diagnostic procedure | 0.00 | BR | | 000 | N |
| | **96000** | Comprehensive computer-based motion analysis by video-taping and 3-D kinematics; | 2.27 | $133.93 | $0.00 | 000 | N |
| | **96001** | Comprehensive computer-based motion analysis by video-taping and 3-D kinematics; with dynamic plantar pressure measurements during walking | 2.66 | $156.94 | $0.00 | 000 | N |
| | **96002** | Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles | 0.53 | $31.27 | $0.00 | 000 | N |
| | **96003** | Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle | 0.48 | $28.32 | $0.00 | 000 | N |
| | **96004** | Physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report | 2.87 | $169.33 | | 000 | N |
| | **96020** | Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or psychologist, with review of test results and report | 0.00 | BR | $0.00 | 000 | N |
| | **96040** | Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family | 0.98 | $57.82 | | 000 | N |
| | **96101** | Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report | 2.30 | $135.70 | | 000 | N |
| | **96102** | Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face | 1.26 | $74.34 | | 000 | N |
| | **96103** | Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report | 0.97 | $57.23 | | 000 | N |
| | **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 | 2.01 | $118.59 | | 000 | N |
| | **96110** | Developmental testing; limited (eg, Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report | 0.36 | $21.24 | | 000 | N |
| | **96111** | Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report | 3.48 | $205.32 | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| | **96116** | Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report | 2.61 | $153.99 | | 000 | N |
| | **96118** | Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report | 3.10 | $182.90 | | 000 | N |
| | **96119** | Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face | 1.82 | $107.38 | | 000 | N |
| | **96120** | Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report | 1.52 | $89.68 | | 000 | N |
| | **96150** | Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment | 0.62 | $36.58 | | 000 | N |
| | **96151** | Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment | 0.60 | $35.40 | | 000 | N |
| | **96152** | Health and behavior intervention, each 15 minutes, face-to-face; individual | 0.57 | $33.63 | | 000 | N |
| | **96153** | Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients) | 0.14 | $8.26 | | 000 | N |
| | **96154** | Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present) | 0.56 | $33.04 | | 000 | N |
| | **96155** | Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present) | 0.58 | $34.22 | | 000 | N |
| | **96401** | Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic | 1.54 | $90.86 | | 000 | N |
| | **96402** | Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic | 1.12 | $66.08 | | 000 | N |
| | **96405** | Chemotherapy administration; intralesional, up to and including 7 lesions | 3.21 | $189.39 | | 000 | N |
| | **96406** | Chemotherapy administration; intralesional, more than 7 lesions | 3.83 | $225.97 | | 000 | N |
| | **96409** | Chemotherapy administration; intravenous, push technique, single or initial substance/drug | 3.16 | $186.44 | | 000 | N |
| + | **96411** | Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure) | 1.82 | $107.38 | | 000 | N |
| | **96413** | Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug | 4.38 | $258.42 | | 000 | N |
| + | **96415** | Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure) | 0.98 | $57.82 | | 000 | N |
| | **96416** | Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump | 4.74 | $279.66 | | 000 | N |
| + | **96417** | Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure) | 2.15 | $126.85 | | 000 | N |
| | **96420** | Chemotherapy administration, intra-arterial; push technique | 2.90 | $171.10 | | 000 | N |
| | **96422** | Chemotherapy administration, intra-arterial; infusion technique, up to one hour | 4.80 | $283.20 | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| + | **96423** | Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure) | 2.06 | $121.54 | | 000 | N |
| | **96425** | Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump | 4.71 | $277.89 | | 000 | N |
| | **96440** | Chemotherapy administration into pleural cavity, requiring and including thoracentesis | 9.78 | $577.02 | | 000 | N |
| | **96445** | Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis | 9.50 | $560.50 | | 000 | N |
| | **96450** | Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture | 7.92 | $467.28 | | 000 | N |
| | **96521** | Refilling and maintenance of portable pump | 3.85 | $227.15 | | 000 | N |
| | **96522** | Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial) | 2.91 | $171.69 | | 000 | N |
| | **96523** | Irrigation of implanted venous access device for drug delivery systems | 0.73 | $43.07 | | 000 | N |
| | **96542** | Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents | 4.81 | $283.79 | | 000 | N |
| | **96549** | Unlisted chemotherapy procedure | 0.00 | BR | | 000 | N |
| | **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 | 2.44 | $143.96 | | 000 | N |
| + | **96570** | Photodynamic therapy by endoscopic application of light to 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) | 1.48 | $87.32 | | 000 | N |
| + | **96571** | Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus) | 0.71 | $41.89 | | 000 | N |
| | **96900** | Actinotherapy (ultraviolet light) | 0.49 | $28.91 | | 000 | N |
| | **96902** | Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality | 0.54 | $31.86 | | 000 | N |
| | **96904** | Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma | 1.85 | $109.15 | | 000 | N |
| | **96910** | Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B | 1.28 | $75.52 | | 000 | N |
| | **96912** | Photochemotherapy; psoralens and ultraviolet A (PUVA) | 1.64 | $96.76 | | 000 | N |
| | **96913** | Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least four to eight hours of care under direct supervision of the physician (includes application of medication and dressings) | 2.27 | $133.93 | | 000 | N |
| | **96920** | Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm | 3.85 | $227.15 | | 000 | N |
| | **96921** | Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm | 3.90 | $230.10 | | 000 | N |
| | **96922** | Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm | 5.70 | $336.30 | | 000 | N |
| | **96999** | Unlisted special dermatological service or procedure | 0.00 | BR | | 000 | N |
| | **99000** | Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory | 0.12 | $7.14 | | 000 | N |
| | **99001** | Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory (distance may be indicated) | 0.14 | $8.32 | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| | **99002** | Handling, conveyance, and/or any other service in connection with the implementation of an order involving devices (eg, designing, fitting, packaging, handling, delivery or mailing) when devices such as orthotics, protectives, prosthetics are fabricated by an outside laboratory or shop but which items have been designed, and are to be fitted and adjusted by the attending physician | 0.16 | $9.50 | | 000 | N |
| | **99024** | Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure | 0.00 | BR | | 000 | N |
| | **99026** | Hospital mandated on call service; in-hospital, each hour | 0.00 | BR | | 000 | N |
| | **99027** | Hospital mandated on call service; out-of-hospital, each hour | 0.00 | BR | | 000 | N |
| | **99050** | Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service | 0.42 | $24.90 | | 000 | N |
| | **99051** | Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service | 0.00 | BR | | 000 | N |
| | **99053** | Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service | 0.00 | BR | | 000 | N |
| | **99056** | Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service | 0.40 | $23.72 | | 000 | N |
| | **99058** | Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service | 0.50 | $29.68 | | 000 | N |
| | **99060** | Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service | 0.56 | $33.22 | | 000 | N |
| | **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) | 0.00 | BR | | 000 | N |
| | **99071** | Educational supplies, such as books, tapes, and pamphlets, provided by the physician for the patient's education at cost to physician | 0.00 | BR | | 000 | N |
| | **99075** | Medical testimony | 0.00 | BR | | 000 | N |
| | **99078** | Physician educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions) | 0.00 | BR | | 000 | N |
| | **99080** | Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form | 0.00 | BR | | 000 | N |
| | **99082** | Unusual travel (eg, transportation and escort of patient) | 0.00 | BR | | 000 | N |
| | **99090** | Analysis of clinical data stored in computers (eg, ECGs, blood pressures, hematologic data) | 0.00 | BR | | 000 | N |
| | **99091** | Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time | 1.28 | $75.52 | | 000 | N |
| ⊘ | **99143** | Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; younger than 5 years of age, first 30 minutes intra-service time | 1.21 | $71.39 | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| ⊘ | **99144** | Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; age 5 years or older, first 30 minutes intra-service time | 1.01 | $59.59 | | 000 | N |
| + | **99145** | Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time (List separately in addition to code for primary service) | 0.40 | $23.60 | | 000 | N |
| ⊘ | **99148** | Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; younger than 5 years of age, first 30 minutes intra-service time | 1.11 | $65.25 | | 000 | N |
| +⊘ | **99149** | Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; age 5 years or older, first 30 minutes intra-service time | 0.91 | $53.40 | | 000 | N |
| | **99150** | Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service) | 0.40 | $23.72 | | 000 | N |
| | **99170** | Anogenital examination with colposcopic magnification in childhood for suspected trauma | 3.35 | $197.65 | | 000 | N |
| | **99172** | Visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision (may include all or some screening of the determination(s) for contrast sensitivity, vision under glare) | 0.44 | $26.08 | $5.22 | 000 | N |
| | **99173** | Screening test of visual acuity, quantitative, bilateral | 0.07 | $4.13 | | 000 | N |
| | **99175** | Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison | 1.23 | $72.57 | | 000 | N |
| | **99183** | Physician attendance and supervision of hyperbaric oxygen therapy, per session | 5.34 | $315.06 | | 000 | N |
| | **99185** | Hypothermia; regional | 0.93 | $54.87 | $21.95 | 000 | N |
| | **99186** | Hypothermia; total body | 2.13 | $125.67 | $50.27 | 000 | N |
| | **99190** | Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); each hour | 10.05 | $592.95 | $0.00 | 000 | N |
| | **99191** | Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); 45 minutes | 7.04 | $415.07 | $0.00 | 000 | N |
| | **99192** | Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); 30 minutes | 5.03 | $296.48 | $0.00 | 000 | N |
| | **99195** | Phlebotomy, therapeutic (separate procedure) | 1.00 | $59.00 | | 000 | N |
| | **99199** | Unlisted special service, procedure or report | 0.00 | BR | | 000 | N |
| | **99500** | Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring | 0.00 | BR | | 000 | N |
| | **99501** | Home visit for postnatal assessment and follow-up care | 0.00 | BR | | 000 | N |
| | **99502** | Home visit for newborn care and assessment | 0.00 | BR | | 000 | N |

| | Code | Description | Relative Value | Amount | PC Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|---|
| | **99503** | Home visit for respiratory therapy care (eg, bronchodilator, oxygen therapy, respiratory assessment, apnea evaluation) | 0.00 | BR | | 000 | N |
| | **99504** | Home visit for mechanical ventilation care | 0.00 | BR | | 000 | N |
| | **99505** | Home visit for stoma care and maintenance including colostomy and cystostomy | 0.00 | BR | | 000 | N |
| | **99506** | Home visit for intramuscular injections | 0.00 | BR | | 000 | N |
| | **99507** | Home visit for care and maintenance of catheter(s) (eg, urinary, drainage, and enteral) | 0.00 | BR | | 000 | N |
| | **99509** | Home visit for assistance with activities of daily living and personal care | 0.00 | BR | | 000 | N |
| | **99510** | Home visit for individual, family, or marriage counseling | 0.00 | BR | | 000 | N |
| | **99511** | Home visit for fecal impaction management and enema administration | 0.00 | BR | | 000 | N |
| | **99512** | Home visit for hemodialysis | 0.00 | BR | | 000 | N |
| | **99600** | Unlisted home visit service or procedure | 0.00 | BR | | 000 | N |
| | **99601** | Home infusion/specialty drug administration, per visit (up to 2 hours); | 0.00 | BR | | 000 | N |
| + | **99602** | Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code for primary procedure) | 0.00 | BR | | 000 | N |

# Physical Medicine

## I. SCOPE

A. **Physical Medicine**
Physical medicine is an integral part of the healing process for a variety of injured workers. Recognizing this, the Fee Schedule includes codes for physical medicine, modalities, procedures, tests, and measurements in the Physical Medicine section representing specific therapeutic procedures performed by licensed physicians, chiropractors, licensed physical therapists, and licensed occupational therapists.

B. **Physical Medical Assessment**
1. An assessment must be performed to determine if a patient will benefit from physical medicine therapy.
2. When a physician examines a patient and an assessment for physical medicine is performed, the billing for the office visit includes the physical medicine assessment.
3. Procedure code 97001 is to be used for an initial assessment by physical therapists. Code 97002 is to be used for re-evaluation of a patient by physical therapists. Procedure code 97003 is to be used for an initial assessment by occupational therapists. Code 97004 is to be used for re-evaluation of a patient by occupational therapists.

C. **Plan of Care**
1. An initial plan of care must be developed and filed with the payer regardless of whether therapy is provided by a physician or practicing therapist. The content of the plan of care, at a minimum, should contain:
    a. The specific therapies to be provided, including the frequency and duration of each
    b. The estimated duration of the therapeutic regimen
    c. The potential degree of restoration and measurable goals (e.g., potential restoration is good, poor, low, guarded)
2. The initial plan of care must be signed by the treating physician and submitted to the payer within fourteen (14) days of approval. Physicians are required to sign the plan of care for physical and/or occupational therapy. The physician's signature indicates approval of the therapy the patient is receiving and for the length of time established for the therapy.
3. The physician has the responsibility of providing documentation of medical necessity to the payer whenever there are questions regarding the extent of therapy being provided or the appropriateness of the therapy regimen.
4. A plan of care must be updated at least every thirty (30) days and submitted to the payer.
5. Preparation of a care plan does not warrant a separate fee.

D. **Qualifications for Reimbursement**
1. The patient's condition must have the potential for restoration of function.
2. The treatment must be prescribed by the authorized attending or treating physician.
3. The treatment must be specific to the injury and have the potential to improve the patient's condition.
4. The physician or therapist must be on-site during the provision of services.

## II. REIMBURSEMENT

A. **Guidelines**
1. Visits for therapy may not exceed one visit per day without prior approval from the payer.
2. Therapy exceeding fifteen (15) visits or thirty (30) days, whichever comes first, must have prior authorization from the payer for continuing care. It must meet the following guidelines:
    a. The treatment must be medically necessary.
    b. Prior authorization may be made by telephone. Documentation should be made in the patient's medical record indicating the date and name of

the payer representative giving authorization for the continued therapy.

3. Reimbursement is limited to no more than two modalities and/or two procedures, for a total of four, concurrently at the same visit. In the event of multiple treatment areas, an additional two modalities and/or two procedures per treatment day may be allowed at the payer's discretion and with pre-authorization.

   ***[In the pain management setting, no more than two (2) modalities and/or procedures may be used on a given day (e.g., heat/cold, ultrasound, diathermy, iontophoresis, TENS, electrical stimulation, muscle stimulation, etc.). No more than one (1) modality may be used concurrently.]***

4. Payment for 97010, which reports application of hot or cold packs, is bundled into payment for other services. Separate reimbursement for hot and cold packs will not be allowed in the treatment of work-related injury/illness.

5. No more than four (4) 15-minute procedures and/or modalities will be reimbursed at each encounter without prior authorization.

6. Only one (1) work hardening or work conditioning program is reimbursed per injury.

B. **Treatment Areas**

1. Spinal areas are recognized as the following five distinct regions:

   - Cranial
   - Cervical
   - Thoracic
   - Lumbar
   - Sacral

   Transitional areas of the spine are not recognized as distinctly different areas (e.g., cervicothoracic, lumbosacral).

2. Pelvis

3. Upper extremity (either left or right) is recognized as the following six distinct regions:

   - Shoulder
   - Upper arm
   - Elbow
   - Forearm
   - Wrist
   - Hand

4. Lower extremity (either left or right) is recognized as the following eight distinct regions:

   - Hip
   - Thigh
   - Knee
   - Calf
   - Ankle
   - Foot
   - Rib cage
   - Anterior trunk

C. **Tests and Measurements**

1. When two or more procedures from 95831 through 95852 are performed on the same day, reimbursement may not exceed the maximum reimbursement allowance (MRA) for procedure code 95834 Total evaluation of body, including hands.

2. Functional capacity evaluation (FCE) must have pre-authorization from the payer before scheduling the tests. Reimbursement will be one hundred dollars ($100.00) per hour for a maximum of five (5) hours.

3. Reimbursement for extremity testing, muscle testing, and range of motion measurements (95831, 95832, 95833, 95834, 95851, 95852) will not be made more than once in a thirty (30) day period for the same body area. If a physician's order specifically indicates testing in more than one plane of motion, (e.g., flexion/extension and internal/external rotation), then each plane of motion test is reimbursable, but not more than once in a thirty (30) day period for that same body area. The multiple procedure rule would apply.

D. **Fabrication of Orthotics**

1. Procedure code 97760 must be billed for the professional services of a physician or therapist to fabricate orthotics.

2. Orthotics, prosthetics, and related supplies used may be billed under the appropriate HCPCS code. The maximum reimbursement allowance is listed in the DME and Other HCPCS Codes section of the Fee Schedule. For orthotics and supplies not listed in the DME and Other HCPCS Codes section, use CPT code 99070. Reimbursement may not exceed a twenty percent (20%) mark-up of the provider's cost and an invoice may be required by the payer before reimbursement is made.

E. **Follow-up Examination of an Established Patient**
A physician, physical therapist, or occupational therapist may charge and be reimbursed for a follow-up examination for physical therapy only if new symptoms present the need for re-examination and evaluation as follows:

1. There is a definitive change in the patient's condition
2. The patient fails to respond to treatment and there is a need to change the treatment plan
3. The patient has completed the therapy regimen and is ready to receive discharge instructions

## III. Work Hardening Rules

A. Work hardening programs are interdisciplinary, goal-specific, vocationally-driven treatment programs designed to maximize the likelihood of return to work through functional, behavioral, and vocational management.

B. Not all claimants require these programs to reach a level of function that will allow successful return to work.

C. Only those programs that meet all of the specific guidelines will be defined as work hardening programs.

D. Programs will be reimbursed per the Fee Schedule after meeting all other requirements.

E. Work hardening will be reimbursed for a maximum of four weeks with prior authorization from the payer. The payer may approve additional two-week increments if the patient demonstrates substantial improvement.

F. For pre-admission criteria, all claimants must complete a preprogram assessment, including a functional capacity evaluation (FCE). The goal of the program is return to work; therefore, for all anticipated returns to previous employment or placement with a new employer, the following must be provided:

1. Specific written critical job demands and/or job site analysis
2. Verified written employment opportunities

G. For the evaluation process, initial screening evaluation is performed to determine if the injured worker will benefit from a work hardening program. The outcome of this evaluation will be:

1. Recommendation of release to return to work
2. Acceptance into the program with an individual written rehabilitation plan stating specific goals and recommended services
3. Rejection from program for specific reasons
4. Referral back to the provider for medical evaluation

H. The individualized work hardening plan must be supervised by a licensed physical or occupational therapist and/or physician within a therapeutic environment. Although some time is spent on a one-to-one basis, more than fifty percent (50%) of the time is self-monitored under the supervision of a physical or occupational therapist and/or physician. Recommended group size is no larger than five-to-one (5 patients to 1 therapist).

I. Progress should be documented and reviewed to ensure continued progress.

J. Simultaneous utilization of work conditioning and work hardening is not allowed. Prior authorization is required for either one of these services and requires documentation of specific goals and outcomes.

K. Discharge criteria must be provided to all claimants in writing prior to initiation of treatment at the time program goals are determined.

L. Voluntary discharge is achieved by:

1. Meeting program goals
2. Early return to work
3. Acute or worsening medical condition
4. The claimant declining further treatment

M. Non-voluntary discharge may be necessary in cases of:

1. Failure to comply with program policies
2. Absenteeism
3. Lack of demonstrable benefit from treatment

N. Non-voluntary discharge requires written documentation of prior and repeated counseling of the claimant, and immediate notification of the employer, insurer, case manager, and treating and attending (if different) provider.

O. Under all circumstances of voluntary and non-voluntary discharge, the claimant will return to the attending provider for release from the program.

P. The attending provider must sign a release to return to work when the program goals are achieved.

Q. The exit/discharge summary should delineate the person's:

1. Present functional status and potential
2. Functional status related to the targeted job, alternative occupations, or competitive labor market

R. For program evaluation, programs must provide insurers and referring providers with:

1. Initial interdisciplinary team evaluation report
2. Proposed treatment plan
3. Progress reports at weekly intervals
4. The opportunity to attend team meetings
5. Final discharge summary report

S. Fees for work hardening programs will be paid in accordance with the Fee Schedule, with written prior approval by the payer, utilizing the following guidelines:

1. In all cases, for both voluntary and non-voluntary discharge, payment is for the actual duration of treatment provided.
2. Non-multi disciplinary work conditioning programs will be reimbursed utilizing existing physical therapy, occupational therapy, and physical medicine codes. CPT code 97545 (initial two hours) and code 97546 (each additional hour) are to be used to bill work hardening. CPT code 97545 is to be billed for the initial two hours of the work hardening program. This is a one-time charge. CPT code 97546 is to be used for billing each additional hour of the work hardening program after the initial two hours (indicated by code 97545).

## IV. Functional Capacity Evaluations

**A. The functional capacity evaluation (FCE) is utilized for the following purposes:**

1. To determine the highest level of safe functionality and of maximal medical improvement.
2. To provide a pre-vocational baseline of functional capabilities to assist in the vocational rehabilitation process.
3. To objectively set restrictions and guidelines for return to work.
4. To determine whether specific job tasks can be safely performed by modification of technique, equipment, or by further training.
5. To determine whether additional treatment or referral to a work hardening program is indicated.
6. To assess outcome at the conclusion of a work hardening program.

**B. General Requirements**

1. The FCE may be prescribed only by a licensed physician, or may be required by the payer when indicated.
2. The FCE requires prior authorization by the payer.
3. The FCE should be billed using code 97750 Functional capacity evaluation.

## V. TENS Units

A. TENS (transcutaneous electrical nerve stimulation) must be provided under the attending or treating physician's prescription.

B. Authorization from the payer must be sought before purchase or rental arrangements are made for a TENS unit. The payer has sole right of selection of vendors for rental or purchase of equipment, supplies, etc.

## VI. Supplies, Equipment, Orthotics, and Prosthetics

A. Physicians and therapists must obtain authorization from the payer before purchase/rental of supplies, equipment, orthotics, and prosthetics costing more than fifty dollars ($50.00) per item for workers' compensation patients. When submitting bills, include the appropriate HCPCS Level II code. Or, if there is not an appropriate HCPCS code, use CPT code 99070.

B. The payer has sole right of selection of vendors.

## VII. Other Instructions

A. Charges will not be reimbursed for publications, books, or videocassettes unless prior approval of the payer is obtained.

B. All charges for services must be clearly itemized by CPT code, and the state professional license number must be on the bill.

C. The treating physician must approve and sign all physical capability/restriction forms for the work-related injury/illness. This form must be submitted to the payer within fourteen (14) working days of the release to work.

D. Documentation may be required by the payer to substantiate the necessity for treatment rendered. Documentation to substantiate charges and reports of tests and measurements are included in the fee for the service and do not warrant additional reimbursement.

E. When patients do not show measurable progress, the payer may request the physician discontinue the treatment or provide documentation to substantiate medical necessity.

F. CPT code 97110 is to be used for each first fifteen (15) minutes of exercise therapy. The total reimbursement for code 97110 is limited to two (2) 15-minute charges in one day.

G. When physical medicine therapies are provided to more than one body area, modifier 51 must be added to the procedure code or codes billed for the additional body area and will be reimbursed according to the multiple procedure rule.

H. Non-surgical debridement should be billed as CPT code 97597 or 97602.

## VIII. Back Schools

All back school programs shall require prior authorization from the payer. The payer and the back school program may agree upon the daily, weekly, or other time-based payment to be made for services provided to the injured/ill worker. This agreement shall supersede the use of this Physical Medicine section when calculating reimbursement, but it shall not exceed the usual and customary fee.

## IX. Massage Therapy

Massage therapy requires prior authorization of the payer before treatment can be rendered. Medical necessity must be established prior to approval. Reimbursement must be arranged between the payer and provider.

## X. Chiropractic Manipulative Treatment

Codes 98940 through 98943 are used to code chiropractic manipulative treatment. Like any other service, a spinal manipulation includes pre-evaluation and post-evaluation that would make it inappropriate to bill with an E/M service. However, if the patient's condition has deteriorated or an injury to another site has occurred, reimbursement can be made for an E/M service if documentation substantiates the additional service. Modifier 25 is added to an E/M service when a significant, separately identifiable E/M service is provided and documented as medically necessary.

| Code | Description | Relative Value | Amount | FUD | Assist Surg |
|---|---|---|---|---|---|
| **97001** | Physical therapy evaluation | 1.86 | $119.04 | 000 | N |
| **97002** | Physical therapy re-evaluation | 0.99 | $63.36 | 000 | N |
| **97003** | Occupational therapy evaluation | 2.00 | $128.00 | 000 | N |
| **97004** | Occupational therapy re-evaluation | 1.20 | $76.80 | 000 | N |
| **97005** | Athletic training evaluation | 0.72 | $46.34 | 000 | N |
| **97006** | Athletic training re-evaluation | 0.36 | $23.17 | 000 | N |
| **97010** | Application of a modality to one or more areas; hot or cold packs | 0.12 | $7.68 | 000 | N |
| **97012** | Application of a modality to one or more areas; traction, mechanical | 0.36 | $23.04 | 000 | N |
| **97014** | Application of a modality to one or more areas; electrical stimulation (unattended) | 0.36 | $23.04 | 000 | N |
| **97016** | Application of a modality to one or more areas; vasopneumatic devices | 0.37 | $23.68 | 000 | N |
| **97018** | Application of a modality to one or more areas; paraffin bath | 0.18 | $11.52 | 000 | N |
| **97022** | Application of a modality to one or more areas; whirlpool | 0.40 | $25.60 | 000 | N |
| **97024** | Application of a modality to one or more areas; diathermy (eg, microwave) | 0.13 | $8.32 | 000 | N |
| **97026** | Application of a modality to one or more areas; infrared | 0.12 | $7.68 | 000 | N |
| **97028** | Application of a modality to one or more areas; ultraviolet | 0.15 | $9.60 | 000 | N |
| **97032** | Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes | 0.40 | $25.60 | 000 | N |
| **97033** | Application of a modality to one or more areas; iontophoresis, each 15 minutes | 0.55 | $35.20 | 000 | N |
| **97034** | Application of a modality to one or more areas; contrast baths, each 15 minutes | 0.36 | $23.04 | 000 | N |
| **97035** | Application of a modality to one or more areas; ultrasound, each 15 minutes | 0.30 | $19.20 | 000 | N |
| **97036** | Application of a modality to one or more areas; Hubbard tank, each 15 minutes | 0.61 | $39.04 | 000 | N |
| **97039** | Unlisted modality (specify type and time if constant attendance) | 0.00 | BR | 000 | N |
| **97110** | Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility | 0.70 | $44.80 | 000 | N |
| **97112** | Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities | 0.73 | $46.72 | 000 | N |
| **97113** | Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises | 0.84 | $53.76 | 000 | N |
| **97116** | Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing) | 0.62 | $39.68 | 000 | N |
| **97124** | Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion) | 0.56 | $35.84 | 000 | N |
| **97139** | Unlisted therapeutic procedure (specify) | 0.00 | BR | 000 | N |
| **97140** | Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes | 0.66 | $42.24 | 000 | N |
| **97150** | Therapeutic procedure(s), group (2 or more individuals) | 0.44 | $28.16 | 000 | N |
| **97530** | Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes | 0.75 | $48.00 | 000 | N |
| **97532** | Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes | 0.62 | $39.68 | 000 | N |
| **97533** | Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes | 0.66 | $42.24 | 000 | N |
| **97535** | Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes | 0.75 | $48.00 | 000 | N |
| **97537** | Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes | 0.68 | $43.52 | 000 | N |
| **97542** | Wheelchair management (eg, assessment, fitting, training), each 15 minutes | 0.69 | $44.16 | 000 | N |

| | Code | Description | Relative Value | Amount | FUD | Assist Surg |
|---|---|---|---|---|---|---|
| | **97545** | Work hardening/conditioning; initial 2 hours | 1.69 | $108.03 | 000 | N |
| + | **97546** | Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure) | 0.67 | $43.07 | 000 | N |
| | **97597** | Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters | 1.34 | $85.76 | 000 | N |
| | **97598** | Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters | 1.68 | $107.52 | 000 | N |
| | **97602** | Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session | 0.50 | $32.19 | 000 | N |
| | **97605** | Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters | 0.87 | $55.68 | 000 | N |
| | **97606** | Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters | 0.94 | $60.16 | 000 | N |
| | **97750** | Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes | 0.74 | $47.36 | 000 | N |
| | **97755** | Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes | 0.86 | $55.04 | 000 | N |
| | **97760** | Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes | 0.79 | $50.56 | 000 | N |
| | **97761** | Prosthetic training, upper and/or lower extremity(s), each 15 minutes | 0.71 | $45.44 | 000 | N |
| | **97762** | Checkout for orthotic/prosthetic use, established patient, each 15 minutes | 0.74 | $47.36 | 000 | N |
| | **97799** | Unlisted physical medicine/rehabilitation service or procedure | 0.00 | BR | 000 | N |
| | **97802** | Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes | 0.80 | $51.20 | 000 | N |
| | **97803** | Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes | 0.72 | $46.08 | 000 | N |
| | **97804** | Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes | 0.38 | $24.32 | 000 | N |
| | **97810** | Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient | 0.92 | $58.88 | 000 | N |
| + | **97811** | Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure) | 0.71 | $45.44 | 000 | N |
| | **97813** | Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient | 0.98 | $62.72 | 000 | N |
| + | **97814** | Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure) | 0.79 | $50.56 | 000 | N |
| | **98925** | Osteopathic manipulative treatment (OMT); one to two body regions involved | 0.73 | $46.72 | 000 | N |
| | **98926** | Osteopathic manipulative treatment (OMT); three to four body regions involved | 1.01 | $64.64 | 000 | N |
| | **98927** | Osteopathic manipulative treatment (OMT); five to six body regions involved | 1.30 | $83.20 | 000 | N |
| | **98928** | Osteopathic manipulative treatment (OMT); seven to eight body regions involved | 1.54 | $98.56 | 000 | N |
| | **98929** | Osteopathic manipulative treatment (OMT); nine to ten body regions involved | 1.77 | $113.28 | 000 | N |
| | **98940** | Chiropractic manipulative treatment (CMT); spinal, one to two regions | 0.64 | $40.96 | 000 | N |

| Code | Description | Relative Value | Amount | FUD | Assist Surg |
|---|---|---|---|---|---|
| **98941** | Chiropractic manipulative treatment (CMT); spinal, three to four regions | 0.88 | $56.32 | 000 | N |
| **98942** | Chiropractic manipulative treatment (CMT); spinal, five regions | 1.16 | $74.24 | 000 | N |
| **98943** | Chiropractic manipulative treatment (CMT); extraspinal, one or more regions | 0.59 | $37.76 | 000 | N |
| **98960** | Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient | 0.49 | $31.36 | 000 | N |
| **98961** | Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients | 0.24 | $15.36 | 000 | N |

# Dental

Dental codes (D0120–D9999), also referred to as D codes, are a separate category of HCPCS Level II national codes that contain the complete *Current Dental Terminology* (CDT) code set, which is developed, maintained, and copyrighted by the American Dental Association (ADA).

CDT is updated every two years. The current edition is *CDT 2007/2008,* which is the edition that has been used in this Fee Schedule.

Decisions regarding the modification, deletion, or addition of CDT codes are made by the ADA and not the national panel responsible for the administration of HCPCS Level II codes. The Department of Health and Human Services has an agreement with the ADA to include *CDT 2007/2008* as a set of HCPCS Level II codes used to report dental services.

| Code | Description | Amount |
|---|---|---|
| D0120 | Periodic oral evaluation, established patient | $28.61 |
| D0140 | Limited oral evaluation — problem focused | $47.12 |
| D0145 | Oral evaluation for a patient under three years of age and counseling with primary caregiver | $46.28 |
| D0150 | Comprehensive oral evaluation — new or established patient | $50.49 |
| D0160 | Detailed and extensive oral evaluation — problem focused, by report | $117.81 |
| D0170 | Re-evaluation — limited, problem focused (established patient; not postoperative visit) | $25.24 |
| D0180 | Comprehensive periodontal evaluation — new or established patient | $51.33 |
| D0210 | Intraoral — complete series (including bitewings) | $77.93 |
| D0220 | Intraoral — periapical, first film | $15.59 |
| D0230 | Intraoral — periapical, each additional film | $12.47 |
| D0240 | Intraoral — occlusal film | $22.60 |
| D0250 | Extraoral — first film | $29.61 |
| D0260 | Extraoral — each additional film | $27.28 |
| D0270 | Bitewing — single film | $16.89 |
| D0272 | Bitewings — two films | $27.02 |
| D0273 | Bitewings, three films | $32.93 |
| D0274 | Bitewings — four films | $37.99 |
| D0277 | Vertical bitewings — 7 to 8 films | $57.41 |
| D0290 | Posterior-anterior or lateral skull and facial bone survey film | $111.52 |
| D0310 | Sialography | $273.03 |
| D0320 | Temporomandibular joint arthrogram, including injection | $442.23 |
| D0321 | Other temporomandibular joint films, by report | BR |
| D0322 | Tomographic survey | $375.32 |
| D0330 | Panoramic film | $71.53 |
| D0340 | Cephalometric film | $88.45 |
| D0350 | Oral/facial photographic images | $384.55 |
| D0360 | Cone beam CT, craniofacial data capture | $493.76 |
| D0362 | Cone beam, two-dimensional image reconstruction using existing data, includes multiple images | $397.62 |
| D0363 | Cone beam, three-dimensional image reconstruction using existing data, includes multiple images | $413.01 |
| D0415 | Collection of microorganisms for culture and sensitivity | $15.28 |
| D0416 | Viral culture | $24.45 |
| D0421 | Genetic test for susceptibility to oral diseases | $15.28 |
| D0425 | Caries susceptibility tests | $14.06 |
| D0431 | Adjunctive pre-diagnostic test that aids In detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures | $24.45 |
| D0460 | Pulp vitality tests | $24.45 |
| D0470 | Diagnostic casts | $51.96 |
| D0472 | Accession of tissue, gross examination, preparation, and transmission of written report | $35.45 |
| D0473 | Accession of tissue, gross and microscopic examination, preparation and transmission of written report | $70.90 |
| D0474 | Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report | $85.57 |
| D0475 | Decalcification procedure | $47.07 |
| D0476 | Special stains for microorganisms | $47.07 |
| D0477 | Special stains, not for microorganisms | $56.85 |
| D0478 | Immunohistochemical stains | $51.96 |
| D0479 | Tissue in-situ hybridization, including interpretation | $79.46 |
| D0480 | Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report | $51.96 |
| D0481 | Electron microscopy — diagnostic | $305.62 |
| D0482 | Direct immunofluorescence | $67.24 |

| Code | Description | Amount |
|---|---|---|
| D0483 | Indirect immunofluorescence | $61.12 |
| D0484 | Consultation on slides prepared elsewhere | $110.02 |
| D0485 | Consultation, including preparation of slides from biopsy material supplied by referring source | $126.53 |
| D0486 | Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report | $56.85 |
| D0502 | Other oral pathology procedures, by report | BR |
| D0999 | Unspecified diagnostic procedure, by report | BR |
| D1110 | Prophylaxis — adult | $56.20 |
| D1120 | Prophylaxis — child | $38.79 |
| D1203 | Topical application of fluoride (prophylaxis not included) — child | $20.44 |
| D1204 | Topical application of fluoride (prophylaxis not included) — adult | $19.07 |
| D1206 | Topical fluoride varnish; therapeutic application for moderate to high caries risk patients | $30.65 |
| D1310 | Nutritional counseling for control of dental disease | $31.86 |
| D1320 | Tobacco counseling for the control and prevention of oral disease | $29.34 |
| D1330 | Oral hygiene instructions | $42.76 |
| D1351 | Sealant — per tooth | $32.70 |
| D1510 | Space maintainer — fixed-unilateral | $209.60 |
| D1515 | Space maintainer — fixed-bilateral | $276.67 |
| D1520 | Space maintainer — removable-unilateral | $251.52 |
| D1525 | Space maintainer — removable-bilateral | $356.32 |
| D1550 | Recementation of space maintainer | $45.27 |
| D1555 | Removal of fixed space maintainer | $41.92 |
| D2140 | Amalgam—one surface, primary or permanent | $76.89 |
| D2150 | Amalgam—two surfaces, primary or permanent | $99.51 |
| D2160 | Amalgam—three surfaces, primary or permanent | $120.32 |
| D2161 | Amalgam—four or more surfaces, primary or permanent | $146.55 |
| D2330 | Resin-based composite — one surface, anterior | $86.04 |
| D2331 | Resin-based composite — two surfaces, anterior | $109.81 |
| D2332 | Resin-based composite — three surfaces, anterior | $134.39 |
| D2335 | Resin-based composite — four or more surfaces or involving incisal angle (anterior) | $158.97 |
| D2390 | Resin-based composite crown, anterior | $176.18 |
| D2391 | Resin-based composite — one surface, posterior | $100.79 |
| D2392 | Resin-based composite — two surfaces, posterior | $131.93 |
| D2393 | Resin-based composite — three surfaces, posterior | $163.89 |
| D2394 | Resin-based composite — four or more surfaces, posterior | $200.77 |
| D2410 | Gold foil — one surface | $180.93 |
| D2420 | Gold foil — two surfaces | $301.55 |
| D2430 | Gold foil — three surfaces | $522.69 |
| D2510 | Inlay — metallic — one surface | $478.46 |
| D2520 | Inlay — metallic — two surfaces | $542.79 |
| D2530 | Inlay — metallic — three or more surfaces | $625.62 |
| D2542 | Onlay — metallic — two surfaces | $613.56 |
| D2543 | Onlay — metallic — three surfaces | $641.70 |
| D2544 | Onlay — metallic — four or more surfaces | $667.44 |
| D2610 | Inlay — porcelain/ceramic — one surface | $562.90 |
| D2620 | Inlay — porcelain/ceramic — two surfaces | $594.26 |
| D2630 | Inlay — porcelain/ceramic — three or more surfaces | $632.86 |
| D2642 | Onlay — porcelain/ceramic — two surfaces | $615.17 |
| D2643 | Onlay — porcelain/ceramic — three surfaces | $663.42 |
| D2644 | Onlay — porcelain/ceramic — four or more surfaces | $703.62 |
| D2650 | Inlay — resin-based composite composite/resin — one surface | $369.90 |

| Code | Description | Amount |
|---|---|---|
| D2651 | Inlay — resin-based composite composite/resin — two surfaces | $440.67 |
| D2652 | Inlay — resin-based composite composite/resin — three or more surfaces | $463.18 |
| D2662 | Onlay — resin-based composite composite/resin — two surfaces | $402.07 |
| D2663 | Onlay — resin-based composite composite/resin — three surfaces | $472.83 |
| D2664 | Onlay — resin-based composite composite/resin — four or more surfaces | $506.61 |
| D2710 | Crown — resin-based composite (indirect) | $285.47 |
| D2712 | Crown — 3/4 resin-based composite (indirect) | $285.47 |
| D2720 | Crown — resin with high noble metal | $703.62 |
| D2721 | Crown — resin with predominantly base metal | $659.39 |
| D2722 | Crown — resin with noble metal | $673.87 |
| D2740 | Crown — porcelain/ceramic substrate | $722.12 |
| D2750 | Crown — porcelain fused to high noble metal | $712.47 |
| D2751 | Crown — porcelain fused to predominantly base metal | $663.42 |
| D2752 | Crown — porcelain fused to noble metal | $679.50 |
| D2780 | Crown — 3/4 cast high noble metal | $683.52 |
| D2781 | Crown — 3/4 cast predominately base metal | $643.31 |
| D2782 | Crown — 3/4 cast noble metal | $664.22 |
| D2783 | Crown — 3/4 porcelain/ceramic | $702.82 |
| D2790 | Crown — full cast high noble metal | $687.54 |
| D2791 | Crown — full cast predominantly base metal | $651.35 |
| D2792 | Crown — full cast noble metal | $663.42 |
| D2794 | Crown — titanium | $703.62 |
| D2799 | Provisional crown | $285.47 |
| D2910 | Recement inlay, onlay or partial coverage restoration | $59.15 |
| D2915 | Recement cast or prefabricated post and core | $59.15 |
| D2920 | Recement crown | $59.97 |
| D2930 | Prefabricated stainless steel crown — primary tooth | $163.49 |
| D2931 | Prefabricated stainless steel crown — permanent tooth | $184.85 |
| D2932 | Prefabricated resin crown | $197.17 |
| D2933 | Prefabricated stainless steel crown with resin window | $225.93 |
| D2934 | Prefabricated esthetic coated stainless steel crown — primary tooth | $225.93 |
| D2940 | Sedative filling | $62.44 |
| D2950 | Core buildup, including any pins | $156.09 |
| D2951 | Pin retention — per tooth, in addition to restoration | $35.33 |
| D2952 | Post and core in addition to crown, indirectly fabricated | $246.47 |
| D2953 | Each additional indirectly fabricated post, same tooth | $123.23 |
| D2954 | Prefabricated post and core in addition to crown | $197.17 |
| D2955 | Post removal (not in conjunction with endodontic therapy) | $151.99 |
| D2957 | Each additional prefabricated post — same tooth | $98.59 |
| D2960 | Labial veneer (resin laminate) — chairside | $476.50 |
| D2961 | Labial veneer (resin laminate) — laboratory | $540.58 |
| D2962 | Labial veneer (porcelain laminate) — laboratory | $587.41 |
| D2971 | Additional procedures to construct new crown under existing partial denture framework | $94.48 |
| D2975 | Coping | $287.54 |
| D2980 | Crown repair, by report | BR |
| D2999 | Unspecified restorative procedure, by report | BR |
| D3110 | Pulp cap — direct (excluding final restoration) | $44.71 |
| D3120 | Pulp cap — indirect (excluding final restoration) | $36.97 |
| D3220 | Therapeutic pulpotomy (excluding final restoration) — removal of pulp coronal to the dentinocemental junction and application of medicament | $105.76 |

| Code | Description | Amount |
|---|---|---|
| D3221 | Pulpal debridement, primary and permanent teeth | $116.07 |
| D3230 | Pulpal therapy (resorbable filling) — anterior, primary tooth (excluding final restoration) | $111.78 |
| D3240 | Pulpal therapy (resorbable filling) — posterior, primary tooth (excluding final restoration) | $120.37 |
| D3310 | Anterior (excluding final restoration) | $447.10 |
| D3320 | Bicuspid (excluding final restoration) | $545.98 |
| D3330 | Molar (excluding final restoration) | $705.04 |
| D3331 | Treatment of root canal obstruction; nonsurgical access | $156.49 |
| D3332 | Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth | $343.92 |
| D3333 | Internal root repair of perforation defects | $137.57 |
| D3346 | Retreatment of previous root canal therapy — anterior | $601.87 |
| D3347 | Retreatment of previous root canal therapy — bicuspid | $709.34 |
| D3348 | Retreatment of previous root canal therapy — molar | $852.93 |
| D3351 | Apexification/recalcification — initial visit (apical closure/calcific repair of perforations, root resorption, etc.) | $253.64 |
| D3352 | Apexification/recalcification — interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) | $110.92 |
| D3353 | Apexification/recalcification — final visit (includes completed root canal therapy — apical closure/calcific repair of perforations, root resorption, etc.) | $374.02 |
| D3410 | Apicoectomy/periradicular surgery — anterior | $511.59 |
| D3421 | Apicoectomy/periradicular surgery — bicuspid (first root) | $558.88 |
| D3425 | Apicoectomy/periradicular surgery — molar (first root) | $631.96 |
| D3426 | Apicoectomy/periradicular surgery (each additional root) | $210.65 |
| D3430 | Retrograde filling — per root | $154.77 |
| D3450 | Root amputation — per root | $313.83 |
| D3460 | Endodontic endosseous implant | $1,506.39 |
| D3470 | Intentional reimplantation (including necessary splinting) | $625.94 |
| D3910 | Surgical procedure for isolation of tooth with rubber dam | $81.68 |
| D3920 | Hemisection (including any root removal), not including root canal therapy | $245.05 |
| D3950 | Canal preparation and fitting of preformed dowel or post | $111.78 |
| D3999 | Unspecified endodontic procedure, by report | BR |
| D4210 | Gingivectomy or gingivoplasty — four or more contiguous teeth or bounded teeth spaces per quadrant | $404.10 |
| D4211 | Gingivectomy or gingivoplasty — one to three contiguous teeth or bounded teeth spaces per quadrant | $169.72 |
| D4230 | Anatomical crown exposure, four or more contiguous teeth per quadrant | $602.10 |
| D4231 | Anatomical crown exposure, one to three teeth per quadrant | $381.47 |
| D4240 | Gingival flap procedure, including root planing — four or more contiguous teeth or bounded teeth spaces per quadrant | $476.83 |
| D4241 | Gingival flap procedure, including root planing — one to three contiguous teeth or bounded teeth spaces per quadrant | $248.11 |
| D4245 | Apically positioned flap | $339.44 |
| D4249 | Clinical crown lengthening — hard tissue | $541.49 |
| D4260 | Osseous surgery (including flap entry and closure) — four or more contiguous teeth or bounded teeth spaces per quadrant | $775.86 |
| D4261 | Osseous surgery (including flap entry and closure) — one to three contiguous teeth or bounded teeth spaces per quadrant | $404.10 |
| D4263 | Bone replacement graft — first site in quadrant | $242.46 |
| D4264 | Bone replacement graft — each additional site in quadrant (use if performed on same date of service as D4263) | $129.31 |
| D4265 | Biologic materials to aid in soft and osseous tissue regeneration | BR |
| D4266 | Guided tissue regeneration — resorbable barrier, per site | $282.87 |
| D4267 | Guided tissue regeneration — nonresorbable barrier, per site (includes membrane removal) | $363.69 |
| D4268 | Surgical revision procedure, per tooth | BR |
| D4270 | Pedicle soft tissue graft procedure | $565.73 |
| D4271 | Free soft tissue graft procedure (including donor site surgery) | $589.98 |

| Code | Description | Amount |
|---|---|---|
| D4273 | Subepithelial connective tissue graft procedures, per tooth | $692.62 |
| D4274 | Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) | $195.58 |
| D4275 | Soft tissue allograft | $363.69 |
| D4276 | Combined connective tissue and double pedicle graft, per tooth | $371.77 |
| D4320 | Provisional splinting — intracoronal | $273.36 |
| D4321 | Provisional splinting — extracoronal | $239.19 |
| D4341 | Periodontal scaling and root planing — four or more teeth per quadrant | $148.07 |
| D4342 | Periodontal scaling and root planing — one to three teeth, per quadrant | $82.01 |
| D4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis | $98.71 |
| D4381 | Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report | BR |
| D4910 | Periodontal maintenance | $88.84 |
| D4920 | Unscheduled dressing change (by someone other than treating dentist) | $75.93 |
| D4999 | Unspecified periodontal procedure, by report | BR |
| D5110 | Complete denture — maxillary | $767.70 |
| D5120 | Complete denture — mandibular | $767.70 |
| D5130 | Immediate denture — maxillary | $837.05 |
| D5140 | Immediate denture — mandibular | $837.05 |
| D5211 | Maxillary partial denture — resin base (including any conventional clasps, rests and teeth) | $647.93 |
| D5212 | Mandibular partial denture — resin base (including any conventional clasps, rests and teeth) | $752.99 |
| D5213 | Maxillary partial denture — cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $848.26 |
| D5214 | Mandibular partial denture — cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $848.26 |
| D5225 | Maxillary partial denture — flexible base (including any clasps, rests and teeth) | $647.93 |
| D5226 | Mandibular partial denture — flexible base (including any clasps, rests and teeth) | $752.99 |
| D5281 | Removable unilateral partial denture — one piece cast metal (including clasps and teeth) | $494.52 |
| D5410 | Adjust complete denture — maxillary | $42.03 |
| D5411 | Adjust complete denture — mandibular | $42.03 |
| D5421 | Adjust partial denture — maxillary | $42.03 |
| D5422 | Adjust partial denture — mandibular | $42.03 |
| D5510 | Repair broken complete denture base | $84.06 |
| D5520 | Replace missing or broken teeth — complete denture (each tooth) | $70.05 |
| D5610 | Repair resin denture base | $91.06 |
| D5620 | Repair cast framework | $98.06 |
| D5630 | Repair or replace broken clasp | $119.08 |
| D5640 | Replace broken teeth — per tooth | $77.05 |
| D5650 | Add tooth to existing partial denture | $105.07 |
| D5660 | Add clasp to existing partial denture | $126.08 |
| D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) | $308.20 |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | $308.20 |
| D5710 | Rebase complete maxillary denture | $311.70 |
| D5711 | Rebase complete mandibular denture | $297.70 |
| D5720 | Rebase maxillary partial denture | $294.19 |
| D5721 | Rebase mandibular partial denture | $294.19 |
| D5730 | Reline complete maxillary denture (chairside) | $175.82 |
| D5731 | Reline complete mandibular denture (chairside) | $175.82 |
| D5740 | Reline maxillary partial denture (chairside) | $161.11 |
| D5741 | Reline mandibular partial denture (chairside) | $161.11 |
| D5750 | Reline complete maxillary denture (laboratory) | $234.65 |

| Code | Description | Amount |
|---|---|---|
| D5751 | Reline complete mandibular denture (laboratory) | $234.65 |
| D5760 | Reline maxillary partial denture (laboratory) | $231.15 |
| D5761 | Reline mandibular partial denture (laboratory) | $231.15 |
| D5810 | Interim complete denture (maxillary) | $371.24 |
| D5811 | Interim complete denture (mandibular) | $399.26 |
| D5820 | Interim partial denture (maxillary) | $287.19 |
| D5821 | Interim partial denture (mandibular) | $304.70 |
| D5850 | Tissue conditioning, maxillary | $73.55 |
| D5851 | Tissue conditioning, mandibular | $73.55 |
| D5860 | Overdenture — complete, by report | BR |
| D5861 | Overdenture — partial, by report | BR |
| D5862 | Precision attachment, by report | BR |
| D5867 | Replacement of replaceable part of semi-precision or precision attachment (male or female component) | BR |
| D5875 | Modification of removable prosthesis following implant surgery | BR |
| D5899 | Unspecified removable prosthodontic procedure, by report | BR |
| D5911 | Facial moulage (sectional) | $194.73 |
| D5912 | Facial moulage (complete) | $194.73 |
| D5913 | Nasal prosthesis | $4,100.49 |
| D5914 | Auricular prosthesis | $4,100.49 |
| D5915 | Orbital prosthesis | $5,549.04 |
| D5916 | Ocular prosthesis | $1,480.07 |
| D5919 | Facial prosthesis | BR |
| D5922 | Nasal septal prosthesis | BR |
| D5923 | Ocular prosthesis, interim | BR |
| D5924 | Cranial prosthesis | BR |
| D5925 | Facial augmentation implant prosthesis | BR |
| D5926 | Nasal prosthesis, replacement | BR |
| D5927 | Auricular prosthesis, replacement | BR |
| D5928 | Orbital prosthesis, replacement | BR |
| D5929 | Facial prosthesis, replacement | BR |
| D5931 | Obturator prosthesis, surgical | $2,207.85 |
| D5932 | Obturator prosthesis, definitive | $4,129.21 |
| D5933 | Obturator prosthesis, modification | BR |
| D5934 | Mandibular resection prosthesis with guide flange | $3,763.57 |
| D5935 | Mandibular resection prosthesis without guide flange | $3,274.65 |
| D5936 | Obturator/prosthesis, interim | $3,678.12 |
| D5937 | Trismus appliance (not for TMD treatment) | $462.30 |
| D5951 | Feeding aid | $600.99 |
| D5952 | Speech aid prosthesis, pediatric | $1,951.48 |
| D5953 | Speech aid prosthesis, adult | $3,706.13 |
| D5954 | Palatal augmentation prosthesis | $3,434.36 |
| D5955 | Palatal lift prosthesis, definitive | $3,176.59 |
| D5958 | Palatal lift prosthesis, interim | BR |
| D5959 | Palatal lift prosthesis, modification | BR |
| D5960 | Speech aid prosthesis, modification | BR |
| D5982 | Surgical stent | $381.75 |
| D5983 | Radiation carrier | $924.61 |
| D5984 | Radiation shield | $924.61 |
| D5985 | Radiation cone locator | $924.61 |
| D5986 | Fluoride gel carrier | $78.45 |

| Code | Description | Amount |
|---|---|---|
| D5987 | Commissure splint | $1,387.61 |
| D5988 | Surgical splint. See also CPT. | BR |
| D5999 | Unspecified maxillofacial prosthesis, by report | BR |
| D6010 | Surgical placement of implant body: endosteal implant | $1,282.54 |
| D6012 | Surgical placement of interim implant body for transitional prosthesis: endosteal implant | $1,211.80 |
| D6040 | Surgical placement: eposteal implant | $4,412.90 |
| D6050 | Surgical placement: transosteal implant | $3,292.16 |
| D6053 | Implant/abutment supported removable denture for completely edentulous arch | $957.53 |
| D6054 | Implant/abutment supported removable denture for partially edentulous arch | $957.53 |
| D6055 | Dental implant supported connecting bar | $325.71 |
| D6056 | Prefabricated abutment — includes placement | $227.65 |
| D6057 | Custom abutment — includes placement | $297.70 |
| D6058 | Abutment supported porcelain/ceramic crown | $738.28 |
| D6059 | Abutment supported porcelain fused to metal crown (high noble metal) | $728.48 |
| D6060 | Abutment supported porcelain fused to metal crown (predominantly base metal) | $688.55 |
| D6061 | Abutment supported porcelain fused to metal crown (noble metal) | $702.56 |
| D6062 | Abutment supported cast metal crown (high noble metal) | $699.76 |
| D6063 | Abutment supported cast metal crown (predominantly base metal) | $600.99 |
| D6064 | Abutment supported cast metal crown (noble metal) | $636.72 |
| D6065 | Implant supported porcelain/ceramic crown | $726.38 |
| D6066 | Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) | $707.46 |
| D6067 | Implant supported metal crown (titanium, titanium alloy, high noble metal) | $686.45 |
| D6068 | Abutment supported retainer for porcelain/ceramic FPD | $738.28 |
| D6069 | Abutment supported retainer for porcelain fused to metal FPD (high noble metal) | $728.48 |
| D6070 | Abutment supported retainer for porcelain fused to metal FPD (predominately base metal) | $688.55 |
| D6071 | Abutment supported retainer for porcelain fused to metal FPD (noble metal) | $702.56 |
| D6072 | Abutment supported retainer for cast metal FPD (high noble metal) | $717.27 |
| D6073 | Abutment supported retainer for cast metal FPD (predominately base metal) | $649.33 |
| D6074 | Abutment supported retainer for cast metal FPD (noble metal) | $699.76 |
| D6075 | Implant supported retainer for ceramic FPD | $726.38 |
| D6076 | Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal) | $707.46 |
| D6077 | Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal) | $686.45 |
| D6078 | Implant/abutment supported fixed denture for completely edentulous arch | BR |
| D6079 | Implant/abutment supported fixed denture for partially edentulous arch | BR |
| D6080 | Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis | $60.24 |
| D6090 | Repair implant supported prosthesis, by report | BR |
| D6091 | Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment | $290.69 |
| D6092 | Recement implant/abutment supported crown | $56.74 |
| D6093 | Recement implant/abutment supported fixed partial denture | $88.96 |
| D6094 | Abutment supported crown (titanium) | $577.88 |
| D6095 | Repair implant abutment, by report | BR |
| D6100 | Implant removal, by report | BR |
| D6190 | Radiographic/surgical implant index, by report | $129.59 |
| D6194 | Abutment supported retainer crown for FPD (titanium) | $595.39 |
| D6199 | Unspecified implant procedure, by report | BR |
| D6205 | Pontic — indirect resin based composite | $429.23 |
| D6210 | Pontic — cast high noble metal | $656.23 |
| D6211 | Pontic — cast predominantly base metal | $614.96 |

| Code | Description | Amount |
|---|---|---|
| D6212 | Pontic — cast noble metal | $639.72 |
| D6214 | Pontic — titanium | $660.36 |
| D6240 | Pontic — porcelain fused to high noble metal | $647.98 |
| D6241 | Pontic — porcelain fused to predominantly base metal | $598.45 |
| D6242 | Pontic — porcelain fused to noble metal | $631.47 |
| D6245 | Pontic — porcelain/ceramic | $668.61 |
| D6250 | Pontic — resin with high noble metal | $639.72 |
| D6251 | Pontic — resin with predominantly base metal | $590.20 |
| D6252 | Pontic — resin with noble metal | $609.18 |
| D6253 | Provisional pontic | $275.70 |
| D6545 | Retainer — cast metal for resin bonded fixed prosthesis | $272.40 |
| D6548 | Retainer — porcelain/ceramic for resin bonded fixed prosthesis | $299.64 |
| D6600 | Inlay — porcelain/ceramic, two surfaces | $540.67 |
| D6601 | Inlay — porcelain/ceramic, three or more surfaces | $567.08 |
| D6602 | Inlay — cast high noble metal, two surfaces | $577.82 |
| D6603 | Inlay — cast high noble metal, three or more surfaces | $635.60 |
| D6604 | Inlay — cast predominantly base metal, two surfaces | $566.26 |
| D6605 | Inlay — cast predominantly base metal, three or more surfaces | $600.10 |
| D6606 | Inlay — cast noble metal, two surfaces | $557.18 |
| D6607 | Inlay — cast noble metal, three or more surfaces | $618.26 |
| D6608 | Onlay — porcelain/ceramic, two surfaces | $587.72 |
| D6609 | Onlay — porcelain/ceramic, three or more surfaces | $613.31 |
| D6610 | Onlay — cast high noble metal, two surfaces | $623.21 |
| D6611 | Onlay — cast high noble metal, three or more surfaces | $681.82 |
| D6612 | Onlay — cast predominantly base metal, two surfaces | $619.91 |
| D6613 | Onlay — cast predominantly base metal, three or more surfaces | $647.98 |
| D6614 | Onlay — cast noble metal, two surfaces | $606.71 |
| D6615 | Onlay — cast noble metal, three or more surfaces | $630.64 |
| D6624 | Inlay — titanium | $577.82 |
| D6634 | Onlay — titanium | $606.71 |
| D6710 | Crown — indirect resin based composite | $619.09 |
| D6720 | Crown — resin with high noble metal | $722.27 |
| D6721 | Crown — resin with predominantly base metal | $685.12 |
| D6722 | Crown — resin with noble metal | $697.51 |
| D6740 | Crown — porcelain/ceramic | $759.41 |
| D6750 | Crown — porcelain fused to high noble metal | $739.60 |
| D6751 | Crown — porcelain fused to predominantly base metal | $690.08 |
| D6752 | Crown — porcelain fused to noble metal | $706.59 |
| D6780 | Crown — 3/4 cast high noble metal | $697.51 |
| D6781 | Crown — 3/4 cast predominately base metal | $697.51 |
| D6782 | Crown — 3/4 cast noble metal | $647.98 |
| D6783 | Crown — 3/4 porcelain/ceramic | $718.14 |
| D6790 | Crown — full cast high noble metal | $714.01 |
| D6791 | Crown — full cast predominantly base metal | $676.87 |
| D6792 | Crown — full cast noble metal | $701.63 |
| D6793 | Provisional retainer crown | $293.03 |
| D6794 | Crown — titanium | $701.63 |
| D6920 | Connector bar | $148.58 |
| D6930 | Recement fixed partial denture | $86.67 |
| D6940 | Stress breaker | $196.46 |

| Code | Description | Amount |
|---|---|---|
| D6950 | Precision attachment | $379.71 |
| D6970 | Post and core in addition to fixed partial denture retainer, indirectly fabricated | $239.38 |
| D6972 | Prefabricated post and core in addition to fixed partial denture retainer | $194.81 |
| D6973 | Core build up for retainer, including any pins | $156.84 |
| D6975 | Coping — metal | $420.98 |
| D6976 | Each additional indirectly fabricated post, same tooth | $111.44 |
| D6977 | Each additional prefabricated post — same tooth | $99.05 |
| D6980 | Fixed partial denture repair, by report | BR |
| D6985 | Pediatric partial denture, fixed | $330.18 |
| D6999 | Unspecified, fixed prosthodontic procedure, by report | BR |
| D7111 | Extraction, coronal remnants — deciduous tooth | $62.54 |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | $83.13 |
| D7210 | Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth | $151.30 |
| D7220 | Removal of impacted tooth — soft tissue | $189.71 |
| D7230 | Removal of impacted tooth — partially bony | $252.42 |
| D7240 | Removal of impacted tooth — completely bony | $296.32 |
| D7241 | Removal of impacted tooth — completely bony, with unusual surgical complications | $372.36 |
| D7250 | Surgical removal of residual tooth roots (cutting procedure) | $159.92 |
| D7260 | Orolantral fistula closure | $1,332.66 |
| D7261 | Primary closure of a sinus perforation | $431.16 |
| D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | $321.41 |
| D7272 | Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization) | $450.75 |
| D7280 | Surgical access of an unerupted tooth | $274.37 |
| D7282 | Mobilization of erupted or malpositioned tooth to aid eruption | $128.56 |
| D7283 | Placement of device to facilitate eruption of impacted tooth | $86.23 |
| D7285 | Biopsy of oral tissue — hard (bone, tooth) | $572.26 |
| D7286 | Biopsy of oral tissue — soft | $258.69 |
| D7287 | Exfoliative cytological sample collection | $82.31 |
| D7288 | Brush biopsy — transepithelial sample collection | $65.07 |
| D7290 | Surgical repositioning of teeth | $290.05 |
| D7291 | Transseptal fiberotomy/supra crestal fiberotomy, by report | BR |
| D7292 | Surgical placement: temporary anchorage device (screw retained plate) requiring surgical flap | $431.16 |
| D7293 | Surgical placement: temporary anchorage device requiring surgical flap | $274.37 |
| D7294 | Surgical placement: temporary anchorage device without surgical flap | $198.33 |
| D7310 | Alveoloplasty in conjunction with extractions—four or more teeth or tooth spaces, per quadrant | $176.38 |
| D7311 | Alveoloplasty in conjunction with extractions — one to three teeth or tooth spaces, per quadrant | $137.19 |
| D7320 | Alveoloplasty not in conjunction with extractions—four or more teeth or tooth spaces, per quadrant | $254.77 |
| D7321 | Alveoloplasty not in conjunction with extractions — one to three teeth or tooth spaces, per quadrant | $215.58 |
| D7340 | Vestibuloplasty — ridge extension (second epithelialization) | $1,411.06 |
| D7350 | Vestibuloplasty — ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) | $4,409.55 |
| D7410 | Excision of benign lesion up to 1.25 cm | $562.07 |
| D7411 | Excision of benign lesion greater than 1.25 cm | $960.30 |
| D7412 | Excision of benign lesion, complicated | $1,067.70 |
| D7413 | Excision of malignant lesion up to 1.25 cm | $725.13 |
| D7414 | Excision of malignant lesion greater than 1.25 cm | $1,077.89 |
| D7415 | Excision of malignant lesion, complicated | $1,156.28 |
| D7440 | Excision of malignant tumor — lesion diameter up to 1.25 cm | $992.44 |
| D7441 | Excision of malignant tumor — lesion diameter greater than 1.25 cm | $1,542.75 |

| Code | Description | Amount |
|---|---|---|
| D7450 | Removal of benign odontogenic cyst or tumor — lesion diameter up to 1.25 cm | $562.07 |
| D7451 | Removal of benign odontogenic cyst or tumor — lesion diameter greater than 1.25 cm | $882.69 |
| D7460 | Removal of benign nonodontogenic cyst or tumor — lesion diameter up to 1.25 cm | $562.07 |
| D7461 | Removal of benign nonodontogenic cyst or tumor — lesion diameter greater than 1.25 cm | $905.43 |
| D7465 | Destruction of lesion(s) by physical or chemical method, by report | $320.62 |
| D7471 | Removal of lateral exostosis (maxilla or mandible) | $582.45 |
| D7472 | Removal of torus palatinus | $692.20 |
| D7473 | Removal of torus mandibularis | $653.01 |
| D7485 | Surgical reduction of osseous tuberosity | $582.45 |
| D7490 | Radical resection of maxilla or mandible | $4,703.52 |
| D7510 | Incision and drainage of abscess — intraoral soft tissue | $168.54 |
| D7511 | Incision and drainage of abscess — intraoral soft tissue — complicated (includes drainage of multiple fascial spaces) | $254.77 |
| D7520 | Incision and drainage of abscess — extraoral soft tissue | $802.73 |
| D7521 | Incision and drainage of abscess — extraoral soft tissue — complicated (includes drainage of multiple fascial spaces) | $881.91 |
| D7530 | Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue | $289.27 |
| D7540 | Removal of reaction-producing foreign bodies, musculoskeletal system | $320.62 |
| D7550 | Partial ostectomy/sequestrectomy for removal of nonvital bone | $199.90 |
| D7560 | Maxillary sinusotomy for removal of tooth fragment or foreign body | $1,587.44 |
| D7610 | Maxilla — open reduction (teeth immobilized, if present) | $2,567.34 |
| D7620 | Maxilla — closed reduction (teeth immobilized, if present) | $1,925.31 |
| D7630 | Mandible — open reduction (teeth immobilized, if present) | $3,337.93 |
| D7640 | Mandible — closed reduction (teeth immobilized, if present) | $2,118.15 |
| D7650 | Malar and/or zygomatic arch — open reduction | $1,604.68 |
| D7660 | Malar and/or zygomatic arch — closed reduction | $946.19 |
| D7670 | Alveolus — closed reduction, may include stabilization of teeth | $738.45 |
| D7671 | Alveolus — open reduction, may include stabilization of teeth | $1,391.46 |
| D7680 | Facial bones — complicated reduction with fixation and multiple surgical approaches | $4,814.05 |
| D7710 | Maxilla — open reduction | $3,017.31 |
| D7720 | Maxilla — closed reduction | $2,118.15 |
| D7730 | Mandible — open reduction | $4,364.87 |
| D7740 | Mandible — closed reduction | $2,159.70 |
| D7750 | Malar and/or zygomatic arch — open reduction | $2,746.86 |
| D7760 | Malar and/or zygomatic arch — closed reduction | $1,102.19 |
| D7770 | Alveolus — open reduction stabilization of teeth | $1,493.37 |
| D7771 | Alveolus, closed reduction stabilization of teeth | $1,152.36 |
| D7780 | Facial bones — complicated reduction with fixation and multiple surgical approaches | $6,418.74 |
| D7810 | Open reduction of dislocation | $2,823.68 |
| D7820 | Closed reduction of dislocation | $462.51 |
| D7830 | Manipulation under anesthesia | $264.96 |
| D7840 | Condylectomy | $3,849.05 |
| D7850 | Surgical discectomy, with/without implant | $3,323.82 |
| D7852 | Disc repair | $3,805.93 |
| D7854 | Synovectomy | $3,927.44 |
| D7856 | Myotomy | $2,786.84 |
| D7858 | Joint reconstruction | $7,943.46 |
| D7860 | Arthrotomy | $3,385.75 |
| D7865 | Arthroplasty | $5,456.08 |
| D7870 | Arthrocentesis | $180.30 |

| Code | Description | Amount |
|---|---|---|
| D7871 | Nonarthroscopic lysis and lavage | $360.60 |
| D7872 | Arthroscopy — diagnosis, with or without biopsy | $1,924.52 |
| D7873 | Arthroscopy — surgical: lavage and lysis of adhesions | $2,317.27 |
| D7874 | Arthroscopy — surgical: disc repositioning and stabilization | $3,323.82 |
| D7875 | Arthroscopy — surgical: synovectomy | $3,641.31 |
| D7876 | Arthroscopy — surgical: discectomy | $3,925.87 |
| D7877 | Arthroscopy — surgical: debridement | $3,464.93 |
| D7880 | Occlusal orthotic device, by report | $432.72 |
| D7899 | Unspecified TMD therapy, by report | BR |
| D7910 | Suture of recent small wounds up to 5 cm | $257.13 |
| D7911 | Complicated suture — up to 5 cm | $642.03 |
| D7912 | Complicated suture — greater than 5 cm | $1,155.50 |
| D7920 | Skin graft (identify defect covered, location and type of graft) | $1,893.17 |
| D7940 | Osteoplasty — for orthognathic deformities | BR |
| D7941 | Osteotomy — mandibular rami | $4,821.11 |
| D7943 | Osteotomy — mandibular rami with bone graft; includes obtaining the graft | $4,429.15 |
| D7944 | Osteotomy—segmented or subapical | $3,947.04 |
| D7945 | Osteotomy — body of mandible | $5,252.26 |
| D7946 | LeFort I (maxilla — total) | $6,506.54 |
| D7947 | LeFort I (maxilla — segmented) | $5,471.76 |
| D7948 | LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) — without bone graft | $7,102.32 |
| D7949 | LeFort II or LeFort III — with bone graft | $9,250.26 |
| D7950 | Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla—autogenous or nonautogenous, by report | BR |
| D7951 | Sinus augmentation with bone or bone substitutes | BR |
| D7953 | Bone replacement graft for ridge preservation — per site | $97.99 |
| D7955 | Repair of maxillofacial soft and/or hard tissue defect | BR |
| D7960 | Frenulectomy (frenectomy or frenotomy) — separate procedure | $172.46 |
| D7963 | Frenuloplasty | $372.36 |
| D7970 | Excision of hyperplastic tissue — per arch | $344.92 |
| D7971 | Excision of pericoronal gingiva | $121.51 |
| D7972 | Surgical reduction of fibrous tuberosity | $439.00 |
| D7980 | Sialolithotomy | $493.87 |
| D7981 | Excision of salivary gland, by report | BR |
| D7982 | Sialodochoplasty | $1,168.04 |
| D7983 | Closure of salivary fistula | $1,121.01 |
| D7990 | Emergency tracheotomy | $964.22 |
| D7991 | Coronoidectomy | $2,351.76 |
| D7995 | Synthetic graft — mandible or facial bones, by report | BR |
| D7996 | Implant — mandible for augmentation purposes (excluding alveolar ridge), by report | BR |
| D7997 | Appliance removal (not by dentist who placed appliance), includes removal of archbar | $180.30 |
| D7998 | Intraoral placement of a fixation device not in conjunction with a fracture | $783.92 |
| D7999 | Unspecified oral surgery procedure, by report | BR |
| D8010 | Limited orthodontic treatment of the primary dentition | BR |
| D8020 | Limited orthodontic treatment of the transitional dentition | BR |
| D8030 | Limited orthodontic treatment of the adolescent dentition | BR |
| D8040 | Limited orthodontic treatment of the adult dentition | BR |
| D8050 | Interceptive orthodontic treatment of the primary dentition | BR |
| D8060 | Interceptive orthodontic treatment of the transitional dentition | BR |
| D8070 | Comprehensive orthodontic treatment of the transitional dentition | BR |

| Code | Description | Amount |
|---|---|---|
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition | BR |
| D8090 | Comprehensive orthodontic treatment of the adult dentition | BR |
| D8210 | Removable appliance therapy | BR |
| D8220 | Fixed appliance therapy | BR |
| D8660 | Preorthodontic treatment visit | BR |
| D8670 | Periodic orthodontic treatment visit (as part of contract) | BR |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of retainer(s)) | BR |
| D8690 | Orthodontic treatment (alternative billing to a contract fee) | BR |
| D8691 | Repair of orthodontic appliance | BR |
| D8692 | Replacement of lost or broken retainer | BR |
| D8693 | Rebonding or recementing; and/or repair, as required, of fixed retainers | BR |
| D8999 | Unspecified orthodontic procedure, by report | BR |
| D9110 | Palliative (emergency) treatment of dental pain — minor procedure | $46.67 |
| D9120 | Fixed partial denture sectioning | $52.73 |
| D9210 | Local anesthesia not in conjunction with operative or surgical procedures | $14.55 |
| D9211 | Regional block anesthesia | $21.21 |
| D9212 | Trigeminal division block anesthesia | $42.43 |
| D9215 | Local anesthesia | $14.55 |
| D9220 | Deep sedation/general anesthesia — first 30 minutes | $187.90 |
| D9221 | Deep sedation/general anesthesia — each additional 15 minutes | $78.80 |
| D9230 | Analgesia, anxiolysis, inhalation of nitrous oxide | $25.46 |
| D9241 | Intravenous conscious sedation/analgesia — first 30 minutes | $147.90 |
| D9242 | Intravenous conscious sedation/analgesia — each additional 15 minutes | $61.83 |
| D9248 | Nonintravenous conscious sedation | $31.52 |
| D9310 | Consultation—diagnostic service provided by dentist or physician other than requesting dentist or physician | $96.98 |
| D9410 | House/extended care facility call | $110.92 |
| D9420 | Hospital call | $179.42 |
| D9430 | Office visit for observation (during regularly scheduled hours) — no other services performed | $30.31 |
| D9440 | Office visit — after regularly scheduled hours | $60.61 |
| D9450 | Case presentation, detailed and extensive treatment planning | $30.31 |
| D9610 | Therapeutic parenteral drug, single administration | BR |
| D9612 | Therapeutic parenteral drugs, two or more administrations, different medications | BR |
| D9630 | Other drugs and/or medicaments, by report | BR |
| D9910 | Application of desensitizing medicament | $21.21 |
| D9911 | Application of desensitizing resin for cervical and/or root surface, per tooth | $33.34 |
| D9920 | Behavior management, by report | BR |
| D9930 | Treatment of complications (postsurgical) — unusual circumstances, by report | BR |
| D9940 | Occlusal guard, by report | $151.54 |
| D9941 | Fabrication of athletic mouthguard | $74.56 |
| D9942 | Repair and/or reline of occlusal guard | $66.68 |
| D9950 | Occlusion analysis — mounted case | $127.29 |
| D9951 | Occlusal adjustment — limited | $59.40 |
| D9952 | Occlusal adjustment — complete | $333.38 |
| D9970 | Enamel microabrasion | $23.03 |
| D9971 | Odontoplasty 1-2 teeth; includes removal of enamel projections | $32.13 |
| D9972 | External bleaching — per arch | $147.29 |
| D9973 | External bleaching — per tooth | $16.37 |
| D9974 | Internal bleaching — per tooth | $125.47 |
| D9999 | Unspecified adjunctive procedure, by report | BR |

# Durable Medical Equipment (DME), Orthotics, Prosthetics and Other HCPCS Codes

## I. Definition

HCPCS is an acronym for CMS's Healthcare Common Procedural Coding System. It is divided into two subsets. HCPCS Level I codes are CPT codes developed and maintained by the AMA. HCPCS Level II codes, with the exception of the dental codes (D0120–D9999), are developed and maintained by CMS and include codes for procedures, equipment, and supplies not found in the CPT book. This section of the Fee Schedule contains HCPCS Level II codes. (See the Dental section for dental codes.) HCPCS Level II codes that are excluded from the Fee Schedule are Physician Voluntary Reporting Program Codes (G8006–G9139), Alcohol/Drug Abuse Treatment Services (H0001–H2037), National Codes for State Medicaid Agencies (T1000–T5999). These three sections are not included because there is no fee associated with the code (G8006–G9139) or the code was created for State Medicaid agencies (H0001–H2307, T1000–T5999) and no fee data is available. Code categories included in this section are as follows:

| | |
|---|---|
| Transportation Services Including Ambulance | A0021–A0999 |
| Medical/Surgical Supplies | A4206–A8004 |
| Administrative, Misc., and Investigational | A9150–A9999 |
| Enteral/Parenteral Therapy | B4034–B9999 |
| Outpatient PPS | C1300–C9727 |
| Durable Medical Equipment (DME) | E0100–E8002 |
| Procedures/Professional Services (Temporary) | G0008–G9139 |
| Drugs and Biologicals | J0120–J9999 |
| K Codes (Temporary) | K0001–K0899 |
| Orthotic Procedures | L0112–L4398 |
| Prosthetic Procedures | L5000–L9900 |
| Medical Services | M0064–M0301 |
| Pathology and Laboratory Services | P2028–P9615 |
| Q Codes (Temporary) | Q0035–Q9964 |
| Diagnostic Radiology Services | R0070–R0076 |
| Temporary National Codes (Non-Medicare) | S0012–S9999 |
| Vision Services | V2020–V2799 |
| Hearing Services | V5008–V5364 |

## II. Guidelines

A. **Transportation Services Including Ambulance (A0021–A0999)**

1. Transportation service codes include ground and air ambulance, nonemergency transportation (taxi, bus, automobile, wheelchair van), and ancillary transportation-related fees.
2. Modifiers are required when reporting transportation services. Modifiers are single digits used to identify origin and destination. The first modifier identifies the transport place of origin and the second modifier the destination. Origin and destination modifiers are as follows:

**D** Diagnostic or therapeutic site other than those identified in "P" or "H"

**E** Residental, domicilary, custodial facility (nursing home, not skilled nursing facility)

**G** Hospital-based dialysis facility (hospital or hospital-related)

**H** Hospital

**I** Site of transfer (for example, airport or helicopter pad) between types of ambulance

**J** Non-hospital-based dialysis facility

**N** Skilled nursing facility (SNF)

**P** Physician's office (includes HMO non-hospital facility, clinic, etc.)

**R** Residence

**S** Scene of accident or acute event

**X** Intermediate stop at physician's office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.)

3. Transportation codes can also be found in the S and T codes. See S0207, S0208, S0209, S0215 and T2001–T2007.

B. **Medical and Surgical Supplies (A4206–A8004)**
   1. A wide variety of medical, surgical, and some DME related supplies and services are represented in this section.
   2. For rules related to DME supplies, accessories, maintenance, and repair, see G. Durable Medical Equipment below.

C. **Administrative, Miscellaneous, and Investigational (A9150–A9999)**
   1. These codes cover nonprescription drugs, exercise equipment, radiopharmaceutical diagnostic imaging agents, as well as other miscellaneous supplies.

D. **Enteral and Parenteral Therapy (B4034–B9999)**
   1. This section covers enteral formulae, enteral medical supplies, parenteral nutrition solutions and supplies, and enteral and parenteral pumps.

E. **Outpatient PPS (C1300–C9727)**
   1. These codes report drugs, biologicals, and devices used by hospitals.
   2. These codes are only used for facility (technical) services.

F. **Durable Medical Equipment (DME) (E0100–E8002)**
   1. All durable medical equipment shall have prior authorization from the payer before obtaining the equipment. The payer has the choice of vendor for purchase or rental of DME.
   2. If an injured/ill employee is receiving DME items for both compensable and non-compensable medical conditions, only those items that apply to the work related injury should be listed on claims and invoices submitted to the employer.
   3. If the rental price for DME exceeds or equals the total purchase price, the employer shall purchase instead of renting equipment. The vendor shall make the payer aware of the price options.
   4. The return of rented equipment is the dual responsibility of the injured worker and the DME supplier. The employer is not responsible for additional rental periods solely due to delay in equipment return.

G. **Procedures/Professional Services (Temporary) (G0008–G3001)**
   1. G codes identify professional health care procedures and services that would otherwise be reported using CPT codes.
   2. Procedures and professional services identified by G codes may have a corresponding CPT code. When both a G code and CPT code describe the same procedure, the CPT code is required for reporting purposes.
   3. G codes also include procedures and professional services that do not currently have a valid CPT code. In such cases, the applicable G code should be used for reporting purposes.

H. **Drugs and Biologicals (J0120–J9999)**
   1. These codes report drugs and biologicals that cannot be self administered and are typically administered by injection, infusion, or inhalation. Exceptions include oral immuosuppressive and oral chemotherapy drugs.
   2. These codes report only the costs associated with provision of the drug. Administration including injection, infusion, or inhalation is reported separately using the applicable CPT code(s).
   3. For oral anti-emetic drugs provided in conjunction with chemotherapy treatment, see Q0163–Q0181.
   4. Additional codes for drugs and biologicals may be found in the Q codes and S codes.

I. **Temporary Codes (K0001–K0899)**
   1. These codes are temporary codes used to report durable medical equipment that does not yet have a permanent national code.
   2. For rules related to DME supplies, accessories, maintenance, and repair, see G. Durable Medical Equipment above.

J. **Orthotic Procedures and Devices (L0112–L4398) and Prosthetic Procedures (L5000–L9900)**
   The payer shall only pay for orthotics and prosthetics prescribed by the treating physician for a compensable injury/illness. Prior authorization must be obtained from the payer.

K. **Medical Services (M0064–M0301)**
   1. These codes are used to report office services, cellular therapy, prolotherapy, intragastric

hypothermia, IV Chelation therapy, and fabric wrapping of an abdominal aneurysm.

2. These codes are rarely reported and may not be reimbursed as they represent services for which the therapeutic efficacy has not been established, the procedure is considered experimental, or the procedure has been replaced with a more effective treatment modality.

L. **Pathology and Laboratory Services (P2028–P9615)**
1. Included in this section are codes for chemistry and toxicology tests, pathology screening tests, microbiology tests, blood, and blood products.
2. Blood and blood product codes report the supply of the blood or blood product only.
3. The administration of blood or blood product is reported separately.
4. Code 36430 for transfusion of blood or blood components is reported only once per encounter regardless of the number of units provided.

M. **Temporary Codes (Q0035–Q9964)**
1. These temporary codes were developed for reporting services and supplies that do not have a permanent national HCPCS code or CPT code. Included in this section are codes for:
   a. Oral anti-emetic drugs
   b. Casting supplies
   c. Splint supplies
   d. Low osmolar contrast
   e. High osmolar contrast
   f. Other supplies/services
2. Cast supplies and splints should be reported with the appropriate code from Q4001–Q4051. These codes report the cost of the supply only.
3. Cast supplies and splints are reported in addition to the CPT code for fracture management.
4. Cast supplies and splints are reported in addition to CPT codes for application of the cast or splint.
5. Refer to the CPT guidelines for rules related to reporting fracture management and cast application.

N. **Diagnostic Radiology Services (R0070–R0076)**
1. These codes are used for transportation of portable x-ray and/or EKG equipment.
2. Only a single reasonable transportion charge is allowed for each trip to a single location.
3. When more than one patient receives x-ray or EKG services at the same location, the allowable transport charge is divided among all patients.

O. **Temporary National Codes (Non-Medicare) (S0012–S9999)**
1. These codes were developed by the Blue Cross/Blue Shield Association (BCBSA) and the Health Insurance Association of America (HIAA) to report drugs, services, and supplies for which there are no CPT or HCPCS Level II codes, but for which codes are needed by the private sector to implement policies, program, or claims processing.
2. See J codes for reporting rules related to drugs and biologicals.
3. For the purposes of pain management, if the drugs used in the refill of the pain pump must be compounded, report the compounding service with code S9430 Pharmacy compounding and dispensing services. The compounding service shall be reimbursed at $157.44 per individual refill. For purposes other than pain management, S9430 shall be reimbursed by report (BR).

P. **Vision, Hearing, and Speech-Language Pathology Services (V2020–V5364)**
1. Vision services includes codes for reporting vision-related supplies, including spectacles, lenses, contact lenses, prostheses, intraocular lenses, and miscellaneous lenses.
2. Hearing services includes codes for hearing tests and related supplies and equipment, speech-language pathology screenings, and repair of augmentative communicative systems.

## III. Modifiers

HCPCS Level II modifiers are required for some supplies and services. Commonly reported HCPCS Level II modifiers include:

| | |
|---|---|
| AU | Item furnished in conjunction with a urological, ostomy, or tracheostomy supply |
| AV | Item funished in conjunction with a prosthetic device, prosthetic, or orthotic |
| AW | Item furnished in conjunction with a surgical dressing |
| KC | Replacement of special power wheelchair interface |
| NU | Purchased new equipment |
| RR | Rental equipment (listed amount is the per-month allowance) |
| UE | Purchased used equipment |

| Code | Mod | Description | Amount |
|---|---|---|---|
| A0021 | | Ambulance service, outside state per mile, transport (Medicaid only) | $11.15 |
| A0080 | | Nonemergency transportation, per mile — vehicle provided by volunteer (individual or organization), with no vested interest | BR |
| A0090 | | Nonemergency transportation, per mile — vehicle provided by individual (family member, self, neighbor) with vested interest | BR |
| A0100 | | Nonemergency transportation; taxi | BR |
| A0110 | | Nonemergency transportation and bus, intra- or interstate carrier | BR |
| A0120 | | Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems | BR |
| A0130 | | Nonemergency transportation: wheelchair van | BR |
| A0140 | | Nonemergency transportation and air travel (private or commercial), intra- or interstate | BR |
| A0160 | | Nonemergency transportation: per mile — caseworker or social worker | $0.37 |
| A0170 | | Transportation ancillary: parking fees, tolls, other | BR |
| A0180 | | Nonemergency transportation: ancillary: lodging — recipient | BR |
| A0190 | | Nonemergency transportation: ancillary: meals — recipient | BR |
| A0200 | | Nonemergency transportation: ancillary: lodging — escort | BR |
| A0210 | | Nonemergency transportation: ancillary: meals — escort | BR |
| A0225 | | Ambulance service, neonatal transport, base rate, emergency transport, one way | $641.20 |
| A0380 | | BLS mileage (per mile) | $9.30 |
| A0382 | | BLS routine disposable supplies | $15.75 |
| A0384 | | BLS specialized service disposable supplies; defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances) | $78.75 |
| A0390 | | ALS mileage (per mile) | $9.30 |
| A0392 | | ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed by BLS ambulances) | $78.75 |
| A0394 | | ALS specialized service disposable supplies; IV drug therapy | $37.80 |
| A0396 | | ALS specialized service disposable supplies; esophageal intubation | $63.00 |
| A0398 | | ALS routine disposable supplies | $15.75 |
| A0420 | | Ambulance waiting time (ALS or BLS), one-half (1/2) hour increments | BR |
| A0422 | | Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation | $58.28 |
| A0424 | | Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review) | BR |
| A0425 | | Ground mileage, per statute mile | $9.30 |
| A0426 | | Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1) | $486.51 |
| A0427 | | Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 — emergency) | $511.36 |
| A0428 | | Ambulance service, basic life support, nonemergency transport (BLS) | $428.00 |
| A0429 | | Ambulance service, basic life support, emergency transport (BLS — emergency) | $444.03 |
| A0430 | | Ambulance service, conventional air services, transport, one way (fixed wing) | BR |
| A0431 | | Ambulance service, conventional air services, transport, one way (rotary wing) | BR |
| A0432 | | Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third-party payers | BR |
| A0433 | | Advanced life support, level 2 (ALS 2) | BR |
| A0434 | | Specialty care transport (SCT) | BR |
| A0435 | | Fixed wing air mileage, per statute mile | BR |
| A0436 | | Rotary wing air mileage, per statute mile | BR |
| A0888 | | Noncovered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility) | BR |
| A0998 | | Ambulance response and treatment, no transport | BR |
| A0999 | | Unlisted ambulance service | BR |
| A4206 | | Syringe with needle, sterile 1 cc, each | $0.22 |
| A4207 | | Syringe with needle, sterile 2 cc, each | BR |
| A4208 | | Syringe with needle, sterile 3 cc, each | $0.20 |
| A4209 | | Syringe with needle, sterile 5 cc or greater, each | $0.32 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| A4210 | | Needle-free injection device, each | $1,037.85 |
| A4211 | | Supplies for self-administered injections | BR |
| A4212 | | Noncoring needle or stylet with or without catheter | $10.09 |
| A4213 | | Syringe, sterile, 20 cc or greater, each | $1.07 |
| A4215 | | Needle, sterile, any size, each | BR |
| A4216 | | Sterile water, saline and/or dextrose, diluent/flush, 10 ml | $0.46 |
| A4217 | | Sterile water/saline, 500 ml | $3.25 |
| A4218 | | Sterile saline or water, metered dose dispenser, 10 ml | BR |
| A4220 | | Refill kit for implantable infusion pump | BR |
| A4221 | | Supplies for maintenance of drug infusion catheter, per week (list drug separately) | $23.49 |
| A4222 | | Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately) | $48.50 |
| A4223 | | Infusion supplies not used with external infusion pump, per cassette or bag (list drugs separately) | BR |
| A4230 | | Infusion set for external insulin pump, nonneedle cannula type | BR |
| A4231 | | Infusion set for external insulin pump, needle type | BR |
| A4232 | | Syringe with needle for external insulin pump, sterile, 3 cc | BR |
| A4233 | NU | Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each | BR |
| A4233 | RR | Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each | BR |
| A4233 | UE | Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each | BR |
| A4234 | NU | Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each | BR |
| A4234 | RR | Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each | BR |
| A4234 | UE | Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each | BR |
| A4235 | NU | Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each | BR |
| A4235 | RR | Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each | BR |
| A4235 | UE | Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each | BR |
| A4236 | NU | Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each | BR |
| A4236 | RR | Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each | BR |
| A4236 | UE | Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each | BR |
| A4244 | | Alcohol or peroxide, per pint | $1.10 |
| A4245 | | Alcohol wipes, per box | $3.37 |
| A4246 | | Betadine or PhisoHex solution, per pint | $3.72 |
| A4247 | | Betadine or iodine swabs/wipes, per box | $5.68 |
| A4248 | | Chlorhexidine containing antiseptic, 1 ml | BR |
| A4250 | | Urine test or reagent strips or tablets (100 tablets or strips) | $21.00 |
| A4253 | | Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips | $39.98 |
| A4255 | | Platforms for home blood glucose monitor, 50 per box | $4.26 |
| A4256 | | Normal, low, and high calibrator solution/chips | $11.87 |
| A4257 | | Replacement lens shield cartridge for use with laser skin piercing device, each | $13.24 |
| A4258 | | Spring-powered device for lancet, each | $18.73 |
| A4259 | | Lancets, per box of 100 | $13.22 |
| A4261 | | Cervical cap for contraceptive use | BR |
| A4262 | | Temporary, absorbable lacrimal duct implant, each | $0.61 |
| A4263 | | Permanent, long-term, nondissolvable lacrimal duct implant, each | $48.02 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| A4265 | | Paraffin, per lb. | $3.52 |
| A4266 | | Diaphragm for contraceptive use | BR |
| A4267 | | Contraceptive supply, condom, male, each | $0.39 |
| A4268 | | Contraceptive supply, condom, female, each | BR |
| A4269 | | Contraceptive supply, spermicide (e.g., foam, gel), each | $1.22 |
| A4270 | | Disposable endoscope sheath, each | BR |
| A4280 | | Adhesive skin support attachment for use with external breast prosthesis, each | $5.45 |
| A4281 | | Tubing for breast pump, replacement | BR |
| A4282 | | Adapter for breast pump, replacement | BR |
| A4283 | | Cap for breast pump bottle, replacement | BR |
| A4284 | | Breast shield and splash protector for use with breast pump, replacement | $21.34 |
| A4285 | | Polycarbonate bottle for use with breast pump, replacement | BR |
| A4286 | | Locking ring for breast pump, replacement | BR |
| A4290 | | Sacral nerve stimulation test lead, each | BR |
| A4300 | | Implantable access catheter, (e.g., venous, arterial, epidural subarachnoid, or peritoneal, etc.) external access | BR |
| A4301 | | Implantable access total catheter, port/reservoir (e.g., venous, arterial, epidural, subarachnoid, peritoneal, etc.) | BR |
| A4305 | | Disposable drug delivery system, flow rate of 50 ml or greater per hour | $15.81 |
| A4306 | | Disposable drug delivery system, flow rate of less than 50 ml per hour | $21.68 |
| A4310 | | Insertion tray without drainage bag and without catheter (accessories only) | $8.01 |
| A4311 | | Insertion tray without drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.) | $15.40 |
| A4312 | | Insertion tray without drainage bag with indwelling catheter, Foley type, two-way, all silicone | $18.72 |
| A4313 | | Insertion tray without drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation | $19.22 |
| A4314 | | Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.) | $26.25 |
| A4315 | | Insertion tray with drainage bag with indwelling catheter, Foley type, two-way, all silicone | $27.39 |
| A4316 | | Insertion tray with drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation | $29.47 |
| A4320 | | Irrigation tray with bulb or piston syringe, any purpose | $5.53 |
| A4321 | | Therapeutic agent for urinary catheter irrigation | BR |
| A4322 | | Irrigation syringe, bulb or piston, each | $3.15 |
| A4326 | | Male external catheter with integral collection chamber, any type, each | $11.20 |
| A4327 | | Female external urinary collection device; metal cup, each | $46.31 |
| A4328 | | Female external urinary collection device; pouch, each | $10.84 |
| A4330 | | Perianal fecal collection pouch with adhesive, each | $7.42 |
| A4331 | | Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each | $3.30 |
| A4332 | | Lubricant, individual sterile packet, each | $0.12 |
| A4333 | | Urinary catheter anchoring device, adhesive skin attachment, each | $2.28 |
| A4334 | | Urinary catheter anchoring device, leg strap, each | $5.12 |
| A4335 | | Incontinence supply; miscellaneous | BR |
| A4338 | | Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each | $12.72 |
| A4340 | | Indwelling catheter; specialty type, (e.g., Coude, mushroom, wing, etc.), each | $32.95 |
| A4344 | | Indwelling catheter, Foley type, two-way, all silicone, each | $16.63 |
| A4346 | | Indwelling catheter; Foley type, three-way for continuous irrigation, each | $20.33 |
| A4349 | | Male external catheter, with or without adhesive, disposable, each | BR |
| A4351 | | Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each | $1.88 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| A4352 | | Intermittent urinary catheter; Coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each | $6.67 |
| A4353 | | Intermittent urinary catheter, with insertion supplies | $7.26 |
| A4354 | | Insertion tray with drainage bag but without catheter | $12.25 |
| A4355 | | Irrigation tubing set for continuous bladder irrigation through a three-way indwelling Foley catheter, each | $9.24 |
| A4356 | | External urethral clamp or compression device (not to be used for catheter clamp), each | $47.36 |
| A4357 | | Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each | $10.07 |
| A4358 | | Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each | $6.89 |
| A4361 | | Ostomy faceplate, each | $19.06 |
| A4362 | | Skin barrier; solid, four by four or equivalent; each | $3.59 |
| A4363 | | Ostomy clamp, any type, replacement only, each | BR |
| A4364 | | Adhesive, liquid, or equal, any type, per oz. | $3.04 |
| A4365 | | Adhesive remover wipes, any type, per 50 | $11.75 |
| A4366 | | Ostomy vent, any type, each | $1.36 |
| A4367 | | Ostomy belt, each | $7.63 |
| A4368 | | Ostomy filter, any type, each | $0.27 |
| A4369 | | Ostomy skin barrier, liquid (spray, brush, etc.), per oz. | $2.52 |
| A4371 | | Ostomy skin barrier, powder, per oz. | $3.79 |
| A4372 | | Ostomy skin barrier, solid 4x4 or equivalent, standard wear, with built-in convexity, each | $4.33 |
| A4373 | | Ostomy skin barrier, with flange (solid, flexible or accordion), with built-in convexity, any size, each | $6.52 |
| A4375 | | Ostomy pouch, drainable, with faceplate attached, plastic, each | $17.83 |
| A4376 | | Ostomy pouch, drainable, with faceplate attached, rubber, each | $49.38 |
| A4377 | | Ostomy pouch, drainable, for use on faceplate, plastic, each | $4.46 |
| A4378 | | Ostomy pouch, drainable, for use on faceplate, rubber, each | $31.92 |
| A4379 | | Ostomy pouch, urinary, with faceplate attached, plastic, each | $15.59 |
| A4380 | | Ostomy pouch, urinary, with faceplate attached, rubber, each | $38.74 |
| A4381 | | Ostomy pouch, urinary, for use on faceplate, plastic, each | $4.79 |
| A4382 | | Ostomy pouch, urinary, for use on faceplate, heavy plastic, each | $25.56 |
| A4383 | | Ostomy pouch, urinary, for use on faceplate, rubber, each | $29.26 |
| A4384 | | Ostomy faceplate equivalent, silicone ring, each | $9.99 |
| A4385 | | Ostomy skin barrier, solid 4 x 4 or equivalent, extended wear, without built-in convexity, each | $5.30 |
| A4387 | | Ostomy pouch, closed, with barrier attached, with built-in convexity (one piece), each | BR |
| A4388 | | Ostomy pouch, drainable, with extended wear barrier attached, (one piece), each | $4.53 |
| A4389 | | Ostomy pouch, drainable, with barrier attached, with built-in convexity (one piece), each | $6.46 |
| A4390 | | Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each | $9.98 |
| A4391 | | Ostomy pouch, urinary, with extended wear barrier attached (1 piece), each | $7.34 |
| A4392 | | Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each | $8.49 |
| A4393 | | Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each | $9.38 |
| A4394 | | Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fluid ounce | $2.67 |
| A4395 | | Ostomy deodorant for use in ostomy pouch, solid, per tablet | $0.05 |
| A4396 | | Ostomy belt with peristomal hernia support | $42.01 |
| A4397 | | Irrigation supply; sleeve, each | $4.97 |
| A4398 | | Ostomy irrigation supply; bag, each | $14.33 |
| A4399 | | Ostomy irrigation supply; cone/catheter, including brush | $12.72 |
| A4400 | | Ostomy irrigation set | $50.72 |
| A4402 | | Lubricant, per oz. | $1.66 |
| A4404 | | Ostomy ring, each | $1.76 |
| A4405 | | Ostomy skin barrier, nonpectin-based, paste, per oz. | $3.53 |
| A4406 | | Ostomy skin barrier, pectin-based, paste, per oz. | $5.96 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| A4407 | | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 in. or smaller, each | $9.10 |
| A4408 | | Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, larger than 4 x 4 in., each | $10.24 |
| A4409 | | Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 in. or smaller, each | $6.46 |
| A4410 | | Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 x 4 in., each | $9.38 |
| A4411 | | Ostomy skin barrier, solid 4x4 or equivalent, extended wear, with built-in convexity, each | BR |
| A4412 | | Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), without filter, each | BR |
| A4413 | | Ostomy pouch, drainable, high output, for use on a barrier with flange (two piece system), with filter, each | $5.71 |
| A4414 | | Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 in. or smaller, each | $5.12 |
| A4415 | | Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4 x 4 in., each | $6.23 |
| A4416 | | Ostomy pouch, closed, with barrier attached, with filter (one piece), each | $2.86 |
| A4417 | | Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (one piece), each | $3.86 |
| A4418 | | Ostomy pouch, closed; without barrier attached, with filter (one piece), each | $1.88 |
| A4419 | | Ostomy pouch, closed; for use on barrier with nonlocking flange, with filter (two piece), each | $1.81 |
| A4420 | | Ostomy pouch, closed; for use on barrier with locking flange (two piece), each | BR |
| A4421 | | Ostomy supply; miscellaneous | BR |
| A4422 | | Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each | $0.12 |
| A4423 | | Ostomy pouch, closed; for use on barrier with locking flange, with filter (two piece), each | $1.93 |
| A4424 | | Ostomy pouch, drainable, with barrier attached, with filter (one piece), each | $4.93 |
| A4425 | | Ostomy pouch, drainable; for use on barrier with nonlocking flange, with filter (two piece system), each | $3.71 |
| A4426 | | Ostomy pouch, drainable; for use on barrier with locking flange (two piece system), each | $2.83 |
| A4427 | | Ostomy pouch, drainable; for use on barrier with locking flange, with filter (two piece system), each | $2.88 |
| A4428 | | Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (one piece), each | $6.75 |
| A4429 | | Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (one piece), each | $8.56 |
| A4430 | | Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (one piece), each | $8.84 |
| A4431 | | Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (one piece), each | $6.46 |
| A4432 | | Ostomy pouch, urinary; for use on barrier with nonlocking flange, with faucet-type tap with valve (two piece), each | $3.72 |
| A4433 | | Ostomy pouch, urinary; for use on barrier with locking flange (two piece), each | $3.47 |
| A4434 | | Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type tap with valve (two piece), each | $3.91 |
| A4450 | | Tape, nonwaterproof, per 18 sq. in. | $0.10 |
| A4452 | | Tape, waterproof, per 18 sq. in. | $0.38 |
| A4455 | | Adhesive remover or solvent (for tape, cement or other adhesive), per oz. | $1.49 |
| A4458 | | Enema bag with tubing, reusable | BR |
| A4461 | | Surgical dressing holder, nonreusable, each | BR |
| A4463 | | Surgical dressing holder, reusable, each | BR |
| A4465 | | Nonelastic binder for extremity | $11.10 |
| A4470 | | Gravlee jet washer | $7.57 |
| A4480 | | VABRA aspirator | $6.06 |
| A4481 | | Tracheostoma filter, any type, any size, each | $0.39 |
| A4483 | | Moisture exchanger, disposable, for use with invasive mechanical ventilation | BR |
| A4490 | | Surgical stocking above knee length, each | $8.11 |
| A4495 | | Surgical stocking thigh length, each | $8.11 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| A4500 | | Surgical stocking below knee length, each | $6.04 |
| A4510 | | Surgical stocking full-length, each | $14.65 |
| A4520 | | Incontinence garment, any type, (e.g., brief, diaper), each | BR |
| A4550 | | Surgical trays | $35.41 |
| A4554 | | Disposable underpads, all sizes (e.g., Chux's) | $3.66 |
| A4556 | | Electrodes (e.g., apnea monitor), per pair | $12.60 |
| A4557 | | Lead wires (e.g., apnea monitor), per pair | $21.90 |
| A4558 | | Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per oz. | $5.65 |
| A4559 | | Coupling gel or paste, for use with ultrasound device, per ounce | BR |
| A4561 | | Pessary, rubber, any type | $20.83 |
| A4562 | | Pessary, nonrubber, any type | $51.83 |
| A4565 | | Slings | $8.55 |
| A4570 | | Splint | $20.76 |
| A4575 | | Topical hyperbaric oxygen chamber, disposable | BR |
| A4580 | | Cast supplies (e.g., plaster) | BR |
| A4590 | | Special casting material (e.g., fiberglass) | $46.70 |
| A4595 | | Electrical stimulator supplies, 2 lead, per month, (e.g. TENS, NMES) | $29.90 |
| A4600 | | Sleeve for intermittent limb compression device, replacement only, each | BR |
| A4601 | | Lithium ion battery for nonprosthetic use, replacement | BR |
| A4604 | NU | Tubing with integrated heating element for use with positive airway pressure device | BR |
| A4604 | RR | Tubing with integrated heating element for use with positive airway pressure device | BR |
| A4604 | UE | Tubing with integrated heating element for use with positive airway pressure device | BR |
| A4605 | | Tracheal suction catheter, closed system, each | BR |
| A4606 | | Oxygen probe for use with oximeter device, replacement | BR |
| A4608 | | Transtracheal oxygen catheter, each | $60.35 |
| A4611 | NU | Battery, heavy duty; replacement for patient-owned ventilator | $203.88 |
| A4611 | RR | Battery, heavy duty; replacement for patient-owned ventilator | $21.14 |
| A4611 | UE | Battery, heavy duty; replacement for patient-owned ventilator | $152.92 |
| A4612 | NU | Battery cables; replacement for patient-owned ventilator | $82.95 |
| A4612 | RR | Battery cables; replacement for patient-owned ventilator | $8.45 |
| A4612 | UE | Battery cables; replacement for patient-owned ventilator | $63.26 |
| A4613 | NU | Battery charger; replacement for patient-owned ventilator | $149.67 |
| A4613 | RR | Battery charger; replacement for patient-owned ventilator | $14.98 |
| A4613 | UE | Battery charger; replacement for patient-owned ventilator | $108.24 |
| A4614 | | Peak expiratory flow rate meter, hand held | $24.68 |
| A4615 | | Cannula, nasal | $1.83 |
| A4616 | | Tubing (oxygen), per foot | $0.76 |
| A4617 | | Mouthpiece | $9.77 |
| A4618 | NU | Breathing circuits | $9.23 |
| A4618 | RR | Breathing circuits | $1.06 |
| A4618 | UE | Breathing circuits | $6.92 |
| A4619 | | Face tent | $1.26 |
| A4620 | | Variable concentration mask | $3.39 |
| A4623 | | Tracheostomy, inner cannula | $6.80 |
| A4624 | | Tracheal suction catheter, any type other than closed system, each | $2.74 |
| A4625 | | Tracheostomy care kit for new tracheostomy | $7.19 |
| A4626 | | Tracheostomy cleaning brush, each | $3.31 |
| A4627 | | Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler | $20.18 |
| A4628 | | Oropharyngeal suction catheter, each | $3.88 |
| A4629 | | Tracheostomy care kit for established tracheostomy | $4.81 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| A4630 | | Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient | $6.48 |
| A4633 | | Replacement bulb/lamp for ultraviolet light therapy system, each | $42.59 |
| A4634 | | Replacement bulb for therapeutic light box, tabletop model | BR |
| A4635 | NU | Underarm pad, crutch, replacement, each | $5.31 |
| A4635 | RR | Underarm pad, crutch, replacement, each | $0.72 |
| A4635 | UE | Underarm pad, crutch, replacement, each | $3.52 |
| A4636 | NU | Replacement, handgrip, cane, crutch, or walker, each | $4.37 |
| A4636 | RR | Replacement, handgrip, cane, crutch, or walker, each | $0.45 |
| A4636 | UE | Replacement, handgrip, cane, crutch, or walker, each | $3.19 |
| A4637 | NU | Replacement, tip, cane, crutch, walker, each | $2.21 |
| A4637 | RR | Replacement, tip, cane, crutch, walker, each | $0.32 |
| A4637 | UE | Replacement, tip, cane, crutch, walker, each | $1.67 |
| A4638 | NU | Replacement battery for patient-owned ear pulse generator, each | BR |
| A4638 | RR | Replacement battery for patient-owned ear pulse generator, each | BR |
| A4638 | UE | Replacement battery for patient-owned ear pulse generator, each | BR |
| A4639 | | Replacement pad for infrared heating pad system, each | $298.08 |
| A4640 | NU | Replacement pad for use with medically necessary alternating pressure pad owned by patient | $65.71 |
| A4640 | RR | Replacement pad for use with medically necessary alternating pressure pad owned by patient | $6.69 |
| A4640 | UE | Replacement pad for use with medically necessary alternating pressure pad owned by patient | $46.56 |
| A4641 | | Radiopharmaceutical, diagnostic, not otherwise classified | BR |
| A4642 | | Indium In-111 satumomab pendetide, diagnostic, per study dose, up to 6 millicuries | BR |
| A4649 | | Surgical supply; miscellaneous | BR |
| A4651 | | Calibrated microcapillary tube, each | BR |
| A4652 | | Microcapillary tube sealant | BR |
| A4653 | | Peritoneal dialysis catheter anchoring device, belt, each | BR |
| A4657 | | Syringe, with or without needle, each | BR |
| A4660 | | Sphygmomanometer/blood pressure apparatus with cuff and stethoscope | $15.93 |
| A4663 | | Blood pressure cuff only | $30.53 |
| A4670 | | Automatic blood pressure monitor | $78.14 |
| A4671 | | Disposable cycler set used with cycler dialysis machine, each | BR |
| A4672 | | Drainage extension line, sterile, for dialysis, each | BR |
| A4673 | | Extension line with easy lock connectors, used with dialysis | BR |
| A4674 | | Chemicals/antiseptics solution used to clean/sterilize dialysis equipment, per 8 oz. | BR |
| A4680 | | Activated carbon filter for hemodialysis, each | $79.37 |
| A4690 | | Dialyzer (artificial kidneys), all types, all sizes, for hemodialysis, each | $786.97 |
| A4706 | | Bicarbonate concentrate, solution, for hemodialysis, per gallon | BR |
| A4707 | | Bicarbonate concentrate, powder, for hemodialysis, per packet | BR |
| A4708 | | Acetate concentrate solution, for hemodialysis, per gallon | BR |
| A4709 | | Acid concentrate, solution, for hemodialysis, per gallon | BR |
| A4714 | | Treated water (deionized, distilled, or reverse osmosis) for peritoneal dialysis, per gallon | BR |
| A4719 | | Y set tubing for peritoneal dialysis | BR |
| A4720 | | Dialysate solution, any concentration of dextrose, fluid volume greater than 249 cc, but less than or equal to 999 cc, for peritoneal dialysis | BR |
| A4721 | | Dialysate solution, any concentration of dextrose, fluid volume greater than 999 cc, but less than or equal to 1999 cc, for peritoneal dialysis | BR |
| A4722 | | Dialysate solution, any concentration of dextrose, fluid volume greater than 1999 cc, but less than or equal to 2999 cc, for peritoneal dialysis | BR |
| A4723 | | Dialysate solution, any concentration of dextrose, fluid volume greater than 2999 cc, but less than or equal to 3999 cc, for peritoneal dialysis | BR |
| A4724 | | Dialysate solution, any concentration of dextrose, fluid volume greater than 3999 cc, but less than or equal to 4999 cc, for peritoneal dialysis | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| A4725 | | Dialysate solution, any concentration of dextrose, fluid volume greater than 4999 cc, but less than or equal to 5999 cc, for peritoneal dialysis | BR |
| A4726 | | Dialysate solution, any concentration of dextrose, fluid volume greater than 5999 cc | BR |
| A4728 | | Dialysate solution, nondextrose containing, 500 ml | BR |
| A4730 | | Fistula cannulation set for hemodialysis, each | BR |
| A4736 | | Topical anesthetic, for dialysis, per gm | BR |
| A4737 | | Injectable anesthetic, for dialysis, per 10 ml | BR |
| A4740 | | Shunt accessory, for hemodialysis, any type, each | BR |
| A4750 | | Blood tubing, arterial or venous, for hemodialysis, each | $15.14 |
| A4755 | | Blood tubing, arterial and venous combined, for hemodialysis, each | BR |
| A4760 | | Dialysate solution test kit, for peritoneal dialysis, any type, each | BR |
| A4765 | | Dialysate concentrate, powder, additive for peritoneal dialysis, per packet | BR |
| A4766 | | Dialysate concentrate, solution, additive for peritoneal dialysis, per 10 ml | BR |
| A4770 | | Blood collection tube, vacuum, for dialysis, per 50 | BR |
| A4771 | | Serum clotting time tube, for dialysis, per 50 | BR |
| A4772 | | Blood glucose test strips, for dialysis, per 50 | $31.75 |
| A4773 | | Occult blood test strips, for dialysis, per 50 | $20.13 |
| A4774 | | Ammonia test strips, for dialysis, per 50 | BR |
| A4802 | | Protamine sulfate, for hemodialysis, per 50 mg | $5.73 |
| A4860 | | Disposable catheter tips for peritoneal dialysis, per 10 | BR |
| A4870 | | Plumbing and/or electrical work for home hemodialysis equipment | BR |
| A4890 | | Contracts, repair and maintenance, for hemodialysis equipment | BR |
| A4911 | | Drain bag/bottle, for dialysis, each | BR |
| A4913 | | Miscellaneous dialysis supplies, not otherwise specified | BR |
| A4918 | | Venous pressure clamp, for hemodialysis, each | BR |
| A4927 | | Gloves, nonsterile, per 100 | $4.88 |
| A4928 | | Surgical mask, per 20 | BR |
| A4929 | | Tourniquet for dialysis, each | $0.17 |
| A4930 | | Gloves, sterile, per pair | $1.03 |
| A4931 | | Oral thermometer, reusable, any type, each | BR |
| A4932 | | Rectal thermometer, reusable, any type, each | BR |
| A5051 | | Ostomy pouch, closed; with barrier attached (one piece), each | $2.15 |
| A5052 | | Ostomy pouch, closed; without barrier attached (one piece), each | $1.55 |
| A5053 | | Ostomy pouch, closed; for use on faceplate, each | $1.81 |
| A5054 | | Ostomy pouch, closed; for use on barrier with flange (two piece), each | $1.86 |
| A5055 | | Stoma cap | $1.49 |
| A5061 | | Ostomy pouch, drainable; with barrier attached, (one piece), each | $3.65 |
| A5062 | | Ostomy pouch, drainable; without barrier attached (one piece), each | $2.31 |
| A5063 | | Ostomy pouch, drainable; for use on barrier with flange (two piece system), each | $2.81 |
| A5071 | | Ostomy pouch, urinary; with barrier attached (one piece), each | $6.24 |
| A5072 | | Ostomy pouch, urinary; without barrier attached (one piece), each | $3.65 |
| A5073 | | Ostomy pouch, urinary; for use on barrier with flange (two piece), each | $3.30 |
| A5081 | | Continent device; plug for continent stoma | $3.43 |
| A5082 | | Continent device; catheter for continent stoma | $12.34 |
| A5093 | | Ostomy accessory; convex insert | $2.03 |
| A5102 | | Bedside drainage bottle, with or without tubing, rigid or expandable, each | $23.43 |
| A5105 | | Urinary suspensory; with or without leg bag, with or without tube, each | $42.31 |
| A5112 | | Urinary leg bag; latex | $35.93 |
| A5113 | | Leg strap; latex, replacement only, per set | $4.88 |
| A5114 | | Leg strap; foam or fabric, replacement only, per set | $9.28 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| A5120 | | Skin barrier, wipes or swabs, each | BR |
| A5121 | | Skin barrier; solid, 6 x 6 or equivalent, each | $7.74 |
| A5122 | | Skin barrier; solid, 8 x 8 or equivalent, each | $13.33 |
| A5126 | | Adhesive or nonadhesive; disk or foam pad | $1.37 |
| A5131 | | Appliance cleaner, incontinence and ostomy appliances, per 16 oz. | $16.46 |
| A5200 | | Percutaneous catheter/tube anchoring device, adhesive skin attachment | $11.73 |
| A5500 | | For diabetics only, fitting (including follow-up) custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe | $65.23 |
| A5501 | | For diabetics only, fitting (including follow-up) custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe | $195.65 |
| A5503 | | For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with roller or rigid rocker bottom, per shoe | $29.01 |
| A5504 | | For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with wedge(s), per shoe | $29.01 |
| A5505 | | For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with metatarsal bar, per shoe | $29.01 |
| A5506 | | For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with off-set heel(s), per shoe | $29.01 |
| A5507 | | For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe, per shoe | $29.01 |
| A5508 | | For diabetics only, deluxe feature of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe | BR |
| A5510 | | For diabetics only, direct formed, compression molded to patient's foot without external heat source, multiple-density insert(s) prefabricated, per shoe | BR |
| A5512 | | For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each | $35.48 |
| A5513 | | For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer or higher, includes arch filler and other shaping material, custom fabricated, each | $52.95 |
| A6000 | | Noncontact wound-warming wound cover for use with the noncontact wound-warming device and warming card | BR |
| A6010 | | Collagen based wound filler, dry form, per gram of collagen | $32.14 |
| A6011 | | Collagen based wound filler, gel/paste, per gram of collagen | $2.37 |
| A6021 | | Collagen dressing, pad size 16 sq. in. or less, each | $21.82 |
| A6022 | | Collagen dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each | $21.82 |
| A6023 | | Collagen dressing, pad size more than 48 sq. in., each | $197.51 |
| A6024 | | Collagen dressing wound filler, per six in. | $6.42 |
| A6025 | | Gel sheet for dermal or epidermal application, (e.g., silicone, hydrogel, other), each | $29.30 |
| A6154 | | Wound pouch, each | $14.92 |
| A6196 | | Alginate or other fiber gelling dressing, wound cover, pad size 16 sq. in. or less, each dressing | $7.63 |
| A6197 | | Alginate or other fiber gelling dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each dressing | $17.06 |
| A6198 | | Alginate or other fiber gelling dressing, wound cover, pad size more than 48 sq. in., each dressing | BR |
| A6199 | | Alginate or other fiber gelling dressing, wound filler, per 6 in. | $5.49 |
| A6200 | | Composite dressing, pad size 16 sq. in. or less, without adhesive border, each dressing | $9.87 |
| A6201 | | Composite dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing | $21.59 |
| A6202 | | Composite dressing, pad size more than 48 sq. in., without adhesive border, each dressing | $36.20 |
| A6203 | | Composite dressing, pad size 16 sq. in. or less, with any size adhesive border, each dressing | $3.48 |
| A6204 | | Composite dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing | $6.47 |
| A6205 | | Composite dressing, pad size more than 48 sq. in., with any size adhesive border, each dressing | BR |
| A6206 | | Contact layer, 16 sq. in. or less, each dressing | $5.35 |
| A6207 | | Contact layer, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing | $7.62 |
| A6208 | | Contact layer, more than 48 sq. in., each dressing | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| A6209 | | Foam dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing | $7.77 |
| A6210 | | Foam dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing | $20.67 |
| A6211 | | Foam dressing, wound cover, pad size more then 48 sq. in., without adhesive border, each dressing | $30.48 |
| A6212 | | Foam dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing | $10.07 |
| A6213 | | Foam dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing | $25.64 |
| A6214 | | Foam dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing | $10.68 |
| A6215 | | Foam dressing, wound filler, per gm | BR |
| A6216 | | Gauze, nonimpregnated, nonsterile, pad size 16 sq. in. or less, without adhesive border, each dressing | $0.05 |
| A6217 | | Gauze, nonimpregnated, nonsterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing | BR |
| A6218 | | Gauze, nonimpregnated, nonsterile, pad size more than 48 sq. in., without adhesive border, each dressing | $0.49 |
| A6219 | | Gauze, nonimpregnated, pad size 16 sq. in. or less, with any size adhesive border, each dressing | $0.99 |
| A6220 | | Gauze, nonimpregnated, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing | $2.67 |
| A6221 | | Gauze, nonimpregnated, pad size more than 48 sq. in., with any size adhesive border, each dressing | BR |
| A6222 | | Gauze, impregnated with other than water, normal saline, or hydrogel, pad size 16 sq. in. or less, without adhesive border, each dressing | $2.21 |
| A6223 | | Gauze, impregnated with other than water, normal saline, or hydrogel, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing | $2.52 |
| A6224 | | Gauze, impregnated with other than water, normal saline, or hydrogel, pad size more than 48 sq. in., without adhesive border, each dressing | $3.75 |
| A6228 | | Gauze, impregnated, water or normal saline, pad size 16 sq. in. or less, without adhesive border, each dressing | $2.30 |
| A6229 | | Gauze, impregnated, water or normal saline, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing | $3.75 |
| A6230 | | Gauze, impregnated, water or normal saline, pad size more than 48 sq. in., without adhesive border, each dressing | $3.79 |
| A6231 | | Gauze, impregnated, hydrogel, for direct wound contact, pad size 16 sq. in. or less, each dressing | $4.86 |
| A6232 | | Gauze, impregnated, hydrogel, for direct wound contact, pad size greater than 16 sq. in., but less than or equal to 48 sq. in., each dressing | $7.14 |
| A6233 | | Gauze, impregnated, hydrogel for direct wound contact, pad size more than 48 sq. in., each dressing | $19.91 |
| A6234 | | Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing | $6.79 |
| A6235 | | Hydrocolloid dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing | $17.46 |
| A6236 | | Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing | $28.28 |
| A6237 | | Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing | $8.21 |
| A6238 | | Hydrocolloid dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing | $23.65 |
| A6239 | | Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing | BR |
| A6240 | | Hydrocolloid dressing, wound filler, paste, per fl. oz. | $12.70 |
| A6241 | | Hydrocolloid dressing, wound filler, dry form, per gm | $2.66 |
| A6242 | | Hydrogel dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing | $6.30 |
| A6243 | | Hydrogel dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing | $12.77 |
| A6244 | | Hydrogel dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing | $40.77 |
| A6245 | | Hydrogel dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing | $7.55 |
| A6246 | | Hydrogel dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing | $10.29 |
| A6247 | | Hydrogel dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing | $24.68 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| A6248 | | Hydrogel dressing, wound filler, gel, per fl. oz. | $16.85 |
| A6250 | | Skin sealants, protectants, moisturizers, ointments, any type, any size | BR |
| A6251 | | Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing | $2.06 |
| A6252 | | Specialty absorptive dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing | $3.37 |
| A6253 | | Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing | $6.58 |
| A6254 | | Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing | $1.26 |
| A6255 | | Specialty absorptive dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing | $3.15 |
| A6256 | | Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing | BR |
| A6257 | | Transparent film, 16 sq. in. or less, each dressing | $1.59 |
| A6258 | | Transparent film, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing | $4.47 |
| A6259 | | Transparent film, more than 48 sq. in., each dressing | $11.36 |
| A6260 | | Wound cleansers, any type, any size | $1.28 |
| A6261 | | Wound filler, gel/paste, per fl. oz., not elsewhere classified | $4.86 |
| A6262 | | Wound filler, dry form, per gm, not elsewhere classified | $1.22 |
| A6266 | | Gauze, impregnated, other than water, normal saline, or zinc paste, any width, per linear yd. | $1.99 |
| A6402 | | Gauze, nonimpregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing | $0.12 |
| A6403 | | Gauze, nonimpregnated, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing | $0.45 |
| A6404 | | Gauze, nonimpregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing | $0.63 |
| A6407 | | Packing strips, nonimpregnated, up to 2 in. in width, per linear yd. | $1.95 |
| A6410 | | Eye pad, sterile, each | $0.40 |
| A6411 | | Eye pad, nonsterile, each | BR |
| A6412 | | Eye patch, occlusive, each | $0.31 |
| A6441 | | Padding bandage, nonelastic, nonwoven/nonknitted, width greater than or equal to 3 in. and less than 5 in., per yd. | $0.70 |
| A6442 | | Conforming bandage, nonelastic, knitted/woven, nonsterile, width less than 3 in., per yd. | $0.17 |
| A6443 | | Conforming bandage, nonelastic, knitted/woven, nonsterile, width greater than or equal to 3 in. and less than 5 in., per yd. | $0.31 |
| A6444 | | Conforming bandage, nonelastic, knitted/woven, nonsterile, width greater than or equal to 5 in., per yd. | $0.59 |
| A6445 | | Conforming bandage, nonelastic, knitted/woven, sterile, width less than 3 in., per yd. | $0.33 |
| A6446 | | Conforming bandage, nonelastic, knitted/woven, sterile, width greater than or equal to 3 in. and less than 5 in., per yd. | $0.43 |
| A6447 | | Conforming bandage, nonelastic, knitted/woven, sterile, width greater than or equal to 5 in., per yd. | $0.70 |
| A6448 | | Light compression bandage, elastic, knitted/woven, width less than 3 in., per yd. | $1.21 |
| A6449 | | Light compression bandage, elastic, knitted/woven, width greater than or equal to three in. and less than five in., per yd. | $1.82 |
| A6450 | | Light compression bandage, elastic, knitted/woven, width greater than or equal to five in., per yd. | BR |
| A6451 | | Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to three in. and less than five in., per yd | BR |
| A6452 | | High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50% maximum stretch, width greater than or equal to three in. and less than five in., per yd. | $6.13 |
| A6453 | | Self-adherent bandage, elastic, nonknitted/nonwoven, width less than three in., per yd. | $0.63 |
| A6454 | | Self-adherent bandage, elastic, nonknitted/nonwoven, width greater than or equal to three in. and less than five in., per yd. | $0.79 |
| A6455 | | Self-adherent bandage, elastic, nonknitted/nonwoven, width greater than or equal to 5 in., per yd. | $1.44 |
| A6456 | | Zinc paste impregnated bandage, nonelastic, knitted/woven, width greater than or equal to 3 in. and less than 5 in., per yd. | $1.33 |
| A6457 | | Tubular dressing with or without elastic, any width, per linear yard | $1.39 |
| A6501 | | Compression burn garment, bodysuit (head to foot), custom fabricated | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| A6502 | | Compression burn garment, chin strap, custom fabricated | BR |
| A6503 | | Compression burn garment, facial hood, custom fabricated | BR |
| A6504 | | Compression burn garment, glove to wrist, custom fabricated | BR |
| A6505 | | Compression burn garment, glove to elbow, custom fabricated | BR |
| A6506 | | Compression burn garment, glove to axilla, custom fabricated | BR |
| A6507 | | Compression burn garment, foot to knee length, custom fabricated | BR |
| A6508 | | Compression burn garment, foot to thigh length, custom fabricated | BR |
| A6509 | | Compression burn garment, upper trunk to waist including arm openings (vest), custom fabricated | BR |
| A6510 | | Compression burn garment, trunk, including arms down to leg openings (leotard), custom fabricated | BR |
| A6511 | | Compression burn garment, lower trunk including leg openings (panty), custom fabricated | BR |
| A6512 | | Compression burn garment, not otherwise classified | BR |
| A6513 | | Compression burn mask, face and/or neck, plastic or equal, custom fabricated | BR |
| A6530 | | Gradient compression stocking, below knee, 18-30 mm Hg, each | BR |
| A6531 | | Gradient compression stocking, below knee, 30-40 mm Hg, each | $52.83 |
| A6532 | | Gradient compression stocking, below knee, 40-50 mm Hg, each | $74.43 |
| A6533 | | Gradient compression stocking, thigh length, 18-30 mm Hg, each | BR |
| A6534 | | Gradient compression stocking, thigh length, 30-40 mm Hg, each | BR |
| A6535 | | Gradient compression stocking, thigh length, 40-50 mm Hg, each | BR |
| A6536 | | Gradient compression stocking, full length/chap style, 18-30 mm Hg, each | BR |
| A6537 | | Gradient compression stocking, full length/chap style, 30-40 mm Hg, each | BR |
| A6538 | | Gradient compression stocking, full length/chap style, 40-50 mm Hg, each | BR |
| A6539 | | Gradient compression stocking, waist length, 18-30 mm Hg, each | BR |
| A6540 | | Gradient compression stocking, waist length, 30-40 mm Hg, each | BR |
| A6541 | | Gradient compression stocking, waist length, 40-50 mm Hg, each | BR |
| A6542 | | Gradient compression stocking, custom made | BR |
| A6543 | | Gradient compression stocking, lymphedema | BR |
| A6544 | | Gradient compression stocking, garter belt | BR |
| A6549 | | Gradient compression stocking, not otherwise specified | BR |
| A6550 | | Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories | $28.46 |
| A7000 | | Canister, disposable, used with suction pump, each | $9.90 |
| A7001 | | Canister, nondisposable, used with suction pump, each | $34.33 |
| A7002 | | Tubing, used with suction pump, each | $3.98 |
| A7003 | | Administration set, with small volume nonfiltered pneumatic nebulizer, disposable | $2.84 |
| A7004 | | Small volume nonfiltered pneumatic nebulizer, disposable | $1.87 |
| A7005 | | Administration set, with small volume nonfiltered pneumatic nebulizer, nondisposable | $32.00 |
| A7006 | | Administration set, with small volume filtered pneumatic nebulizer | $9.90 |
| A7007 | | Large volume nebulizer, disposable, unfilled, used with aerosol compressor | $4.79 |
| A7008 | | Large volume nebulizer, disposable, prefilled, used with aerosol compressor | $11.42 |
| A7009 | | Reservoir bottle, nondisposable, used with large volume ultrasonic nebulizer | $43.63 |
| A7010 | | Corrugated tubing, disposable, used with large volume nebulizer, 100 ft. | $24.48 |
| A7011 | | Corrugated tubing, nondisposable, used with large volume nebulizer, 10 ft. | $24.40 |
| A7012 | | Water collection device, used with large volume nebulizer | $3.92 |
| A7013 | | Filter, disposable, used with aerosol compressor | $0.87 |
| A7014 | | Filter, nondisposable, used with aerosol compressor or ultrasonic generator | $4.66 |
| A7015 | | Aerosol mask, used with DME nebulizer | $1.95 |
| A7016 | | Dome and mouthpiece, used with small volume ultrasonic nebulizer | $7.52 |
| A7017 | NU | Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen | $139.11 |
| A7017 | RR | Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen | $13.91 |
| A7017 | UE | Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen | $104.32 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| A7018 | | Water, distilled, used with large volume nebulizer, 1000 ml | $0.39 |
| A7025 | | High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each | $451.40 |
| A7026 | | High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each | $29.84 |
| A7030 | | Full face mask used with positive airway pressure device, each | $195.78 |
| A7031 | | Face mask interface, replacement for full face mask, each | $72.41 |
| A7032 | | Cushion for use on nasal mask interface, replacement only, each | $42.06 |
| A7033 | | Pillow for use on nasal cannula type interface, replacement only, pair | $29.49 |
| A7034 | | Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap | $122.09 |
| A7035 | | Headgear used with positive airway pressure device | $41.26 |
| A7036 | | Chinstrap used with positive airway pressure device | $18.89 |
| A7037 | | Tubing used with positive airway pressure device | $42.58 |
| A7038 | | Filter, disposable, used with positive airway pressure device | $5.59 |
| A7039 | | Filter, nondisposable, used with positive airway pressure device | $15.91 |
| A7040 | | One way chest drain valve | BR |
| A7041 | | Water seal drainage container and tubing for use with implanted chest tube | BR |
| A7042 | | Implanted pleural catheter, each | $186.90 |
| A7043 | | Vacuum drainage bottle and tubing for use with implanted catheter | $26.76 |
| A7044 | | Oral interface used with positive airway pressure device, each | $125.48 |
| A7045 | | Exhalation port with or without swivel used with accessories for positive airway devices, replacement only | BR |
| A7046 | | Water chamber for humidifier, used with positive airway pressure device, replacement, each | $20.24 |
| A7501 | | Tracheostoma valve, including diaphragm, each | $109.01 |
| A7502 | | Replacement diaphragm/faceplate for tracheostoma valve, each | $51.79 |
| A7503 | | Filter holder or filter cap, reusable, for use in a tracheostoma heat and moisture exchange system, each | $11.76 |
| A7504 | | Filter for use in a tracheostoma heat and moisture exchange system, each | $0.70 |
| A7505 | | Housing, reusable without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each | $4.86 |
| A7506 | | Adhesive disc for use in a heat and moisture exchange system and/or with tracheostoma valve, any type each | $0.34 |
| A7507 | | Filter holder and integrated filter without adhesive, for use in a tracheostoma heat and moisture exchange system, each | $2.59 |
| A7508 | | Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system and/or with a tracheostoma valve, each | $2.98 |
| A7509 | | Filter holder and integrated filter housing, and adhesive, for use as a tracheostoma heat and moisture exchange system, each | $1.47 |
| A7520 | | Tracheostomy/laryngectomy tube, noncuffed, polyvinylchloride (PVC), silicone or equal, each | $49.28 |
| A7521 | | Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each | $48.83 |
| A7522 | | Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each | $46.87 |
| A7523 | | Tracheostomy shower protector, each | BR |
| A7524 | | Tracheostoma stent/stud/button, each | $80.33 |
| A7525 | | Tracheostomy mask, each | $2.15 |
| A7526 | | Tracheostomy tube collar/holder, each | $3.49 |
| A7527 | | Tracheostomy/laryngectomy tube plug/stop, each | BR |
| A8000 | | Helmet, protective, soft, prefabricated, includes all components and accessories | BR |
| A8001 | | Helmet, protective, hard, prefabricated, includes all components and accessories | BR |
| A8002 | | Helmet, protective, soft, custom fabricated, includes all components and accessories | BR |
| A8003 | | Helmet, protective, hard, custom fabricated, includes all components and accessories | BR |
| A8004 | | Soft interface for helmet, replacement only | BR |
| A9150 | | Nonprescription drug | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| A9152 | | Single vitamin/mineral/trace element, oral, per dose, not otherwise specified | BR |
| A9153 | | Multiple vitamins, with or without minerals and trace elements, oral, per dose, not otherwise specified | BR |
| A9180 | | Pediculosis (lice infestation) treatment, topical, for administration by patient/caretaker | BR |
| A9270 | | Noncovered item or service | BR |
| A9275 | | Home glucose disposable monitor, includes test strips | BR |
| A9279 | | Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified | BR |
| A9280 | | Alert or alarm device, not otherwise classified | BR |
| A9281 | | Reaching/grabbing device, any type, any length, each | BR |
| A9282 | | Wig, any type, each | BR |
| A9300 | | Exercise equipment | BR |
| A9500 | | Technetium Tc-99m sestamibi, diagnostic, per study dose, up to 40 millicuries | BR |
| A9502 | | Technetium Tc-99m tetrofosmin, diagnostic, per study dose, up to 40 millicuries | BR |
| A9503 | | Technetium Tc-99m medronate, diagnostic, per study dose, up to 30 millicuries | BR |
| A9504 | | Technetium Tc-99m apcitide, diagnostic, per study dose, up to 20 millicuries | BR |
| A9505 | | Thallium Tl-201 thallous chloride, diagnostic, per millicurie | BR |
| A9507 | | Indium In-111 capromab pendetide, diagnostic, per study dose, up to 10 millicuries | BR |
| A9508 | | Iodine I-131 iobenguane sulfate, diagnostic, per 0.5 millicurie | BR |
| A9510 | | Technetium Tc-99m disofenin, diagnostic, per study dose, up to 15 millicuries | BR |
| A9512 | | Technetium Tc-99m pertechnetate, diagnostic, per millicurie | BR |
| A9516 | | Iodine I-123 sodium iodide capsule(s), diagnostic, per 100 microcuries | BR |
| A9517 | | Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie | BR |
| A9521 | | Technetium Tc-99m exametazime, diagnostic, per study dose, up to 25 millicuries | BR |
| A9524 | | Iodine I-131 iodinated serum albumin, diagnostic, per 5 microcuries | BR |
| A9526 | | Nitrogen N-13 ammonia, diagnostic, per study dose, up to 40 millicuries | BR |
| A9527 | | Iodine I-125, sodium iodide solution, therapeutic, per millicurie | BR |
| A9528 | | Iodine I-131 sodium iodide capsule(s), diagnostic, per millicurie | $175.80 |
| A9529 | | Iodine I-131 sodium iodide solution, diagnostic, per millicurie | BR |
| A9530 | | Iodine I-131 sodium iodide solution, therapeutic, per millicurie | BR |
| A9531 | | Iodine I-131 sodium iodide, diagnostic, per microcurie (up to 100 microcuries) | BR |
| A9532 | | Iodine I-125 serum albumin, diagnostic, per 5 microcuries | $381.05 |
| A9535 | | Injection, methylene blue, 1 ml | BR |
| A9536 | | Technetium Tc-99m depreotide, diagnostic, per study dose, up to 35 millicuries | BR |
| A9537 | | Technetium Tc-99m mebrofenin, diagnostic, per study dose, up to 15 millicuries | BR |
| A9538 | | Technetium Tc-99m pyrophosphate, diagnostic, per study dose, up to 25 millicuries | BR |
| A9539 | | Technetium Tc-99m pentetate, diagnostic, per study dose, up to 25 millicuries | BR |
| A9540 | | Technetium Tc-99m macroaggregated albumin, diagnostic, per study dose, up to 10 millicuries | BR |
| A9541 | | Technetium Tc-99m sulfur colloid, diagnostic, per study dose, up to 20 millicuries | BR |
| A9542 | | Indium In-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries | BR |
| A9543 | | Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries | BR |
| A9544 | | Iodine I-131 tositumomab, diagnostic, per study dose | BR |
| A9545 | | Iodine I-131 tositumomab, therapeutic, per treatment dose | BR |
| A9546 | | Cobalt Co-57/58, cyanocobalamin, diagnostic, per study dose, up to 1 microcurie | BR |
| A9547 | | Indium In-111 oxyquinoline, diagnostic, per 0.5 millicurie | $549.45 |
| A9548 | | Indium In-111 pentetate, diagnostic, per 0.5 millicurie | $329.67 |
| A9550 | | Technetium Tc-99m sodium gluceptate, diagnostic, per study dose, up to 25 millicurie | BR |
| A9551 | | Technetium Tc-99m succimer, diagnostic, per study dose, up to 10 millicuries | BR |
| A9552 | | Fluorodeoxyglucose F-18 FDG, diagnostic, per study dose, up to 45 millicuries | BR |
| A9553 | | Chromium Cr-51 sodium chromate, diagnostic, per study dose, up to 250 microcuries | BR |
| A9554 | | Iodine I-125 sodium iothalamate, diagnostic, per study dose, up to 10 microcuries | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| A9555 | | Rubidium Rb-82, diagnostic, per study dose, up to 60 millicuries | BR |
| A9556 | | Gallium Ga-67 citrate, diagnostic, per millicurie | $41.18 |
| A9557 | | Technetium Tc-99m bicisate, diagnostic, per study dose, up to 25 millicuries | BR |
| A9558 | | Xenon Xe-133 gas, diagnostic, per 10 millicuries | BR |
| A9559 | | Cobalt Co-57 cyanocobalamin, oral, diagnostic, per study dose, up to 1 microcurie | BR |
| A9560 | | Technetium Tc-99m labeled red blood cells, diagnostic, per study dose, up to 30 millicuries | BR |
| A9561 | | Technetium Tc-99m oxidronate, diagnostic, per study dose, up to 30 millicuries | BR |
| A9562 | | Technetium Tc-99m mertiatide, diagnostic, per study dose, up to 15 millicuries | BR |
| A9563 | | Sodium phosphate P-32, therapeutic, per millicurie | BR |
| A9564 | | Chromic phosphate P-32 suspension, therapeutic, per millicurie | $281.32 |
| A9565 | | Indium In-111 pentetreotide, diagnostic, per millicurie | $670.33 |
| A9566 | | Technetium Tc-99m fanolesomab, diagnostic, per study dose, up to 25 millicuries | BR |
| A9567 | | Technetium Tc-99m pentetate, diagnostic, aerosol, per study dose, up to 75 millicuries | BR |
| A9568 | | Technetium Tc-99m arcitumomab, diagnostic, per study dose, up to 45 millicuries | BR |
| A9600 | | Strontium Sr-89 chloride, therapeutic, per millicurie | $710.99 |
| A9605 | | Samarium Sm-153 lexidronamm, therapeutic, per 50 millicuries | BR |
| A9698 | | Nonradioactive contrast imaging material, not otherwise classified, per study | BR |
| A9699 | | Radiopharmaceutical, therapeutic, not otherwise classified | BR |
| A9700 | | Supply of injectable contrast material for use in echocardiography, per study | BR |
| A9900 | | Miscellaneous DME supply, accessory, and/or service component of another HCPCS code | BR |
| A9901 | | DME delivery, set up, and/or dispensing service component of another HCPCS code | BR |
| A9999 | | Miscellaneous DME supply or accessory, not otherwise specified | BR |
| B4034 | | Enteral feeding supply kit; syringe, per day | $7.29 |
| B4035 | | Enteral feeding supply kit; pump fed, per day | $13.89 |
| B4036 | | Enteral feeding supply kit; gravity fed, per day | $9.52 |
| B4081 | | Nasogastric tubing with stylet | $25.75 |
| B4082 | | Nasogastric tubing without stylet | $19.17 |
| B4083 | | Stomach tube — Levine type | $2.93 |
| B4086 | | Gastrostomy/jejunostomy tube, any material, any type, (standard or low profile), each | $42.52 |
| B4100 | | Food thickener, administered orally, per oz. | BR |
| B4102 | | Enteral formula, for adults, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit | BR |
| B4103 | | Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit | BR |
| B4104 | | Additive for enteral formula (e.g., fiber) | BR |
| B4149 | | Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | $1.87 |
| B4150 | | Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | $0.79 |
| B4152 | | Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | $0.67 |
| B4153 | | Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | $2.27 |
| B4154 | | Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | $1.45 |
| B4155 | | Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arginine), fat (e.g., medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit | $1.14 |
| B4157 | | Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| **B4158** | | Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit | BR |
| **B4159** | | Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit | BR |
| **B4160** | | Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | BR |
| **B4161** | | Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | BR |
| **B4162** | | Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | BR |
| **B4164** | | Parenteral nutrition solution; carbohydrates (dextrose), 50% or less (500 ml = 1 unit) — home mix | $19.63 |
| **B4168** | | Parenteral nutrition solution; amino acid, 3.5%, (500 ml = 1 unit) — home mix | $28.60 |
| **B4172** | | Parenteral nutrition solution; amino acid, 5.5% through 7%, (500 ml = 1 unit) — home mix | $77.80 |
| **B4176** | | Parenteral nutrition solution; amino acid, 7% through 8.5%, (500 ml = 1 unit) — home mix | $55.35 |
| **B4178** | | Parenteral nutrition solution; amino acid, greater than 8.5% (500 ml = 1 unit) — home mix | $66.45 |
| **B4180** | | Parenteral nutrition solution; carbohydrates (dextrose), greater than 50% (500 ml = 1 unit) — home mix | $28.14 |
| **B4185** | | Parenteral nutrition solution, per 10 grams lipids | BR |
| **B4189** | | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 grams of protein — premix | $205.26 |
| **B4193** | | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein — premix | $265.25 |
| **B4197** | | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, 74 to 100 grams of protein — premix | $322.92 |
| **B4199** | | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, over 100 grams of protein — premix | $369.00 |
| **B4216** | | Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes) — home mix, per day | $8.93 |
| **B4220** | | Parenteral nutrition supply kit; premix, per day | $9.24 |
| **B4222** | | Parenteral nutrition supply kit; home mix, per day | $11.40 |
| **B4224** | | Parenteral nutrition administration kit, per day | $28.89 |
| **B5000** | | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal — Amirosyn RF, NephrAmine, RenAmine — premix | $13.72 |
| **B5100** | | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic — FreAmine HBC, HepatAmine — premix | $5.37 |
| **B5200** | | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress — branch chain amino acids — premix | BR |
| **B9000** | **NU** | Enteral nutrition infusion pump — without alarm | $1,460.74 |
| **B9000** | **RR** | Enteral nutrition infusion pump — without alarm | $134.22 |
| **B9000** | **UE** | Enteral nutrition infusion pump — without alarm | $1,095.55 |
| **B9002** | **NU** | Enteral nutrition infusion pump — with alarm | $1,460.74 |
| **B9002** | **RR** | Enteral nutrition infusion pump — with alarm | $141.48 |
| **B9002** | **UE** | Enteral nutrition infusion pump — with alarm | $1,095.55 |
| **B9004** | **NU** | Parenteral nutrition infusion pump, portable | $2,913.77 |
| **B9004** | **RR** | Parenteral nutrition infusion pump, portable | $461.28 |
| **B9004** | **UE** | Parenteral nutrition infusion pump, portable | $2,185.33 |
| **B9006** | **NU** | Parenteral nutrition infusion pump, stationary | $2,913.77 |
| **B9006** | **RR** | Parenteral nutrition infusion pump, stationary | $461.28 |
| **B9006** | **UE** | Parenteral nutrition infusion pump, stationary | $2,185.33 |
| **B9998** | | NOC for enteral supplies | BR |
| **B9999** | | NOC for parenteral supplies | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| C1300 | | Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval | BR |
| C1713 | | Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable) | BR |
| C1714 | | Catheter, transluminal atherectomy, directional | BR |
| C1715 | | Brachytherapy needle | BR |
| C1716 | | Brachytherapy source, gold 198, per source | BR |
| C1717 | | Brachytherapy source, high dose rate iridium 192, per source | BR |
| C1718 | | Brachytherapy source, iodine 125, per source | BR |
| C1719 | | Brachytherapy source, nonhigh dose rate iridium 192, per source | BR |
| C1720 | | Brachytherapy source, palladium 103, per source | BR |
| C1721 | | Cardioverter-defibrillator, dual chamber (implantable) | BR |
| C1722 | | Cardioverter-defibrillator, single chamber (implantable) | BR |
| C1724 | | Catheter, transluminal atherectomy, rotational | BR |
| C1725 | | Catheter, transluminal angioplasty, nonlaser (may include guidance, infusion/perfusion capability) | BR |
| C1726 | | Catheter, balloon dilatation, nonvascular | BR |
| C1727 | | Catheter, balloon tissue dissector, nonvascular (insertable) | BR |
| C1728 | | Catheter, brachytherapy seed administration | BR |
| C1729 | | Catheter, drainage | BR |
| C1730 | | Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes) | BR |
| C1731 | | Catheter, electrophysiology, diagnostic, other than 3D mapping (20 or more electrodes) | BR |
| C1732 | | Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping | BR |
| C1733 | | Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip | BR |
| C1750 | | Catheter, hemodialysis/peritoneal, long-term | BR |
| C1751 | | Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis) | BR |
| C1752 | | Catheter, hemodialysis/peritoneal, short-term | BR |
| C1753 | | Catheter, intravascular ultrasound | BR |
| C1754 | | Catheter, intradiscal | BR |
| C1755 | | Catheter, intraspinal | BR |
| C1756 | | Catheter, pacing, transesophageal | BR |
| C1757 | | Catheter, thrombectomy/embolectomy | BR |
| C1758 | | Catheter, ureteral | BR |
| C1759 | | Catheter, intracardiac echocardiography | BR |
| C1760 | | Closure device, vascular (implantable/insertable) | BR |
| C1762 | | Connective tissue, human (includes fascia lata) | BR |
| C1763 | | Connective tissue, nonhuman (includes synthetic) | BR |
| C1764 | | Event recorder, cardiac (implantable) | BR |
| C1765 | | Adhesion barrier | BR |
| C1766 | | Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away | BR |
| C1767 | | Generator, neurostimulator (implantable), nonrechargeable | BR |
| C1768 | | Graft, vascular | BR |
| C1769 | | Guide wire | BR |
| C1770 | | Imaging coil, magnetic resonance (insertable) | BR |
| C1771 | | Repair device, urinary, incontinence, with sling graft | BR |
| C1772 | | Infusion pump, programmable (implantable) | BR |
| C1773 | | Retrieval device, insertable (used to retrieve fractured medical devices) | BR |
| C1776 | | Joint device (implantable) | BR |
| C1777 | | Lead, cardioverter-defibrillator, endocardial single coil (implantable) | BR |
| C1778 | | Lead, neurostimulator (implantable) | BR |
| C1779 | | Lead, pacemaker, transvenous VDD single pass | BR |
| C1780 | | Lens, intraocular (new technology) | BR |
| C1781 | | Mesh (implantable) | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| C1782 | | Morcellator | BR |
| C1783 | | Ocular implant, aqueous drainage assist device | BR |
| C1784 | | Ocular device, intraoperative, detached retina | BR |
| C1785 | | Pacemaker, dual chamber, rate-responsive (implantable) | BR |
| C1786 | | Pacemaker, single chamber, rate-responsive (implantable) | BR |
| C1787 | | Patient programmer, neurostimulator | BR |
| C1788 | | Port, indwelling (implantable) | BR |
| C1789 | | Prosthesis, breast (implantable) | BR |
| C1813 | | Prosthesis, penile, inflatable | BR |
| C1814 | | Retinal tamponade device, silicone oil | BR |
| C1815 | | Prosthesis, urinary sphincter (implantable) | BR |
| C1816 | | Receiver and/or transmitter, neurostimulator (implantable) | BR |
| C1817 | | Septal defect implant system, intracardiac | BR |
| C1818 | | Integrated keratoprosthesis | BR |
| C1819 | | Surgical tissue localization and excision device (implantable) | BR |
| C1820 | | Generator, neurostimulator (implantable), with rechargeable battery and charging system | BR |
| C1821 | | Interspinous process distraction device (implantable) | BR |
| C1874 | | Stent, coated/covered, with delivery system | BR |
| C1875 | | Stent, coated/covered, without delivery system | BR |
| C1876 | | Stent, noncoated/noncovered, with delivery system | BR |
| C1877 | | Stent, noncoated/noncovered, without delivery system | BR |
| C1878 | | Material for vocal cord medialization, synthetic (implantable) | BR |
| C1879 | | Tissue marker (implantable) | BR |
| C1880 | | Vena cava filter | BR |
| C1881 | | Dialysis access system (implantable) | BR |
| C1882 | | Cardioverter-defibrillator, other than single or dual chamber (implantable) | BR |
| C1883 | | Adaptor/extension, pacing lead or neurostimulator lead (implantable) | BR |
| C1884 | | Embolization protective system | BR |
| C1885 | | Catheter, transluminal angioplasty, laser | BR |
| C1887 | | Catheter, guiding (may include infusion/perfusion capability) | BR |
| C1888 | | Catheter, ablation, noncardiac, endovascular (implantable) | BR |
| C1891 | | Infusion pump, nonprogrammable, permanent (implantable) | BR |
| C1892 | | Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away | BR |
| C1893 | | Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away | BR |
| C1894 | | Introducer/sheath, other than guiding, other than intracardiac electrophysiological, nonlaser | BR |
| C1895 | | Lead, cardioverter-defibrillator, endocardial dual coil (implantable) | BR |
| C1896 | | Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable) | BR |
| C1897 | | Lead, neurostimulator test kit (implantable) | BR |
| C1898 | | Lead, pacemaker, other than transvenous VDD single pass | BR |
| C1899 | | Lead, pacemaker/cardioverter-defibrillator combination (implantable) | BR |
| C1900 | | Lead, left ventricular coronary venous system | BR |
| C2614 | | Probe, percutaneous lumbar discectomy | BR |
| C2615 | | Sealant, pulmonary, liquid | BR |
| C2616 | | Brachytherapy source, yttrium 90, per source | BR |
| C2617 | | Stent, noncoronary, temporary, without delivery system | BR |
| C2618 | | Probe, cryoablation | BR |
| C2619 | | Pacemaker, dual chamber, nonrate-responsive (implantable) | BR |
| C2620 | | Pacemaker, single chamber, non rate-responsive (implantable) | BR |
| C2621 | | Pacemaker, other than single or dual chamber (implantable) | BR |
| C2622 | | Prosthesis, penile, non-inflatable | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| C2625 | | Stent, noncoronary, temporary, with delivery system | BR |
| C2626 | | Infusion pump, nonprogrammable, temporary (implantable) | BR |
| C2627 | | Catheter, suprapubic/cystoscopic | BR |
| C2628 | | Catheter, occlusion | BR |
| C2629 | | Introducer/sheath, other than guiding, intracardiac electrophysiological, laser | BR |
| C2630 | | Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip | BR |
| C2631 | | Repair device, urinary, incontinence, without sling graft | BR |
| C2633 | | Brachytherapy source, cesium-131, per source | BR |
| C2634 | | Brachytherapy source, high-activity, Iodine-125, greater than 1.01 mCi (NIST), per source | BR |
| C2635 | | Brachytherapy source, high-activity, Paladium-103, greater than 2.2 mCi (NIST), per source | BR |
| C2636 | | Brachytherapy linear source, paladium 103, per 1 mm | BR |
| C2637 | | Brachytherapy source, ytterbium-169, per source | BR |
| C8900 | | Magnetic resonance angiography with contrast, abdomen | BR |
| C8901 | | Magnetic resonance angiography without contrast, abdomen | BR |
| C8902 | | Magnetic resonance angiography without contrast followed by with contrast, abdomen | BR |
| C8903 | | Magnetic resonance imaging with contrast, breast; unilateral | BR |
| C8904 | | Magnetic resonance imaging without contrast, breast; unilateral | BR |
| C8905 | | Magnetic resonance imaging without contrast followed by with contrast, breast; unilateral | BR |
| C8906 | | Magnetic resonance imaging with contrast, breast; bilateral | BR |
| C8907 | | Magnetic resonance imaging without contrast, breast; bilateral | BR |
| C8908 | | Magnetic resonance imaging without contrast followed by with contrast, breast; bilateral | BR |
| C8909 | | Magnetic resonance angiography with contrast, chest (excluding myocardium) | BR |
| C8910 | | Magnetic resonance angiography without contrast, chest (excluding myocardium) | BR |
| C8911 | | Magnetic resonance angiography without contrast followed by with contrast, chest (excluding myocardium) | BR |
| C8912 | | Magnetic resonance angiography with contrast, lower extremity | BR |
| C8913 | | Magnetic resonance angiography without contrast, lower extremity | BR |
| C8914 | | Magnetic resonance angiography without contrast followed by with contrast, lower extremity | BR |
| C8918 | | Magnetic resonance angiography with contrast, pelvis | BR |
| C8919 | | Magnetic resonance angiography without contrast, pelvis | BR |
| C8920 | | Magnetic resonance angiography without contrast followed by with contrast, pelvis | BR |
| C8957 | | Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than eight hours), requiring use of portable or implantable pump | BR |
| C9003 | | Palivizumab-RSV-IgM, per 50 mg | BR |
| C9113 | | Injection, pantoprazole sodium, per vial | BR |
| C9121 | | Injection, argatroban, per 5 mg | BR |
| C9232 | | Injection, idursulfase, 1 mg | BR |
| C9233 | | Injection, ranibizumab, 0.5 mg | BR |
| C9234 | | Injection, alglucosidase alfa, 10 mg | BR |
| C9235 | | Injection, panitumumab, 10 mg | BR |
| C9350 | | Microporous collagen tube of nonhuman origin, per centimeter length | BR |
| C9351 | | Acellular dermal tissue matrix of nonhuman origin, per square centimeter (Do not report C9351 in conjunction with J7345) | BR |
| C9399 | | Unclassified drugs or biologicals | BR |
| C9716 | | Creations of thermal anal lesions by radiofrequency energy | BR |
| C9723 | | Dynamic infrared blood perfusion imaging (DIRI) | BR |
| C9724 | | Endoscopic full-thickness plication in the gastric cardia using endoscopic plication system (EPS); includes endoscopy | BR |
| C9725 | | Placement of endorectal intracavitary applicator for high intensity brachytherapy | BR |
| C9726 | | Placement and removal (if performed) of applicator into breast for radiation therapy | BR |
| C9727 | | Insertion of implants into the soft palate; minimum of three implants | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0100 | NU | Cane, includes canes of all materials, adjustable or fixed, with tip | $27.21 |
| E0100 | RR | Cane, includes canes of all materials, adjustable or fixed, with tip | $7.67 |
| E0100 | UE | Cane, includes canes of all materials, adjustable or fixed, with tip | $21.69 |
| E0105 | NU | Cane, quad or three-prong, includes canes of all materials, adjustable or fixed, with tips | $63.40 |
| E0105 | RR | Cane, quad or three-prong, includes canes of all materials, adjustable or fixed, with tips | $11.44 |
| E0105 | UE | Cane, quad or three-prong, includes canes of all materials, adjustable or fixed, with tips | $48.88 |
| E0110 | NU | Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips | $100.18 |
| E0110 | RR | Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips | $20.64 |
| E0110 | UE | Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips | $75.11 |
| E0111 | NU | Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrip | $68.77 |
| E0111 | RR | Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrip | $10.89 |
| E0111 | UE | Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrip | $53.07 |
| E0112 | NU | Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips | $47.77 |
| E0112 | RR | Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips | $12.82 |
| E0112 | UE | Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips | $36.46 |
| E0113 | NU | Crutch, underarm, wood, adjustable or fixed, each, with pad, tip and handgrip | $27.28 |
| E0113 | RR | Crutch, underarm, wood, adjustable or fixed, each, with pad, tip and handgrip | $6.65 |
| E0113 | UE | Crutch, underarm, wood, adjustable or fixed, each, with pad, tip and handgrip | $20.48 |
| E0114 | NU | Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips | $60.93 |
| E0114 | RR | Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips | $11.06 |
| E0114 | UE | Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips | $46.06 |
| E0116 | NU | Crutch, underarm, other than wood, adjustable or fixed, with PAD, tip, handgrip, with or without shock absorber, each | $35.82 |
| E0116 | RR | Crutch, underarm, other than wood, adjustable or fixed, with PAD, tip, handgrip, with or without shock absorber, each | $6.97 |
| E0116 | UE | Crutch, underarm, other than wood, adjustable or fixed, with PAD, tip, handgrip, with or without shock absorber, each | $26.96 |
| E0117 | NU | Crutch, underarm, articulating, spring assisted, each | $248.81 |
| E0117 | RR | Crutch, underarm, articulating, spring assisted, each | $24.87 |
| E0117 | UE | Crutch, underarm, articulating, spring assisted, each | $186.64 |
| E0118 | | Crutch substitute, lower leg platform, with or without wheels, each | BR |
| E0130 | NU | Walker, rigid (pickup), adjustable or fixed height | $90.68 |
| E0130 | RR | Walker, rigid (pickup), adjustable or fixed height | $21.72 |
| E0130 | UE | Walker, rigid (pickup), adjustable or fixed height | $70.66 |
| E0135 | NU | Walker, folding (pickup), adjustable or fixed height | $108.24 |
| E0135 | RR | Walker, folding (pickup), adjustable or fixed height | $22.28 |
| E0135 | UE | Walker, folding (pickup), adjustable or fixed height | $83.04 |
| E0140 | NU | Walker, with trunk support, adjustable or fixed height, any type | $465.73 |
| E0140 | RR | Walker, with trunk support, adjustable or fixed height, any type | $46.59 |
| E0140 | UE | Walker, with trunk support, adjustable or fixed height, any type | $349.31 |
| E0141 | NU | Walker, rigid, wheeled, adjustable or fixed height | $148.86 |
| E0141 | RR | Walker, rigid, wheeled, adjustable or fixed height | $28.88 |
| E0141 | UE | Walker, rigid, wheeled, adjustable or fixed height | $111.65 |
| E0143 | NU | Walker, folding, wheeled, adjustable or fixed height | $155.24 |
| E0143 | RR | Walker, folding, wheeled, adjustable or fixed height | $27.87 |
| E0143 | UE | Walker, folding, wheeled, adjustable or fixed height | $116.17 |
| E0144 | NU | Walker, enclosed, four sided framed, rigid or folding, wheeled with posterior seat | $411.16 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0144 | RR | Walker, enclosed, four sided framed, rigid or folding, wheeled with posterior seat | $41.13 |
| E0144 | UE | Walker, enclosed, four sided framed, rigid or folding, wheeled with posterior seat | $308.37 |
| E0147 | NU | Walker, heavy duty, multiple braking system, variable wheel resistance | $742.17 |
| E0147 | RR | Walker, heavy duty, multiple braking system, variable wheel resistance | $74.22 |
| E0147 | UE | Walker, heavy duty, multiple braking system, variable wheel resistance | $556.65 |
| E0148 | NU | Walker, heavy duty, without wheels, rigid or folding, any type, each | $164.04 |
| E0148 | RR | Walker, heavy duty, without wheels, rigid or folding, any type, each | $16.42 |
| E0148 | UE | Walker, heavy duty, without wheels, rigid or folding, any type, each | $123.02 |
| E0149 | NU | Walker, heavy duty, wheeled, rigid or folding, any type | $288.18 |
| E0149 | RR | Walker, heavy duty, wheeled, rigid or folding, any type | $28.82 |
| E0149 | UE | Walker, heavy duty, wheeled, rigid or folding, any type | $216.12 |
| E0153 | NU | Platform attachment, forearm crutch, each | $89.58 |
| E0153 | RR | Platform attachment, forearm crutch, each | $10.12 |
| E0153 | UE | Platform attachment, forearm crutch, each | $67.19 |
| E0154 | NU | Platform attachment, walker, each | $91.03 |
| E0154 | RR | Platform attachment, walker, each | $11.06 |
| E0154 | UE | Platform attachment, walker, each | $69.16 |
| E0155 | NU | Wheel attachment, rigid pick-up walker, per pair seat attachment, walker | $40.75 |
| E0155 | RR | Wheel attachment, rigid pick-up walker, per pair seat attachment, walker | $4.97 |
| E0155 | UE | Wheel attachment, rigid pick-up walker, per pair seat attachment, walker | $31.05 |
| E0156 | NU | Seat attachment, walker | $34.13 |
| E0156 | RR | Seat attachment, walker | $4.36 |
| E0156 | UE | Seat attachment, walker | $25.63 |
| E0157 | NU | Crutch attachment, walker, each | $105.77 |
| E0157 | RR | Crutch attachment, walker, each | $11.61 |
| E0157 | UE | Crutch attachment, walker, each | $79.34 |
| E0158 | NU | Leg extensions for walker, per set of four (4) | $41.54 |
| E0158 | RR | Leg extensions for walker, per set of four (4) | $4.59 |
| E0158 | UE | Leg extensions for walker, per set of four (4) | $31.37 |
| E0159 | NU | Brake attachment for wheeled walker, replacement, each | $23.07 |
| E0159 | RR | Brake attachment for wheeled walker, replacement, each | $2.38 |
| E0159 | UE | Brake attachment for wheeled walker, replacement, each | $17.30 |
| E0160 | NU | Sitz type bath or equipment, portable, used with or without commode | $42.68 |
| E0160 | RR | Sitz type bath or equipment, portable, used with or without commode | $5.59 |
| E0160 | UE | Sitz type bath or equipment, portable, used with or without commode | $31.97 |
| E0161 | NU | Sitz type bath or equipment, portable, used with or without commode, with faucet attachment(s) | $33.87 |
| E0161 | RR | Sitz type bath or equipment, portable, used with or without commode, with faucet attachment(s) | $4.60 |
| E0161 | UE | Sitz type bath or equipment, portable, used with or without commode, with faucet attachment(s) | $25.35 |
| E0162 | NU | Sitz bath chair | $188.13 |
| E0162 | RR | Sitz bath chair | $19.75 |
| E0162 | UE | Sitz bath chair | $145.90 |
| E0163 | NU | Commode chair, mobile or stationary, with fixed arms | $142.41 |
| E0163 | RR | Commode chair, mobile or stationary, with fixed arms | $31.55 |
| E0163 | UE | Commode chair, mobile or stationary, with fixed arms | $109.81 |
| E0165 | NU | Commode chair, mobile or stationary, with detachable arms | $239.85 |
| E0165 | RR | Commode chair, mobile or stationary, with detachable arms | $23.99 |
| E0165 | UE | Commode chair, mobile or stationary, with detachable arms | $179.90 |
| E0167 | NU | Pail or pan for use with commode chair, replacement only | $15.49 |
| E0167 | RR | Pail or pan for use with commode chair, replacement only | $1.63 |
| E0167 | UE | Pail or pan for use with commode chair, replacement only | $11.67 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0168 | NU | Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each | $194.86 |
| E0168 | RR | Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each | $19.58 |
| E0168 | UE | Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each | $146.13 |
| E0170 | RR | Commode chair with integrated seat lift mechanism, electric, any type | BR |
| E0171 | RR | Commode chair with integrated seat lift mechanism, non-electric, any type | BR |
| E0172 | | Seat lift mechanism placed over or on top of toilet, any type | BR |
| E0175 | NU | Foot rest, for use with commode chair, each | $85.52 |
| E0175 | RR | Foot rest, for use with commode chair, each | $8.55 |
| E0175 | UE | Foot rest, for use with commode chair, each | $62.93 |
| E0181 | NU | Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty | $310.94 |
| E0181 | RR | Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty | $31.09 |
| E0181 | UE | Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty | $233.21 |
| E0182 | NU | Pump for alternating pressure pad, for replacement only | $337.98 |
| E0182 | RR | Pump for alternating pressure pad, for replacement only | $33.80 |
| E0182 | UE | Pump for alternating pressure pad, for replacement only | $253.49 |
| E0184 | NU | Dry pressure mattress | $251.39 |
| E0184 | RR | Dry pressure mattress | $31.72 |
| E0184 | UE | Dry pressure mattress | $192.79 |
| E0185 | NU | Gel or gel-like pressure pad for mattress, standard mattress length and width | $412.99 |
| E0185 | RR | Gel or gel-like pressure pad for mattress, standard mattress length and width | $58.03 |
| E0185 | UE | Gel or gel-like pressure pad for mattress, standard mattress length and width | $316.95 |
| E0186 | NU | Air pressure mattress | $262.18 |
| E0186 | RR | Air pressure mattress | $26.22 |
| E0186 | UE | Air pressure mattress | $196.63 |
| E0187 | NU | Water pressure mattress | $299.70 |
| E0187 | RR | Water pressure mattress | $29.97 |
| E0187 | UE | Water pressure mattress | $224.78 |
| E0188 | NU | Synthetic sheepskin pad | $34.13 |
| E0188 | RR | Synthetic sheepskin pad | $4.01 |
| E0188 | UE | Synthetic sheepskin pad | $25.63 |
| E0189 | NU | Lambswool sheepskin pad, any size | $67.09 |
| E0189 | RR | Lambswool sheepskin pad, any size | $7.28 |
| E0189 | UE | Lambswool sheepskin pad, any size | $50.32 |
| E0190 | NU | Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories | BR |
| E0190 | RR | Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories | BR |
| E0190 | UE | Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories | BR |
| E0191 | NU | Heel or elbow protector, each | $12.90 |
| E0191 | RR | Heel or elbow protector, each | $1.32 |
| E0193 | RR | Powered air flotation bed (low air loss therapy) | $1,166.50 |
| E0194 | NU | Air fluidized bed | $42,018.43 |
| E0194 | RR | Air fluidized bed | $4,201.84 |
| E0194 | UE | Air fluidized bed | $31,513.83 |
| E0196 | NU | Gel pressure mattress | $419.55 |
| E0196 | RR | Gel pressure mattress | $41.95 |
| E0196 | UE | Gel pressure mattress | $314.66 |
| E0197 | NU | Air pressure pad for mattress, standard mattress length and width | $286.09 |
| E0197 | RR | Air pressure pad for mattress, standard mattress length and width | $39.46 |
| E0197 | UE | Air pressure pad for mattress, standard mattress length and width | $251.30 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0198 | NU | Water pressure pad for mattress, standard mattress length and width | $286.09 |
| E0198 | RR | Water pressure pad for mattress, standard mattress length and width | $29.64 |
| E0198 | UE | Water pressure pad for mattress, standard mattress length and width | $217.10 |
| E0199 | NU | Dry pressure pad for mattress, standard mattress length and width | $41.38 |
| E0199 | RR | Dry pressure pad for mattress, standard mattress length and width | $4.12 |
| E0199 | UE | Dry pressure pad for mattress, standard mattress length and width | $31.03 |
| E0200 | NU | Heat lamp, without stand (table model), includes bulb, or infrared element | $102.37 |
| E0200 | RR | Heat lamp, without stand (table model), includes bulb, or infrared element | $13.90 |
| E0200 | UE | Heat lamp, without stand (table model), includes bulb, or infrared element | $76.82 |
| E0202 | RR | Phototherapy (bilirubin) light with photometer | $80.84 |
| E0203 | | Therapeutic lightbox, minimum 10,000 lux, table top model | BR |
| E0205 | NU | Heat lamp, with stand, includes bulb, or infrared element | $250.56 |
| E0205 | RR | Heat lamp, with stand, includes bulb, or infrared element | $27.55 |
| E0205 | UE | Heat lamp, with stand, includes bulb, or infrared element | $187.92 |
| E0210 | NU | Electric heat pad, standard | $42.14 |
| E0210 | RR | Electric heat pad, standard | $3.96 |
| E0210 | UE | Electric heat pad, standard | $31.61 |
| E0215 | NU | Electric heat pad, moist | $91.46 |
| E0215 | RR | Electric heat pad, moist | $9.57 |
| E0215 | UE | Electric heat pad, moist | $68.61 |
| E0217 | NU | Water circulating heat pad with pump | $641.02 |
| E0217 | RR | Water circulating heat pad with pump | $71.38 |
| E0217 | UE | Water circulating heat pad with pump | $480.72 |
| E0218 | NU | Water circulating cold pad with pump | $512.66 |
| E0218 | RR | Water circulating cold pad with pump | $59.24 |
| E0218 | UE | Water circulating cold pad with pump | $384.31 |
| E0220 | NU | Hot water bottle | $10.94 |
| E0220 | RR | Hot water bottle | $1.15 |
| E0220 | UE | Hot water bottle | $8.17 |
| E0221 | | Infrared heating pad system | BR |
| E0225 | NU | Hydrocollator unit, includes pads | $501.80 |
| E0225 | RR | Hydrocollator unit, includes pads | $49.46 |
| E0225 | UE | Hydrocollator unit, includes pads | $399.50 |
| E0230 | NU | Ice cap or collar | $10.95 |
| E0230 | RR | Ice cap or collar | $1.23 |
| E0230 | UE | Ice cap or collar | $8.19 |
| E0231 | | Noncontact wound warming device (temperature control unit, AC adapter and power cord) for use with warming card and wound cover | BR |
| E0232 | | Warming card for use with the noncontact wound warming device and noncontact wound warming wound cover | BR |
| E0235 | NU | Paraffin bath unit, portable (see medical supply code A4265 for paraffin) | $222.84 |
| E0235 | RR | Paraffin bath unit, portable (see medical supply code A4265 for paraffin) | $22.28 |
| E0235 | UE | Paraffin bath unit, portable (see medical supply code A4265 for paraffin) | $167.14 |
| E0236 | NU | Pump for water circulating pad | $571.30 |
| E0236 | RR | Pump for water circulating pad | $57.13 |
| E0236 | UE | Pump for water circulating pad | $428.48 |
| E0238 | NU | Nonelectric heat pad, moist | $34.91 |
| E0238 | RR | Nonelectric heat pad, moist | $3.51 |
| E0238 | UE | Nonelectric heat pad, moist | $25.67 |
| E0239 | NU | Hydrocollator unit, portable | $580.80 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0239 | RR | Hydrocollator unit, portable | $58.09 |
| E0239 | UE | Hydrocollator unit, portable | $435.62 |
| E0240 | NU | Bath/shower chair, with or without wheels, any size | BR |
| E0240 | RR | Bath/shower chair, with or without wheels, any size | BR |
| E0240 | UE | Bath/shower chair, with or without wheels, any size | BR |
| E0241 | | Bathtub wall rail, each | $35.70 |
| E0242 | | Bathtub rail, floor base | $80.89 |
| E0243 | | Toilet rail, each | $64.18 |
| E0244 | | Raised toilet seat | $48.61 |
| E0245 | | Tub stool or bench | $80.13 |
| E0246 | | Transfer tub rail attachment | $109.37 |
| E0247 | NU | Transfer bench for tub or toilet with or without commode opening | $78.99 |
| E0247 | RR | Transfer bench for tub or toilet with or without commode opening | $7.90 |
| E0247 | UE | Transfer bench for tub or toilet with or without commode opening | $54.68 |
| E0248 | NU | Transfer bench, heavy duty, for tub or toilet with or without commode opening | BR |
| E0248 | RR | Transfer bench, heavy duty, for tub or toilet with or without commode opening | BR |
| E0248 | UE | Transfer bench, heavy duty, for tub or toilet with or without commode opening | BR |
| E0249 | NU | Pad for water circulating heat unit | $128.60 |
| E0249 | RR | Pad for water circulating heat unit | $14.14 |
| E0249 | UE | Pad for water circulating heat unit | $96.46 |
| E0250 | NU | Hospital bed, fixed height, with any type side rails, with mattress | $1,262.29 |
| E0250 | RR | Hospital bed, fixed height, with any type side rails, with mattress | $126.23 |
| E0250 | UE | Hospital bed, fixed height, with any type side rails, with mattress | $946.72 |
| E0251 | NU | Hospital bed, fixed height, with any type side rails, without mattress | $956.51 |
| E0251 | RR | Hospital bed, fixed height, with any type side rails, without mattress | $95.65 |
| E0251 | UE | Hospital bed, fixed height, with any type side rails, without mattress | $717.39 |
| E0255 | NU | Hospital bed, variable height, hi-lo, with any type side rails, with mattress | $1,516.87 |
| E0255 | RR | Hospital bed, variable height, hi-lo, with any type side rails, with mattress | $151.69 |
| E0255 | UE | Hospital bed, variable height, hi-lo, with any type side rails, with mattress | $1,137.66 |
| E0256 | NU | Hospital bed, variable height, hi-lo, with any type side rails, without mattress | $1,076.21 |
| E0256 | RR | Hospital bed, variable height, hi-lo, with any type side rails, without mattress | $107.62 |
| E0256 | UE | Hospital bed, variable height, hi-lo, with any type side rails, without mattress | $807.17 |
| E0260 | NU | Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress | BR |
| E0260 | RR | Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress | $213.34 |
| E0260 | UE | Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress | BR |
| E0261 | NU | Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress | $1,768.12 |
| E0261 | RR | Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress | $176.81 |
| E0261 | UE | Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress | $1,326.09 |
| E0265 | NU | Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress | $2,580.78 |
| E0265 | RR | Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress | $258.08 |
| E0265 | UE | Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress | $1,935.59 |
| E0266 | NU | Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress | $2,292.93 |
| E0266 | RR | Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress | $229.29 |
| E0266 | UE | Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress | $1,719.71 |
| E0270 | NU | Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress | BR |
| E0270 | RR | Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress | BR |
| E0270 | UE | Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress | BR |
| E0271 | NU | Mattress, inner spring | $286.68 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0271 | RR | Mattress, inner spring | $29.77 |
| E0271 | UE | Mattress, inner spring | $223.96 |
| E0272 | NU | Mattress, foam rubber | $261.28 |
| E0272 | RR | Mattress, foam rubber | $27.28 |
| E0272 | UE | Mattress, foam rubber | $195.02 |
| E0273 | NU | Bed board | $38.73 |
| E0273 | RR | Bed board | $15.19 |
| E0273 | UE | Bed board | $30.38 |
| E0274 | NU | Over-bed table | $62.28 |
| E0274 | RR | Over-bed table | $27.34 |
| E0274 | UE | Over-bed table | $50.13 |
| E0275 | NU | Bed pan, standard, metal or plastic | $19.76 |
| E0275 | RR | Bed pan, standard, metal or plastic | $2.07 |
| E0275 | UE | Bed pan, standard, metal or plastic | $14.83 |
| E0276 | NU | Bed pan, fracture, metal or plastic | $17.18 |
| E0276 | RR | Bed pan, fracture, metal or plastic | $2.02 |
| E0276 | UE | Bed pan, fracture, metal or plastic | $13.58 |
| E0277 | NU | Powered pressure-reducing air mattress | BR |
| E0277 | RR | Powered pressure-reducing air mattress | $980.45 |
| E0277 | UE | Powered pressure-reducing air mattress | BR |
| E0280 | NU | Bed cradle, any type | $49.32 |
| E0280 | RR | Bed cradle, any type | $5.30 |
| E0280 | UE | Bed cradle, any type | $36.99 |
| E0290 | NU | Hospital bed, fixed height, without side rails, with mattress | $965.02 |
| E0290 | RR | Hospital bed, fixed height, without side rails, with mattress | $96.50 |
| E0290 | UE | Hospital bed, fixed height, without side rails, with mattress | $723.77 |
| E0291 | NU | Hospital bed, fixed height, without side rails, without mattress | $701.17 |
| E0291 | RR | Hospital bed, fixed height, without side rails, without mattress | $70.12 |
| E0291 | UE | Hospital bed, fixed height, without side rails, without mattress | $525.88 |
| E0292 | NU | Hospital bed, variable height, hi-lo, without side rails, with mattress | $1,085.02 |
| E0292 | RR | Hospital bed, variable height, hi-lo, without side rails, with mattress | $108.50 |
| E0292 | UE | Hospital bed, variable height, hi-lo, without side rails, with mattress | $813.77 |
| E0293 | NU | Hospital bed, variable height, hi-lo, without side rails, without mattress | $923.25 |
| E0293 | RR | Hospital bed, variable height, hi-lo, without side rails, without mattress | $92.32 |
| E0293 | UE | Hospital bed, variable height, hi-lo, without side rails, without mattress | $692.44 |
| E0294 | NU | Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress | $1,686.85 |
| E0294 | RR | Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress | $168.68 |
| E0294 | UE | Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress | $1,265.14 |
| E0295 | NU | Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress | $1,644.32 |
| E0295 | RR | Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress | $164.43 |
| E0295 | UE | Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress | $1,233.25 |
| E0296 | NU | Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress | $2,120.07 |
| E0296 | RR | Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress | $212.01 |
| E0296 | UE | Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress | $1,590.06 |
| E0297 | NU | Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress | $1,816.27 |
| E0297 | RR | Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress | $181.63 |
| E0297 | UE | Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress | $1,362.21 |
| E0300 | NU | Pediatric crib, hospital grade, fully enclosed | $3,665.09 |
| E0300 | RR | Pediatric crib, hospital grade, fully enclosed | $366.50 |
| E0300 | UE | Pediatric crib, hospital grade, fully enclosed | $2,748.81 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0301 | NU | Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress | $3,495.37 |
| E0301 | RR | Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress | $349.54 |
| E0301 | UE | Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress | $2,621.54 |
| E0302 | NU | Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress | $9,237.34 |
| E0302 | RR | Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress | $923.73 |
| E0302 | UE | Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress | $6,928.01 |
| E0303 | NU | Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress | $3,924.79 |
| E0303 | RR | Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress | $392.48 |
| E0303 | UE | Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress | $2,943.59 |
| E0304 | NU | Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress | BR |
| E0304 | RR | Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress | BR |
| E0304 | UE | Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress | BR |
| E0305 | NU | Bedside rails, half-length | $229.67 |
| E0305 | RR | Bedside rails, half-length | $22.97 |
| E0305 | UE | Bedside rails, half-length | $172.25 |
| E0310 | NU | Bedside rails, full-length | $250.67 |
| E0310 | RR | Bedside rails, full-length | $29.39 |
| E0310 | UE | Bedside rails, full-length | $189.68 |
| E0315 | | Bed accessory: board, table, or support device, any type | BR |
| E0316 | RR | Safety enclosure frame/canopy for use with hospital bed, any type | $272.80 |
| E0325 | NU | Urinal; male, jug-type, any material | $13.05 |
| E0325 | RR | Urinal; male, jug-type, any material | $1.94 |
| E0325 | UE | Urinal; male, jug-type, any material | $8.64 |
| E0326 | NU | Urinal; female, jug-type, any material | $13.56 |
| E0326 | RR | Urinal; female, jug-type, any material | $1.53 |
| E0326 | UE | Urinal; female, jug-type, any material | $10.16 |
| E0350 | NU | Control unit for electronic bowel irrigation/evacuation system | BR |
| E0350 | RR | Control unit for electronic bowel irrigation/evacuation system | BR |
| E0350 | UE | Control unit for electronic bowel irrigation/evacuation system | BR |
| E0352 | | Disposable pack (water reservoir bag, speculum, valving mechanism and collection bag/box) for use with the electronic bowel irrigation/evacuation system | BR |
| E0370 | | Air pressure elevator for heel | BR |
| E0371 | RR | Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width | $573.89 |
| E0372 | RR | Powered air overlay for mattress, standard mattress length and width | $696.37 |
| E0373 | RR | Nonpowered advanced pressure reducing mattress | $793.37 |
| E0424 | RR | Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing | $295.42 |
| E0425 | NU | Stationary compressed gas system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing | $4,830.42 |
| E0425 | UE | Stationary compressed gas system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing | $3,645.60 |
| E0430 | NU | Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing | $2,187.36 |
| E0430 | UE | Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing | $1,640.52 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0431 | RR | Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing | $46.44 |
| E0434 | RR | Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing | $46.44 |
| E0435 | NU | Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing, and refill adapter | $1,503.81 |
| E0435 | UE | Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing, and refill adapter | $1,127.86 |
| E0439 | RR | Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing | $295.42 |
| E0440 | NU | Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing | $3,053.19 |
| E0440 | UE | Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing | $2,289.89 |
| E0441 | | Oxygen contents, gaseous (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned), one month's supply = one unit | $210.43 |
| E0442 | | Oxygen contents, liquid (for use with owned liquid stationary systems or when both a stationary and portable liquid system are owned), one month's supply = one unit | $210.43 |
| E0443 | | Portable oxygen contents, gaseous (for use only with portable gaseous systems when no stationary gas or liquid system is used), one month's supply = one unit | $27.65 |
| E0444 | | Portable oxygen contents, liquid (for use only with portable liquid systems when no stationary gas or liquid system is used), one month's supply = one unit | $27.65 |
| E0445 | | Oximeter device for measuring blood oxygen levels noninvasively | BR |
| E0450 | NU | Volume control ventilator, without pressure support mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube) | $12,324.25 |
| E0450 | RR | Volume control ventilator, without pressure support mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube) | $1,232.43 |
| E0450 | UE | Volume control ventilator, without pressure support mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube) | $9,243.19 |
| E0455 | NU | Oxygen tent, excluding croup or pediatric tents | BR |
| E0455 | RR | Oxygen tent, excluding croup or pediatric tents | BR |
| E0455 | UE | Oxygen tent, excluding croup or pediatric tents | BR |
| E0457 | NU | Chest shell (cuirass) | $793.42 |
| E0457 | RR | Chest shell (cuirass) | $79.34 |
| E0457 | UE | Chest shell (cuirass) | $595.02 |
| E0459 | NU | Chest wrap | $657.12 |
| E0459 | RR | Chest wrap | $65.71 |
| E0459 | UE | Chest wrap | $492.84 |
| E0460 | NU | Negative pressure ventilator; portable or stationary | $9,471.42 |
| E0460 | RR | Negative pressure ventilator; portable or stationary | $947.14 |
| E0460 | UE | Negative pressure ventilator; portable or stationary | $7,103.57 |
| E0461 | RR | Volume control ventilator, without pressure support mode, may include pressure control mode, used with noninvasive interface (e.g., mask) | $1,293.79 |
| E0462 | NU | Rocking bed, with or without side rails | $3,762.41 |
| E0462 | RR | Rocking bed, with or without side rails | $376.24 |
| E0462 | UE | Rocking bed, with or without side rails | $2,821.82 |
| E0463 | | Pressure support ventilator with volume control mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube) | BR |
| E0464 | | Pressure support ventilator with volume control mode, may include pressure control mode, used with noninvasive interface (e.g., mask) | BR |
| E0470 | NU | Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) | $3,313.09 |
| E0470 | RR | Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) | $331.31 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0470 | UE | Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) | $2,484.83 |
| E0471 | NU | Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) | $8,291.31 |
| E0471 | RR | Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) | $829.13 |
| E0471 | UE | Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) | $6,218.48 |
| E0472 | NU | Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device) | $8,291.31 |
| E0472 | RR | Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device) | $829.13 |
| E0472 | UE | Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device) | $6,218.48 |
| E0480 | NU | Percussor, electric or pneumatic, home model | $567.35 |
| E0480 | RR | Percussor, electric or pneumatic, home model | $56.73 |
| E0480 | UE | Percussor, electric or pneumatic, home model | $425.52 |
| E0481 | | Intrapulmonary percussive ventilation system and related accessories | BR |
| E0482 | RR | Cough stimulating device, alternating positive and negative airway pressure | $555.22 |
| E0483 | RR | High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each | $1,372.66 |
| E0484 | NU | Oscillatory positive expiratory pressure device, nonelectric, any type, each | $47.67 |
| E0484 | RR | Oscillatory positive expiratory pressure device, nonelectric, any type, each | $4.77 |
| E0484 | UE | Oscillatory positive expiratory pressure device, nonelectric, any type, each | $35.77 |
| E0485 | | Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment | BR |
| E0486 | | Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment | BR |
| E0500 | NU | IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source | $1,417.23 |
| E0500 | RR | IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source | $141.72 |
| E0500 | UE | IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source | $1,062.92 |
| E0550 | NU | Humidifier, durable for extensive supplemental humidification during ippb treatments or oxygen delivery | $647.25 |
| E0550 | RR | Humidifier, durable for extensive supplemental humidification during ippb treatments or oxygen delivery | $64.72 |
| E0550 | UE | Humidifier, durable for extensive supplemental humidification during ippb treatments or oxygen delivery | $485.44 |
| E0555 | NU | Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter | $10.63 |
| E0555 | RR | Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter | $7.60 |
| E0555 | UE | Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter | $9.11 |
| E0560 | NU | Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery | $221.46 |
| E0560 | RR | Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery | $25.96 |
| E0560 | UE | Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery | $166.09 |
| E0561 | NU | Humidifier, nonheated, used with positive airway pressure device | $138.15 |
| E0561 | RR | Humidifier, nonheated, used with positive airway pressure device | $13.81 |
| E0561 | UE | Humidifier, nonheated, used with positive airway pressure device | $103.60 |
| E0562 | NU | Humidifier, heated, used with positive airway pressure device | $388.92 |
| E0562 | RR | Humidifier, heated, used with positive airway pressure device | $38.87 |
| E0562 | UE | Humidifier, heated, used with positive airway pressure device | $291.68 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0565 | NU | Compressor, air power source for equipment which is not self-contained or cylinder driven | $787.75 |
| E0565 | RR | Compressor, air power source for equipment which is not self-contained or cylinder driven | $78.78 |
| E0565 | UE | Compressor, air power source for equipment which is not self-contained or cylinder driven | $590.82 |
| E0570 | NU | Nebulizer, with compressor | BR |
| E0570 | RR | Nebulizer, with compressor | $23.61 |
| E0570 | UE | Nebulizer, with compressor | BR |
| E0571 | RR | Aerosol compressor, battery powered, for use with small volume nebulizer | $38.69 |
| E0572 | RR | Aerosol compressor, adjustable pressure, light duty for intermittent use | $49.19 |
| E0574 | RR | Ultrasonic/electronic aerosol generator with small volume nebulizer | $51.98 |
| E0575 | NU | Nebulizer, ultrasonic, large volume | $1,327.00 |
| E0575 | RR | Nebulizer, ultrasonic, large volume | $132.70 |
| E0575 | UE | Nebulizer, ultrasonic, large volume | $995.25 |
| E0580 | NU | Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter | $173.06 |
| E0580 | RR | Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter | $17.30 |
| E0580 | UE | Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter | $129.78 |
| E0585 | NU | Nebulizer, with compressor and heater | $452.81 |
| E0585 | RR | Nebulizer, with compressor and heater | $45.28 |
| E0585 | UE | Nebulizer, with compressor and heater | $339.62 |
| E0600 | NU | Respiratory suction pump, home model, portable or stationary, electric | $591.19 |
| E0600 | RR | Respiratory suction pump, home model, portable or stationary, electric | $59.12 |
| E0600 | UE | Respiratory suction pump, home model, portable or stationary, electric | $443.40 |
| E0601 | NU | Continuous airway pressure (CPAP) device | $1,442.29 |
| E0601 | RR | Continuous airway pressure (CPAP) device | $144.23 |
| E0601 | UE | Continuous airway pressure (CPAP) device | $1,081.73 |
| E0602 | NU | Breast pump, manual, any type | $38.11 |
| E0602 | RR | Breast pump, manual, any type | $3.83 |
| E0602 | UE | Breast pump, manual, any type | $28.59 |
| E0603 | NU | Breast pump, electric (AC and/or DC), any type | $113.93 |
| E0603 | RR | Breast pump, electric (AC and/or DC), any type | $37.98 |
| E0603 | UE | Breast pump, electric (AC and/or DC), any type | $91.14 |
| E0604 | NU | Breast pump, heavy duty, hospital grade, piston operated, pulsatile vacuum suction/release cycles, vacuum regulator, supplies, transformer, electric (AC and/or DC) | $328.10 |
| E0604 | RR | Breast pump, heavy duty, hospital grade, piston operated, pulsatile vacuum suction/release cycles, vacuum regulator, supplies, transformer, electric (AC and/or DC) | $126.08 |
| E0604 | UE | Breast pump, heavy duty, hospital grade, piston operated, pulsatile vacuum suction/release cycles, vacuum regulator, supplies, transformer, electric (AC and/or DC) | $246.08 |
| E0605 | NU | Vaporizer, room type | $34.13 |
| E0605 | RR | Vaporizer, room type | $3.96 |
| E0605 | UE | Vaporizer, room type | $28.10 |
| E0606 | NU | Postural drainage board | $296.21 |
| E0606 | RR | Postural drainage board | $29.62 |
| E0606 | UE | Postural drainage board | $222.15 |
| E0607 | NU | Home blood glucose monitor | $101.50 |
| E0607 | RR | Home blood glucose monitor | $10.15 |
| E0607 | UE | Home blood glucose monitor | $76.10 |
| E0610 | NU | Pacemaker monitor, self-contained, checks battery depletion, includes audible and visible check systems | $307.11 |
| E0610 | RR | Pacemaker monitor, self-contained, checks battery depletion, includes audible and visible check systems | $32.40 |
| E0610 | UE | Pacemaker monitor, self-contained, checks battery depletion, includes audible and visible check systems | $230.37 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0615 | NU | Pacemaker monitor, self-contained, checks battery depletion and other pacemaker components, includes digital/visible check systems | $618.23 |
| E0615 | RR | Pacemaker monitor, self-contained, checks battery depletion and other pacemaker components, includes digital/visible check systems | $75.54 |
| E0615 | UE | Pacemaker monitor, self-contained, checks battery depletion and other pacemaker components, includes digital/visible check systems | $463.67 |
| E0616 | | Implantable cardiac event recorder with memory, activator and programmer | BR |
| E0617 | RR | External defibrillator with integrated electrocardiogram analysis | $392.57 |
| E0618 | RR | Apnea monitor, without recording feature | $361.98 |
| E0619 | RR | Apnea monitor, with recording feature | BR |
| E0620 | NU | Skin piercing device for collection of capillary blood, laser, each | $1,128.97 |
| E0620 | RR | Skin piercing device for collection of capillary blood, laser, each | $112.89 |
| E0620 | UE | Skin piercing device for collection of capillary blood, laser, each | $846.72 |
| E0621 | NU | Sling or seat, patient lift, canvas or nylon | $123.94 |
| E0621 | RR | Sling or seat, patient lift, canvas or nylon | $11.94 |
| E0621 | UE | Sling or seat, patient lift, canvas or nylon | $93.43 |
| E0625 | NU | Patient lift, bathroom or toilet, not otherwise classified | BR |
| E0625 | RR | Patient lift, bathroom or toilet, not otherwise classified | BR |
| E0625 | UE | Patient lift, bathroom or toilet, not otherwise classified | BR |
| E0627 | NU | Seat lift mechanism incorporated into a combination lift-chair mechanism | $435.53 |
| E0627 | RR | Seat lift mechanism incorporated into a combination lift-chair mechanism | $43.56 |
| E0627 | UE | Seat lift mechanism incorporated into a combination lift-chair mechanism | $326.66 |
| E0628 | NU | Separate seat lift mechanism for use with patient owned furniture — electric | $435.53 |
| E0628 | RR | Separate seat lift mechanism for use with patient owned furniture — electric | $43.56 |
| E0628 | UE | Separate seat lift mechanism for use with patient owned furniture — electric | $326.66 |
| E0629 | NU | Separate seat lift mechanism for use with patient owned furniture — nonelectric | $426.99 |
| E0629 | RR | Separate seat lift mechanism for use with patient owned furniture — nonelectric | $42.71 |
| E0629 | UE | Separate seat lift mechanism for use with patient owned furniture — nonelectric | $320.22 |
| E0630 | NU | Patient lift, hydraulic, with seat or sling | $1,315.61 |
| E0630 | RR | Patient lift, hydraulic, with seat or sling | $131.56 |
| E0630 | UE | Patient lift, hydraulic, with seat or sling | $986.71 |
| E0635 | NU | Patient lift, electric, with seat or sling | $1,579.91 |
| E0635 | RR | Patient lift, electric, with seat or sling | $157.99 |
| E0635 | UE | Patient lift, electric, with seat or sling | $1,184.94 |
| E0636 | RR | Multipositional patient support system, with integrated lift, patient accessible controls | $1,361.60 |
| E0637 | NU | Combination sit to stand system, any size including pediatric, with seatlift feature, with or without wheels | $2,717.83 |
| E0637 | RR | Combination sit to stand system, any size including pediatric, with seatlift feature, with or without wheels | $271.78 |
| E0637 | UE | Combination sit to stand system, any size including pediatric, with seatlift feature, with or without wheels | $2,038.38 |
| E0638 | NU | Standing frame system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels | BR |
| E0638 | RR | Standing frame system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels | BR |
| E0638 | UE | Standing frame system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels | BR |
| E0639 | | Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories | BR |
| E0640 | | Patient lift, fixed system, includes all components/accessories | BR |
| E0641 | | Standing frame system, multi-position (e.g., three-way stander), any size including pediatric, with or without wheels | BR |
| E0642 | | Standing frame system, mobile (dynamic stander), any size including pediatric | BR |
| E0650 | NU | Pneumatic compressor, nonsegmental home model | $929.92 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0650 | RR | Pneumatic compressor, nonsegmental home model | $114.75 |
| E0650 | UE | Pneumatic compressor, nonsegmental home model | $697.43 |
| E0651 | NU | Pneumatic compressor, segmental home model without calibrated gradient pressure | $1,185.82 |
| E0651 | RR | Pneumatic compressor, segmental home model without calibrated gradient pressure | $121.14 |
| E0651 | UE | Pneumatic compressor, segmental home model without calibrated gradient pressure | $889.37 |
| E0652 | NU | Pneumatic compressor, segmental home model with calibrated gradient pressure | $6,844.96 |
| E0652 | RR | Pneumatic compressor, segmental home model with calibrated gradient pressure | $676.50 |
| E0652 | UE | Pneumatic compressor, segmental home model with calibrated gradient pressure | $5,129.13 |
| E0655 | NU | Nonsegmental pneumatic appliance for use with pneumatic compressor, half arm | $139.34 |
| E0655 | RR | Nonsegmental pneumatic appliance for use with pneumatic compressor, half arm | $16.37 |
| E0655 | UE | Nonsegmental pneumatic appliance for use with pneumatic compressor, half arm | $104.64 |
| E0660 | NU | Nonsegmental pneumatic appliance for use with pneumatic compressor, full leg | $206.27 |
| E0660 | RR | Nonsegmental pneumatic appliance for use with pneumatic compressor, full leg | $21.48 |
| E0660 | UE | Nonsegmental pneumatic appliance for use with pneumatic compressor, full leg | $154.68 |
| E0665 | NU | Nonsegmental pneumatic appliance for use with pneumatic compressor, full arm | $176.87 |
| E0665 | RR | Nonsegmental pneumatic appliance for use with pneumatic compressor, full arm | $18.17 |
| E0665 | UE | Nonsegmental pneumatic appliance for use with pneumatic compressor, full arm | $132.84 |
| E0666 | NU | Nonsegmental pneumatic appliance for use with pneumatic compressor, half leg | $178.29 |
| E0666 | RR | Nonsegmental pneumatic appliance for use with pneumatic compressor, half leg | $18.38 |
| E0666 | UE | Nonsegmental pneumatic appliance for use with pneumatic compressor, half leg | $133.75 |
| E0667 | NU | Segmental pneumatic appliance for use with pneumatic compressor, full leg | $418.03 |
| E0667 | RR | Segmental pneumatic appliance for use with pneumatic compressor, full leg | $47.21 |
| E0667 | UE | Segmental pneumatic appliance for use with pneumatic compressor, full leg | $313.54 |
| E0668 | NU | Segmental pneumatic appliance for use with pneumatic compressor, full arm | $570.54 |
| E0668 | RR | Segmental pneumatic appliance for use with pneumatic compressor, full arm | $56.31 |
| E0668 | UE | Segmental pneumatic appliance for use with pneumatic compressor, full arm | $467.85 |
| E0669 | NU | Segmental pneumatic appliance for use with pneumatic compressor, half leg | $236.68 |
| E0669 | RR | Segmental pneumatic appliance for use with pneumatic compressor, half leg | $23.68 |
| E0669 | UE | Segmental pneumatic appliance for use with pneumatic compressor, half leg | $177.54 |
| E0671 | NU | Segmental gradient pressure pneumatic appliance, full leg | $536.28 |
| E0671 | RR | Segmental gradient pressure pneumatic appliance, full leg | $53.64 |
| E0671 | UE | Segmental gradient pressure pneumatic appliance, full leg | $402.20 |
| E0672 | NU | Segmental gradient pressure pneumatic appliance, full arm | $416.69 |
| E0672 | RR | Segmental gradient pressure pneumatic appliance, full arm | $41.68 |
| E0672 | UE | Segmental gradient pressure pneumatic appliance, full arm | $312.53 |
| E0673 | NU | Segmental gradient pressure pneumatic appliance, half leg | $346.24 |
| E0673 | RR | Segmental gradient pressure pneumatic appliance, half leg | $34.63 |
| E0673 | UE | Segmental gradient pressure pneumatic appliance, half leg | $259.72 |
| E0675 | NU | Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system) | $4,965.16 |
| E0675 | RR | Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system) | $496.52 |
| E0675 | UE | Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system) | $3,723.87 |
| E0676 | | Intermittent limb compression device (includes all accessories), not otherwise specified | BR |
| E0691 | NU | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area two square feet or less | $1,160.21 |
| E0691 | RR | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area two square feet or less | $116.02 |
| E0691 | UE | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area two square feet or less | $870.16 |
| E0692 | NU | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, four foot panel | $1,456.89 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0692 | RR | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, four foot panel | $145.69 |
| E0692 | UE | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, four foot panel | $1,092.69 |
| E0693 | NU | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, six foot panel | $1,795.96 |
| E0693 | RR | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, six foot panel | $179.61 |
| E0693 | UE | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, six foot panel | $1,346.97 |
| E0694 | NU | Ultraviolet multidirectional light therapy system in six foot cabinet, includes bulbs/lamps, timer and eye protection | $5,716.36 |
| E0694 | RR | Ultraviolet multidirectional light therapy system in six foot cabinet, includes bulbs/lamps, timer and eye protection | $571.63 |
| E0694 | UE | Ultraviolet multidirectional light therapy system in six foot cabinet, includes bulbs/lamps, timer and eye protection | $4,287.30 |
| E0700 | | Safety equipment (e.g., belt, harness or vest) | BR |
| E0705 | | Transfer board or device, any type, each | BR |
| E0710 | | Restraint, any type (body, chest, wrist or ankle) | BR |
| E0720 | NU | Transcutaneous electrical nerve stimulation (TENS) device, two lead, localized stimulation | $474.60 |
| E0720 | RR | Transcutaneous electrical nerve stimulation (TENS) device, two lead, localized stimulation | $47.45 |
| E0720 | UE | Transcutaneous electrical nerve stimulation (TENS) device, two lead, localized stimulation | $355.95 |
| E0730 | NU | Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation | $478.45 |
| E0730 | RR | Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation | $47.85 |
| E0730 | UE | Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation | $358.85 |
| E0731 | | Form-fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric) | $460.55 |
| E0740 | NU | Incontinence treatment system, pelvic floor stimulator, monitor, sensor and/or trainer | $675.10 |
| E0740 | RR | Incontinence treatment system, pelvic floor stimulator, monitor, sensor and/or trainer | $67.52 |
| E0740 | UE | Incontinence treatment system, pelvic floor stimulator, monitor, sensor and/or trainer | $506.36 |
| E0744 | NU | Neuromuscular stimulator for scoliosis | $1,182.24 |
| E0744 | RR | Neuromuscular stimulator for scoliosis | $118.22 |
| E0744 | UE | Neuromuscular stimulator for scoliosis | $886.69 |
| E0745 | NU | Neuromuscular stimulator, electronic shock unit | $1,155.66 |
| E0745 | RR | Neuromuscular stimulator, electronic shock unit | $115.57 |
| E0745 | UE | Neuromuscular stimulator, electronic shock unit | $866.74 |
| E0746 | NU | Electromyography (EMG), biofeedback device | BR |
| E0746 | RR | Electromyography (EMG), biofeedback device | BR |
| E0746 | UE | Electromyography (EMG), biofeedback device | BR |
| E0747 | NU | Osteogenesis stimulator, electrical, noninvasive, other than spinal applications | $4,803.23 |
| E0747 | RR | Osteogenesis stimulator, electrical, noninvasive, other than spinal applications | $477.32 |
| E0747 | UE | Osteogenesis stimulator, electrical, noninvasive, other than spinal applications | $3,568.71 |
| E0748 | NU | Osteogenesis stimulator, electrical, noninvasive, spinal applications | $4,772.11 |
| E0748 | RR | Osteogenesis stimulator, electrical, noninvasive, spinal applications | $477.21 |
| E0748 | UE | Osteogenesis stimulator, electrical, noninvasive, spinal applications | $3,579.10 |
| E0749 | RR | Osteogenesis stimulator, electrical, surgically implanted | $348.79 |
| E0755 | | Electronic salivary reflex stimulator (intraoral/noninvasive) | BR |
| E0760 | NU | Osteogenesis stimulator, low intensity ultrasound, noninvasive | $3,965.53 |
| E0760 | RR | Osteogenesis stimulator, low intensity ultrasound, noninvasive | $396.57 |
| E0760 | UE | Osteogenesis stimulator, low intensity ultrasound, noninvasive | $2,974.16 |
| E0761 | | Nonthermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device | BR |
| E0762 | | Transcutaneous electrical joint stimulation device system, includes all accessories | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0764 | NU | Functional neuromuscular stimulator, transcutaneous stimulation of muscles of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program | $13,913.27 |
| E0764 | RR | Functional neuromuscular stimulator, transcutaneous stimulation of muscles of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program | $1,391.31 |
| E0764 | UE | Functional neuromuscular stimulator, transcutaneous stimulation of muscles of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program | $10,434.95 |
| E0765 | NU | FDA approved nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting | $108.62 |
| E0765 | RR | FDA approved nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting | $10.89 |
| E0765 | UE | FDA approved nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting | $81.49 |
| E0769 | | Electrical stimulation or electromagnetic wound treatment device, not otherwise classified | BR |
| E0776 | NU | IV pole | $151.13 |
| E0776 | RR | IV pole | $38.25 |
| E0776 | UE | IV pole | $113.35 |
| E0779 | RR | Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater | $21.60 |
| E0780 | | Ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours | $13.38 |
| E0781 | RR | Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient | $341.99 |
| E0782 | NU | Infusion pump, implantable, nonprogrammable (includes all components, e.g., pump, catheter, connectors, etc.) | $5,266.05 |
| E0782 | RR | Infusion pump, implantable, nonprogrammable (includes all components, e.g., pump, catheter, connectors, etc.) | $526.62 |
| E0782 | UE | Infusion pump, implantable, nonprogrammable (includes all components, e.g., pump, catheter, connectors, etc.) | $3,949.55 |
| E0783 | NU | Infusion pump system, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.) | $10,041.58 |
| E0783 | RR | Infusion pump system, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.) | $1,004.18 |
| E0783 | UE | Infusion pump system, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.) | $7,531.20 |
| E0784 | NU | External ambulatory infusion pump, insulin | $5,391.39 |
| E0784 | RR | External ambulatory infusion pump, insulin | $539.14 |
| E0784 | UE | External ambulatory infusion pump, insulin | $4,043.55 |
| E0785 | | Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump, replacement | $579.54 |
| E0786 | NU | Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter) | $9,794.97 |
| E0786 | RR | Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter) | $979.48 |
| E0786 | UE | Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter) | $7,346.22 |
| E0791 | NU | Parenteral infusion pump, stationary, single or multichannel | $4,082.62 |
| E0791 | RR | Parenteral infusion pump, stationary, single or multichannel | $408.26 |
| E0791 | UE | Parenteral infusion pump, stationary, single or multichannel | $3,061.97 |
| E0830 | | Ambulatory traction device, all types, each | BR |
| E0840 | NU | Traction frame, attached to headboard, cervical traction | $94.62 |
| E0840 | RR | Traction frame, attached to headboard, cervical traction | $21.07 |
| E0840 | UE | Traction frame, attached to headboard, cervical traction | $70.92 |
| E0849 | | Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible | BR |
| E0850 | NU | Traction stand, freestanding, cervical traction | $135.65 |
| E0850 | RR | Traction stand, freestanding, cervical traction | $18.64 |
| E0850 | UE | Traction stand, freestanding, cervical traction | $101.74 |
| E0855 | NU | Cervical traction equipment not requiring additional stand or frame | $648.98 |
| E0855 | RR | Cervical traction equipment not requiring additional stand or frame | $64.89 |
| E0855 | UE | Cervical traction equipment not requiring additional stand or frame | $486.72 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0860 | NU | Traction equipment, overdoor, cervical | $49.75 |
| E0860 | RR | Traction equipment, overdoor, cervical | $8.40 |
| E0860 | UE | Traction equipment, overdoor, cervical | $38.10 |
| E0870 | NU | Traction frame, attached to footboard, extremity traction (e.g., Buck's) | $150.17 |
| E0870 | RR | Traction frame, attached to footboard, extremity traction (e.g., Buck's) | $17.30 |
| E0870 | UE | Traction frame, attached to footboard, extremity traction (e.g., Buck's) | $113.14 |
| E0880 | NU | Traction stand, freestanding, extremity traction (e.g., Buck's) | $162.09 |
| E0880 | RR | Traction stand, freestanding, extremity traction (e.g., Buck's) | $25.44 |
| E0880 | UE | Traction stand, freestanding, extremity traction (e.g., Buck's) | $122.69 |
| E0890 | NU | Traction frame, attached to footboard, pelvic traction | $155.47 |
| E0890 | RR | Traction frame, attached to footboard, pelvic traction | $42.40 |
| E0890 | UE | Traction frame, attached to footboard, pelvic traction | $125.23 |
| E0900 | NU | Traction stand, freestanding, pelvic traction (e.g., Buck's) | $165.42 |
| E0900 | RR | Traction stand, freestanding, pelvic traction (e.g., Buck's) | $35.67 |
| E0900 | UE | Traction stand, freestanding, pelvic traction (e.g., Buck's) | $124.10 |
| E0910 | NU | Trapeze bars, also known as Patient Helper, attached to bed, with grab bar | $258.23 |
| E0910 | RR | Trapeze bars, also known as Patient Helper, attached to bed, with grab bar | $25.82 |
| E0910 | UE | Trapeze bars, also known as Patient Helper, attached to bed, with grab bar | $193.67 |
| E0911 | RR | Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar | BR |
| E0912 | RR | Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar | BR |
| E0920 | NU | Fracture frame, attached to bed, includes weights | $595.75 |
| E0920 | RR | Fracture frame, attached to bed, includes weights | $59.58 |
| E0920 | UE | Fracture frame, attached to bed, includes weights | $598.71 |
| E0930 | RR | Fracture frame, freestanding, includes weights | $59.00 |
| E0935 | RR | Continuous passive motion exercise device for use on knee only | $29.35 |
| E0936 | | Continuous passive motion exercise device for use other than knee | BR |
| E0940 | NU | Trapeze bar, freestanding, complete with grab bar | $448.86 |
| E0940 | RR | Trapeze bar, freestanding, complete with grab bar | $44.89 |
| E0940 | UE | Trapeze bar, freestanding, complete with grab bar | $336.66 |
| E0941 | RR | Gravity assisted traction device, any type | $56.05 |
| E0942 | NU | Cervical head harness/halter | $25.63 |
| E0942 | RR | Cervical head harness/halter | $3.02 |
| E0942 | UE | Cervical head harness/halter | $19.22 |
| E0944 | NU | Pelvic belt/harness/boot | $59.24 |
| E0944 | RR | Pelvic belt/harness/boot | $5.94 |
| E0944 | UE | Pelvic belt/harness/boot | $44.42 |
| E0945 | NU | Extremity belt/harness | $57.22 |
| E0945 | RR | Extremity belt/harness | $5.73 |
| E0945 | UE | Extremity belt/harness | $44.29 |
| E0946 | RR | Fracture frame, dual with cross bars, attached to bed (e.g., Balken, Four Poster) | $76.39 |
| E0947 | NU | Fracture frame, attachments for complex pelvic traction | $783.03 |
| E0947 | RR | Fracture frame, attachments for complex pelvic traction | $81.21 |
| E0947 | UE | Fracture frame, attachments for complex pelvic traction | $587.26 |
| E0948 | NU | Fracture frame, attachments for complex cervical traction | $757.37 |
| E0948 | RR | Fracture frame, attachments for complex cervical traction | $75.71 |
| E0948 | UE | Fracture frame, attachments for complex cervical traction | $534.16 |
| E0950 | NU | Wheelchair accessory, tray, each | $134.22 |
| E0950 | RR | Wheelchair accessory, tray, each | $13.44 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0950 | UE | Wheelchair accessory, tray, each | $100.66 |
| E0951 | NU | Heel loop/holder, any type, with or without ankle strap, each | $24.50 |
| E0951 | RR | Heel loop/holder, any type, with or without ankle strap, each | $2.54 |
| E0951 | UE | Heel loop/holder, any type, with or without ankle strap, each | $18.36 |
| E0952 | NU | Toe loop/holder, any type, each | $24.32 |
| E0952 | RR | Toe loop/holder, any type, each | $2.54 |
| E0952 | UE | Toe loop/holder, any type, each | $18.24 |
| E0955 | NU | Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each | $261.04 |
| E0955 | RR | Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each | $26.13 |
| E0955 | UE | Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each | $195.78 |
| E0956 | NU | Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each | $127.28 |
| E0956 | RR | Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each | $12.74 |
| E0956 | UE | Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each | $95.45 |
| E0957 | NU | Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each | $178.09 |
| E0957 | RR | Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each | $17.80 |
| E0957 | UE | Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each | $133.57 |
| E0958 | NU | Manual wheelchair accessory, one-arm drive attachment, each | $563.40 |
| E0958 | RR | Manual wheelchair accessory, one-arm drive attachment, each | $56.34 |
| E0958 | UE | Manual wheelchair accessory, one-arm drive attachment, each | $422.56 |
| E0959 | NU | Manual wheelchair accessory, adapter for amputee, each | $57.08 |
| E0959 | RR | Manual wheelchair accessory, adapter for amputee, each | $5.74 |
| E0959 | UE | Manual wheelchair accessory, adapter for amputee, each | $43.20 |
| E0960 | NU | Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware | $117.46 |
| E0960 | RR | Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware | $11.76 |
| E0960 | UE | Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware | $88.10 |
| E0961 | NU | Manual wheelchair accessory, wheel lock brake extension (handle), each | $38.40 |
| E0961 | RR | Manual wheelchair accessory, wheel lock brake extension (handle), each | $4.01 |
| E0961 | UE | Manual wheelchair accessory, wheel lock brake extension (handle), each | $19.18 |
| E0966 | NU | Manual wheelchair accessory, headrest extension, each | $92.14 |
| E0966 | RR | Manual wheelchair accessory, headrest extension, each | $9.08 |
| E0966 | UE | Manual wheelchair accessory, headrest extension, each | $69.10 |
| E0967 | NU | Manual wheelchair accessory, hand rim with projections, any type, each | $84.82 |
| E0967 | RR | Manual wheelchair accessory, hand rim with projections, any type, each | $8.48 |
| E0967 | UE | Manual wheelchair accessory, hand rim with projections, any type, each | $63.59 |
| E0968 | NU | Commode seat, wheelchair | $285.95 |
| E0968 | RR | Commode seat, wheelchair | $28.48 |
| E0968 | UE | Commode seat, wheelchair | $182.28 |
| E0969 | NU | Narrowing device, wheelchair | $202.24 |
| E0969 | RR | Narrowing device, wheelchair | $20.02 |
| E0969 | UE | Narrowing device, wheelchair | $151.69 |
| E0970 | NU | No. 2 footplates, except for elevating legrest | $76.71 |
| E0970 | RR | No. 2 footplates, except for elevating legrest | $6.84 |
| E0970 | UE | No. 2 footplates, except for elevating legrest | $57.72 |
| E0971 | NU | Manual wheelchair accessory, anti-tipping device, each | $84.90 |
| E0971 | RR | Manual wheelchair accessory, anti-tipping device, each | $9.63 |
| E0971 | UE | Manual wheelchair accessory, anti-tipping device, each | $63.66 |
| E0973 | NU | Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each | $148.44 |
| E0973 | RR | Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each | $14.14 |
| E0973 | UE | Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each | $111.34 |
| E0974 | NU | Manual wheelchair accessory, anti-rollback device, each | $101.24 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E0974 | RR | Manual wheelchair accessory, anti-rollback device, each | $10.72 |
| E0974 | UE | Manual wheelchair accessory, anti-rollback device, each | $76.50 |
| E0978 | NU | Wheelchair accessory, positioning belt/safety belt/pelvic strap, each | $55.14 |
| E0978 | RR | Wheelchair accessory, positioning belt/safety belt/pelvic strap, each | $5.53 |
| E0978 | UE | Wheelchair accessory, positioning belt/safety belt/pelvic strap, each | $40.88 |
| E0980 | NU | Safety vest, wheelchair | $42.68 |
| E0980 | RR | Safety vest, wheelchair | $4.27 |
| E0980 | UE | Safety vest, wheelchair | $31.84 |
| E0981 | NU | Wheelchair accessory, seat upholstery, replacement only, each | $60.88 |
| E0981 | RR | Wheelchair accessory, seat upholstery, replacement only, each | $6.20 |
| E0981 | UE | Wheelchair accessory, seat upholstery, replacement only, each | $46.10 |
| E0982 | NU | Wheelchair accessory, back upholstery, replacement only, each | $66.53 |
| E0982 | RR | Wheelchair accessory, back upholstery, replacement only, each | $6.65 |
| E0982 | UE | Wheelchair accessory, back upholstery, replacement only, each | $49.88 |
| E0983 | RR | Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control | $322.70 |
| E0984 | NU | Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control | $2,466.84 |
| E0984 | RR | Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control | $229.29 |
| E0984 | UE | Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control | $1,903.50 |
| E0985 | NU | Wheelchair accessory, seat lift mechanism | $261.91 |
| E0985 | RR | Wheelchair accessory, seat lift mechanism | $26.22 |
| E0985 | UE | Wheelchair accessory, seat lift mechanism | $196.41 |
| E0986 | NU | Manual wheelchair accessory, push activated power assist, each | $6,280.46 |
| E0986 | RR | Manual wheelchair accessory, push activated power assist, each | $628.06 |
| E0986 | UE | Manual wheelchair accessory, push activated power assist, each | $4,710.37 |
| E0990 | NU | Wheelchair accessory, elevating leg rest, complete assembly, each | $151.63 |
| E0990 | RR | Wheelchair accessory, elevating leg rest, complete assembly, each | $17.07 |
| E0990 | UE | Wheelchair accessory, elevating leg rest, complete assembly, each | $118.47 |
| E0992 | NU | Manual wheelchair accessory, solid seat insert | $122.86 |
| E0992 | RR | Manual wheelchair accessory, solid seat insert | $11.94 |
| E0992 | UE | Manual wheelchair accessory, solid seat insert | $92.14 |
| E0994 | NU | Armrest, each | $22.77 |
| E0994 | RR | Armrest, each | $2.29 |
| E0994 | UE | Armrest, each | $17.09 |
| E0995 | NU | Wheelchair accessory, calf rest/pad, each | $39.25 |
| E0995 | RR | Wheelchair accessory, calf rest/pad, each | $3.93 |
| E0995 | UE | Wheelchair accessory, calf rest/pad, each | $29.41 |
| E1002 | NU | Wheelchair accessory, power seating system, tilt only | $5,310.53 |
| E1002 | RR | Wheelchair accessory, power seating system, tilt only | $531.09 |
| E1002 | UE | Wheelchair accessory, power seating system, tilt only | $3,982.89 |
| E1003 | NU | Wheelchair accessory, power seating system, recline only, without shear reduction | $5,669.83 |
| E1003 | RR | Wheelchair accessory, power seating system, recline only, without shear reduction | $567.00 |
| E1003 | UE | Wheelchair accessory, power seating system, recline only, without shear reduction | $4,252.38 |
| E1004 | NU | Wheelchair accessory, power seating system, recline only, with mechanical shear reduction | $6,286.67 |
| E1004 | RR | Wheelchair accessory, power seating system, recline only, with mechanical shear reduction | $628.67 |
| E1004 | UE | Wheelchair accessory, power seating system, recline only, with mechanical shear reduction | $4,714.98 |
| E1005 | NU | Wheelchair accessory, power seating system, recline only, with power shear reduction | $6,804.83 |
| E1005 | RR | Wheelchair accessory, power seating system, recline only, with power shear reduction | $680.48 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E1005 | UE | Wheelchair accessory, power seating system, recline only, with power shear reduction | $5,103.63 |
| E1006 | NU | Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction | $8,335.28 |
| E1006 | RR | Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction | $833.51 |
| E1006 | UE | Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction | $6,251.46 |
| E1007 | NU | Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction | $11,286.29 |
| E1007 | RR | Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction | $1,128.63 |
| E1007 | UE | Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction | $8,464.70 |
| E1008 | NU | Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction | $11,287.29 |
| E1008 | RR | Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction | $1,128.72 |
| E1008 | UE | Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction | $8,465.49 |
| E1009 | NU | Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each | BR |
| E1009 | RR | Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each | BR |
| E1009 | UE | Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each | BR |
| E1010 | NU | Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair | BR |
| E1010 | RR | Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair | BR |
| E1010 | UE | Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair | BR |
| E1011 | NU | Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair) | BR |
| E1011 | RR | Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair) | BR |
| E1011 | UE | Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair) | BR |
| E1014 | NU | Reclining back, addition to pediatric size wheelchair | $471.45 |
| E1014 | RR | Reclining back, addition to pediatric size wheelchair | $47.15 |
| E1014 | UE | Reclining back, addition to pediatric size wheelchair | $353.58 |
| E1015 | NU | Shock absorber for manual wheelchair, each | $148.10 |
| E1015 | RR | Shock absorber for manual wheelchair, each | $14.80 |
| E1015 | UE | Shock absorber for manual wheelchair, each | $111.07 |
| E1016 | NU | Shock absorber for power wheelchair, each | $169.54 |
| E1016 | RR | Shock absorber for power wheelchair, each | $16.97 |
| E1016 | UE | Shock absorber for power wheelchair, each | $127.16 |
| E1017 | NU | Heavy duty shock absorber for heavy duty or extra heavy duty manual wheelchair, each | BR |
| E1017 | RR | Heavy duty shock absorber for heavy duty or extra heavy duty manual wheelchair, each | BR |
| E1017 | UE | Heavy duty shock absorber for heavy duty or extra heavy duty manual wheelchair, each | BR |
| E1018 | NU | Heavy duty shock absorber for heavy duty or extra heavy duty power wheelchair, each | BR |
| E1018 | RR | Heavy duty shock absorber for heavy duty or extra heavy duty power wheelchair, each | BR |
| E1018 | UE | Heavy duty shock absorber for heavy duty or extra heavy duty power wheelchair, each | BR |
| E1020 | NU | Residual limb support system for wheelchair | $314.28 |
| E1020 | RR | Residual limb support system for wheelchair | $31.40 |
| E1020 | UE | Residual limb support system for wheelchair | $235.70 |
| E1028 | NU | Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory | $266.68 |
| E1028 | RR | Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory | $26.66 |
| E1028 | UE | Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory | $199.99 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E1029 | NU | Wheelchair accessory, ventilator tray, fixed | $477.13 |
| E1029 | RR | Wheelchair accessory, ventilator tray, fixed | $47.71 |
| E1029 | UE | Wheelchair accessory, ventilator tray, fixed | $357.85 |
| E1030 | NU | Wheelchair accessory, ventilator tray, gimbaled | $1,504.54 |
| E1030 | RR | Wheelchair accessory, ventilator tray, gimbaled | $150.46 |
| E1030 | UE | Wheelchair accessory, ventilator tray, gimbaled | $1,128.42 |
| E1031 | NU | Rollabout chair, any and all types with casters five inches or greater | $652.11 |
| E1031 | RR | Rollabout chair, any and all types with casters five inches or greater | $65.21 |
| E1031 | UE | Rollabout chair, any and all types with casters five inches or greater | $489.09 |
| E1035 | RR | Multi-positional patient transfer system, with integrated seat, operated by care giver | $791.73 |
| E1037 | RR | Transport chair, pediatric size | $140.08 |
| E1038 | RR | Transport chair, adult size, patient weight capacity up to and including 300 pounds | $51.66 |
| E1039 | RR | Transport chair, adult size, heavy duty, patient weight capacity greater than 300 pounds | $51.95 |
| E1050 | NU | Fully reclining wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $1,314.85 |
| E1050 | RR | Fully reclining wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $131.48 |
| E1050 | UE | Fully reclining wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $986.13 |
| E1060 | NU | Fully reclining wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $1,627.76 |
| E1060 | RR | Fully reclining wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $162.78 |
| E1060 | UE | Fully reclining wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $1,220.82 |
| E1070 | NU | Fully reclining wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $1,414.19 |
| E1070 | RR | Fully reclining wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $141.42 |
| E1070 | UE | Fully reclining wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $1,060.64 |
| E1083 | NU | Hemi-wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $1,016.67 |
| E1083 | RR | Hemi-wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $101.67 |
| E1083 | UE | Hemi-wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $762.51 |
| E1084 | NU | Hemi-wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $1,266.69 |
| E1084 | RR | Hemi-wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $126.67 |
| E1084 | UE | Hemi-wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $950.03 |
| E1085 | NU | Hemi-wheelchair; fixed full-length arms, swing-away, detachable footrests | $1,184.82 |
| E1085 | RR | Hemi-wheelchair; fixed full-length arms, swing-away, detachable footrests | $118.48 |
| E1085 | UE | Hemi-wheelchair; fixed full-length arms, swing-away, detachable footrests | $850.64 |
| E1086 | NU | Hemi-wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $1,443.05 |
| E1086 | RR | Hemi-wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $131.39 |
| E1086 | UE | Hemi-wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $1,048.11 |
| E1087 | NU | High-strength lightweight wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $1,633.38 |
| E1087 | RR | High-strength lightweight wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $163.34 |
| E1087 | UE | High-strength lightweight wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $1,225.04 |
| E1088 | NU | High-strength lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $1,946.60 |
| E1088 | RR | High-strength lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $194.66 |
| E1088 | UE | High-strength lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $1,459.96 |
| E1089 | NU | High-strength lightweight wheelchair; fixed-length arms, swing-away, detachable footrests | $1,915.46 |
| E1089 | RR | High-strength lightweight wheelchair; fixed-length arms, swing-away, detachable footrests | $191.39 |
| E1089 | UE | High-strength lightweight wheelchair; fixed-length arms, swing-away, detachable footrests | $1,436.59 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E1090 | NU | High-strength lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $1,974.70 |
| E1090 | RR | High-strength lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $191.39 |
| E1090 | UE | High-strength lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $1,443.05 |
| E1092 | NU | Wide, heavy-duty wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $1,659.20 |
| E1092 | RR | Wide, heavy-duty wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $165.92 |
| E1092 | UE | Wide, heavy-duty wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $1,244.41 |
| E1093 | NU | Wide, heavy-duty wheelchair; detachable arms, desk or full-length arms, swing-away, detachable footrests | $1,426.95 |
| E1093 | RR | Wide, heavy-duty wheelchair; detachable arms, desk or full-length arms, swing-away, detachable footrests | $142.69 |
| E1093 | UE | Wide, heavy-duty wheelchair; detachable arms, desk or full-length arms, swing-away, detachable footrests | $1,070.21 |
| E1100 | NU | Semi-reclining wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $1,340.37 |
| E1100 | RR | Semi-reclining wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $134.04 |
| E1100 | UE | Semi-reclining wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $1,005.27 |
| E1110 | NU | Semi-reclining wheelchair; detachable arms, desk or full-length, elevating legrest | $1,312.57 |
| E1110 | RR | Semi-reclining wheelchair; detachable arms, desk or full-length, elevating legrest | $131.26 |
| E1110 | UE | Semi-reclining wheelchair; detachable arms, desk or full-length, elevating legrest | $984.43 |
| E1130 | NU | Standard wheelchair; fixed full-length arms, fixed or swing-away, detachable footrests | $759.50 |
| E1130 | RR | Standard wheelchair; fixed full-length arms, fixed or swing-away, detachable footrests | $75.95 |
| E1130 | UE | Standard wheelchair; fixed full-length arms, fixed or swing-away, detachable footrests | $577.22 |
| E1140 | NU | Wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $1,093.68 |
| E1140 | RR | Wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $109.37 |
| E1140 | UE | Wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $774.69 |
| E1150 | NU | Wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $1,053.27 |
| E1150 | RR | Wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $105.33 |
| E1150 | UE | Wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $789.96 |
| E1160 | NU | Wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $807.04 |
| E1160 | RR | Wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $80.70 |
| E1160 | UE | Wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $605.29 |
| E1161 | NU | Manual adult size wheelchair, includes tilt in space | $3,054.98 |
| E1161 | RR | Manual adult size wheelchair, includes tilt in space | $305.50 |
| E1161 | UE | Manual adult size wheelchair, includes tilt in space | $2,291.26 |
| E1170 | NU | Amputee wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $1,153.07 |
| E1170 | RR | Amputee wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $115.31 |
| E1170 | UE | Amputee wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $864.81 |
| E1171 | NU | Amputee wheelchair; fixed full-length arms, without footrests or legrests | $1,034.89 |
| E1171 | RR | Amputee wheelchair; fixed full-length arms, without footrests or legrests | $103.49 |
| E1171 | UE | Amputee wheelchair; fixed full-length arms, without footrests or legrests | $776.18 |
| E1172 | NU | Amputee wheelchair; detachable arms, desk or full-length, without footrests or legrests | $1,264.72 |
| E1172 | RR | Amputee wheelchair; detachable arms, desk or full-length, without footrests or legrests | $126.47 |
| E1172 | UE | Amputee wheelchair; detachable arms, desk or full-length, without footrests or legrests | $948.54 |
| E1180 | NU | Amputee wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $1,308.47 |
| E1180 | RR | Amputee wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $130.85 |
| E1180 | UE | Amputee wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $981.35 |
| E1190 | NU | Amputee wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $1,511.56 |
| E1190 | RR | Amputee wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $151.16 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E1190 | UE | Amputee wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests | $1,133.68 |
| E1195 | NU | Heavy duty wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $1,622.14 |
| E1195 | RR | Heavy duty wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $162.21 |
| E1195 | UE | Heavy duty wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | $1,216.61 |
| E1200 | NU | Amputee wheelchair; fixed full-length arms, swing-away, detachable footrests | $1,123.45 |
| E1200 | RR | Amputee wheelchair; fixed full-length arms, swing-away, detachable footrests | $112.35 |
| E1200 | UE | Amputee wheelchair; fixed full-length arms, swing-away, detachable footrests | $842.59 |
| E1220 | | Wheelchair; specially sized or constructed (indicate brand name, model number, if any, and justification) | BR |
| E1221 | NU | Wheelchair with fixed arm, footrests | $613.37 |
| E1221 | RR | Wheelchair with fixed arm, footrests | $61.34 |
| E1221 | UE | Wheelchair with fixed arm, footrests | $460.03 |
| E1222 | NU | Wheelchair with fixed arm, elevating legrests | $875.25 |
| E1222 | RR | Wheelchair with fixed arm, elevating legrests | $87.52 |
| E1222 | UE | Wheelchair with fixed arm, elevating legrests | $656.44 |
| E1223 | NU | Wheelchair with detachable arms, footrests | $955.75 |
| E1223 | RR | Wheelchair with detachable arms, footrests | $95.58 |
| E1223 | UE | Wheelchair with detachable arms, footrests | $716.82 |
| E1224 | NU | Wheelchair with detachable arms, elevating legrests | $1,047.81 |
| E1224 | RR | Wheelchair with detachable arms, elevating legrests | $104.78 |
| E1224 | UE | Wheelchair with detachable arms, elevating legrests | $785.85 |
| E1225 | NU | Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each | $583.60 |
| E1225 | RR | Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each | $58.36 |
| E1225 | UE | Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each | $437.70 |
| E1226 | NU | Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each | $704.51 |
| E1226 | RR | Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each | $72.52 |
| E1226 | UE | Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each | $528.34 |
| E1227 | NU | Special height arms for wheelchair | $358.30 |
| E1227 | RR | Special height arms for wheelchair | $35.83 |
| E1227 | UE | Special height arms for wheelchair | $268.76 |
| E1228 | NU | Special back height for wheelchair | $483.42 |
| E1228 | RR | Special back height for wheelchair | $48.23 |
| E1228 | UE | Special back height for wheelchair | $362.66 |
| E1229 | | Wheelchair, pediatric size, not otherwise specified | BR |
| E1230 | NU | Power operated vehicle (three- or four-wheel nonhighway), specify brand name and model number | $2,920.31 |
| E1230 | RR | Power operated vehicle (three- or four-wheel nonhighway), specify brand name and model number | $287.21 |
| E1230 | UE | Power operated vehicle (three- or four-wheel nonhighway), specify brand name and model number | $2,309.62 |
| E1231 | NU | Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system | BR |
| E1231 | RR | Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system | BR |
| E1231 | UE | Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system | BR |
| E1232 | NU | Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system | $2,761.01 |
| E1232 | RR | Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system | $276.11 |
| E1232 | UE | Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system | $2,070.78 |
| E1233 | NU | Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system | $2,860.84 |
| E1233 | RR | Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system | $286.07 |
| E1233 | UE | Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system | $2,145.62 |
| E1234 | NU | Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system | $2,490.57 |
| E1234 | RR | Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system | $249.07 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E1234 | UE | Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system | $1,867.91 |
| E1235 | NU | Wheelchair, pediatric size, rigid, adjustable, with seating system | $2,398.23 |
| E1235 | RR | Wheelchair, pediatric size, rigid, adjustable, with seating system | $239.83 |
| E1235 | UE | Wheelchair, pediatric size, rigid, adjustable, with seating system | $1,798.66 |
| E1236 | NU | Wheelchair, pediatric size, folding, adjustable, with seating system | $2,115.85 |
| E1236 | RR | Wheelchair, pediatric size, folding, adjustable, with seating system | $211.58 |
| E1236 | UE | Wheelchair, pediatric size, folding, adjustable, with seating system | $1,586.88 |
| E1237 | NU | Wheelchair, pediatric size, rigid, adjustable, without seating system | $2,134.33 |
| E1237 | RR | Wheelchair, pediatric size, rigid, adjustable, without seating system | $213.43 |
| E1237 | UE | Wheelchair, pediatric size, rigid, adjustable, without seating system | $1,600.77 |
| E1238 | NU | Wheelchair, pediatric size, folding, adjustable, without seating system | $2,225.37 |
| E1238 | RR | Wheelchair, pediatric size, folding, adjustable, without seating system | $222.55 |
| E1238 | UE | Wheelchair, pediatric size, folding, adjustable, without seating system | $1,668.99 |
| E1239 | | Power wheelchair, pediatric size, not otherwise specified | BR |
| E1240 | NU | Lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrest | $1,330.19 |
| E1240 | RR | Lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrest | $133.02 |
| E1240 | UE | Lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrest | $997.65 |
| E1250 | NU | Lightweight wheelchair; fixed full-length arms, swing-away, detachable footrests | $1,169.63 |
| E1250 | RR | Lightweight wheelchair; fixed full-length arms, swing-away, detachable footrests | $106.33 |
| E1250 | UE | Lightweight wheelchair; fixed full-length arms, swing-away, detachable footrests | $926.59 |
| E1260 | NU | Lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $1,367.10 |
| E1260 | RR | Lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $136.71 |
| E1260 | UE | Lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $1,078.49 |
| E1270 | NU | Lightweight wheelchair; fixed full-length arms, swing-away, detachable elevating legrests | $1,019.25 |
| E1270 | RR | Lightweight wheelchair; fixed full-length arms, swing-away, detachable elevating legrests | $101.92 |
| E1270 | UE | Lightweight wheelchair; fixed full-length arms, swing-away, detachable elevating legrests | $764.44 |
| E1280 | NU | Heavy-duty wheelchair; detachable arms, desk or full-length, elevating legrests | $1,694.75 |
| E1280 | RR | Heavy-duty wheelchair; detachable arms, desk or full-length, elevating legrests | $169.47 |
| E1280 | UE | Heavy-duty wheelchair; detachable arms, desk or full-length, elevating legrests | $1,271.07 |
| E1285 | NU | Heavy-duty wheelchair; fixed full-length arms, swing-away, detachable footrests | $1,762.04 |
| E1285 | RR | Heavy-duty wheelchair; fixed full-length arms, swing-away, detachable footrests | $176.20 |
| E1285 | UE | Heavy-duty wheelchair; fixed full-length arms, swing-away, detachable footrests | $1,291.15 |
| E1290 | NU | Heavy-duty wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $1,822.80 |
| E1290 | RR | Heavy-duty wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $182.28 |
| E1290 | UE | Heavy-duty wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests | $1,329.13 |
| E1295 | NU | Heavy-duty wheelchair; fixed full-length arms, elevating legrests | $1,568.37 |
| E1295 | RR | Heavy-duty wheelchair; fixed full-length arms, elevating legrests | $156.84 |
| E1295 | UE | Heavy-duty wheelchair; fixed full-length arms, elevating legrests | $1,176.30 |
| E1296 | NU | Special wheelchair seat height from floor | $634.82 |
| E1296 | RR | Special wheelchair seat height from floor | $64.48 |
| E1296 | UE | Special wheelchair seat height from floor | $476.12 |
| E1297 | NU | Special wheelchair seat depth, by upholstery | $135.07 |
| E1297 | RR | Special wheelchair seat depth, by upholstery | $15.01 |
| E1297 | UE | Special wheelchair seat depth, by upholstery | $101.29 |
| E1298 | NU | Special wheelchair seat depth and/or width, by construction | $546.99 |
| E1298 | RR | Special wheelchair seat depth and/or width, by construction | $55.98 |
| E1298 | UE | Special wheelchair seat depth and/or width, by construction | $410.24 |
| E1300 | NU | Whirlpool, portable (overtub type) | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E1300 | RR | Whirlpool, portable (overtub type) | BR |
| E1300 | UE | Whirlpool, portable (overtub type) | BR |
| E1310 | NU | Whirlpool, nonportable (built-in type) | $2,772.62 |
| E1310 | RR | Whirlpool, nonportable (built-in type) | $237.15 |
| E1310 | UE | Whirlpool, nonportable (built-in type) | $2,079.47 |
| E1340 | | Repair or nonroutine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes | BR |
| E1353 | NU | Regulator | $113.93 |
| E1353 | RR | Regulator | $6.08 |
| E1353 | UE | Regulator | $91.14 |
| E1355 | NU | Stand/rack | $77.47 |
| E1355 | RR | Stand/rack | $9.11 |
| E1355 | UE | Stand/rack | $62.28 |
| E1372 | NU | Immersion external heater for nebulizer | $210.50 |
| E1372 | RR | Immersion external heater for nebulizer | $30.59 |
| E1372 | UE | Immersion external heater for nebulizer | $155.82 |
| E1390 | NU | Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate | BR |
| E1390 | RR | Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate | $295.42 |
| E1390 | UE | Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate | BR |
| E1391 | RR | Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each | $295.42 |
| E1392 | RR | Portable oxygen concentrator, rental | $46.44 |
| E1399 | | Durable medical equipment, miscellaneous | BR |
| E1405 | NU | Oxygen and water vapor enriching system with heated delivery | BR |
| E1405 | RR | Oxygen and water vapor enriching system with heated delivery | $340.70 |
| E1405 | UE | Oxygen and water vapor enriching system with heated delivery | BR |
| E1406 | NU | Oxygen and water vapor enriching system without heated delivery | BR |
| E1406 | RR | Oxygen and water vapor enriching system without heated delivery | $319.87 |
| E1406 | UE | Oxygen and water vapor enriching system without heated delivery | BR |
| E1500 | | Centrifuge, for dialysis | BR |
| E1510 | NU | Kidney, dialysate delivery system kidney machine, pump recirculating, air removal system, flowrate meter, power off, heater and temp control with alarm, IV poles, pressure gauge, concentrate container | BR |
| E1510 | RR | Kidney, dialysate delivery system kidney machine, pump recirculating, air removal system, flowrate meter, power off, heater and temp control with alarm, IV poles, pressure gauge, concentrate container | BR |
| E1510 | UE | Kidney, dialysate delivery system kidney machine, pump recirculating, air removal system, flowrate meter, power off, heater and temp control with alarm, IV poles, pressure gauge, concentrate container | BR |
| E1520 | NU | Heparin infusion pump for hemodialysis | BR |
| E1520 | RR | Heparin infusion pump for hemodialysis | BR |
| E1520 | UE | Heparin infusion pump for hemodialysis | BR |
| E1530 | NU | Air bubble detector for hemodialysis, each, replacement | BR |
| E1530 | RR | Air bubble detector for hemodialysis, each, replacement | BR |
| E1530 | UE | Air bubble detector for hemodialysis, each, replacement | BR |
| E1540 | NU | Pressure alarm for hemodialysis, each, replacement | BR |
| E1540 | RR | Pressure alarm for hemodialysis, each, replacement | BR |
| E1540 | UE | Pressure alarm for hemodialysis, each, replacement | BR |
| E1550 | NU | Bath conductivity meter for hemodialysis, each | BR |
| E1550 | RR | Bath conductivity meter for hemodialysis, each | BR |
| E1550 | UE | Bath conductivity meter for hemodialysis, each | BR |
| E1560 | NU | Blood leak detector for hemodialysis, each, replacement | BR |
| E1560 | RR | Blood leak detector for hemodialysis, each, replacement | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E1560 | UE | Blood leak detector for hemodialysis, each, replacement | BR |
| E1570 | NU | Adjustable chair, for ESRD patients | BR |
| E1570 | RR | Adjustable chair, for ESRD patients | BR |
| E1570 | UE | Adjustable chair, for ESRD patients | BR |
| E1575 | NU | Transducer protectors/fluid barriers, for hemodialysis, any size, per 10 | BR |
| E1575 | RR | Transducer protectors/fluid barriers, for hemodialysis, any size, per 10 | BR |
| E1575 | UE | Transducer protectors/fluid barriers, for hemodialysis, any size, per 10 | BR |
| E1580 | NU | Unipuncture control system for hemodialysis | BR |
| E1580 | RR | Unipuncture control system for hemodialysis | BR |
| E1580 | UE | Unipuncture control system for hemodialysis | BR |
| E1590 | NU | Hemodialysis machine | BR |
| E1590 | RR | Hemodialysis machine | BR |
| E1590 | UE | Hemodialysis machine | BR |
| E1592 | NU | Automatic intermittent peritoneal dialysis system | BR |
| E1592 | RR | Automatic intermittent peritoneal dialysis system | BR |
| E1592 | UE | Automatic intermittent peritoneal dialysis system | BR |
| E1594 | NU | Cycler dialysis machine for peritoneal dialysis | BR |
| E1594 | RR | Cycler dialysis machine for peritoneal dialysis | BR |
| E1594 | UE | Cycler dialysis machine for peritoneal dialysis | BR |
| E1600 | NU | Delivery and/or installation charges for hemodialysis equipment | BR |
| E1600 | RR | Delivery and/or installation charges for hemodialysis equipment | BR |
| E1600 | UE | Delivery and/or installation charges for hemodialysis equipment | BR |
| E1610 | NU | Reverse osmosis water purification system, for hemodialysis | BR |
| E1610 | RR | Reverse osmosis water purification system, for hemodialysis | BR |
| E1610 | UE | Reverse osmosis water purification system, for hemodialysis | BR |
| E1615 | NU | Deionizer water purification system, for hemodialysis | BR |
| E1615 | RR | Deionizer water purification system, for hemodialysis | BR |
| E1615 | UE | Deionizer water purification system, for hemodialysis | BR |
| E1620 | NU | Blood pump for hemodialysis, replacement | BR |
| E1620 | RR | Blood pump for hemodialysis, replacement | BR |
| E1620 | UE | Blood pump for hemodialysis, replacement | BR |
| E1625 | NU | Water softening system, for hemodialysis | BR |
| E1625 | RR | Water softening system, for hemodialysis | BR |
| E1625 | UE | Water softening system, for hemodialysis | BR |
| E1630 | NU | Reciprocating peritoneal dialysis system | BR |
| E1630 | RR | Reciprocating peritoneal dialysis system | BR |
| E1630 | UE | Reciprocating peritoneal dialysis system | BR |
| E1632 | NU | Wearable artificial kidney, each | BR |
| E1632 | RR | Wearable artificial kidney, each | BR |
| E1632 | UE | Wearable artificial kidney, each | BR |
| E1634 | | Peritoneal dialysis clamps, each | BR |
| E1635 | NU | Compact (portable) travel hemodialyzer system | BR |
| E1635 | RR | Compact (portable) travel hemodialyzer system | BR |
| E1635 | UE | Compact (portable) travel hemodialyzer system | BR |
| E1636 | NU | Sorbent cartridges, for hemodialysis, per 10 | BR |
| E1636 | RR | Sorbent cartridges, for hemodialysis, per 10 | BR |
| E1636 | UE | Sorbent cartridges, for hemodialysis, per 10 | BR |
| E1637 | | Hemostats, each | BR |
| E1639 | | Scale, each | BR |
| E1699 | | Dialysis equipment, not otherwise specified | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E1700 | NU | Jaw motion rehabilitation system | $445.23 |
| E1700 | RR | Jaw motion rehabilitation system | $43.67 |
| E1700 | UE | Jaw motion rehabilitation system | $333.94 |
| E1701 | | Replacement cushions for jaw motion rehabilitation system, package of six | $13.70 |
| E1702 | | Replacement measuring scales for jaw motion rehabilitation system, package of 200 | $29.13 |
| E1800 | RR | Dynamic adjustable elbow extension/flexion device, includes soft interface material | $158.17 |
| E1801 | RR | Bi-directional static progressive stretch elbow device with range of motion adjustment, includes cuffs | $166.56 |
| E1802 | RR | Dynamic adjustable forearm pronation/supination device, includes soft interface material | $421.95 |
| E1805 | RR | Dynamic adjustable wrist extension/flexion device, includes soft interface material | $163.13 |
| E1806 | RR | Bi-directional static progressive stretch wrist device with range of motion adjustment, includes cuffs | $136.74 |
| E1810 | RR | Dynamic adjustable knee extension/flexion device, includes soft interface material | $160.85 |
| E1811 | RR | Bi-directional static progressive stretch knee device with range of motion adjustment, includes cuffs | $173.17 |
| E1812 | RR | Dynamic knee, extension/flexion device with active resistance control | BR |
| E1815 | RR | Dynamic adjustable ankle extension/flexion device, includes soft interface material | $163.13 |
| E1816 | RR | Bi-directional static progressive stretch ankle device with range of motion adjustment, includes cuffs | $175.90 |
| E1818 | RR | Bi-directional static progressive stretch forearm pronation/supination device with range of motion adjustment, includes cuffs | $179.59 |
| E1820 | NU | Replacement soft interface material, dynamic adjustable extension/flexion device | $105.54 |
| E1820 | RR | Replacement soft interface material, dynamic adjustable extension/flexion device | $10.54 |
| E1820 | UE | Replacement soft interface material, dynamic adjustable extension/flexion device | $79.16 |
| E1821 | NU | Replacement soft interface material/cuffs for bi-directional static progressive stretch device | $135.89 |
| E1821 | RR | Replacement soft interface material/cuffs for bi-directional static progressive stretch device | $13.56 |
| E1821 | UE | Replacement soft interface material/cuffs for bi-directional static progressive stretch device | $101.94 |
| E1825 | RR | Dynamic adjustable finger extension/flexion device, includes soft interface material | $163.13 |
| E1830 | RR | Dynamic adjustable toe extension/flexion device, includes soft interface material | $163.13 |
| E1840 | RR | Dynamic adjustable shoulder flexion/abduction/rotation device, includes soft interface material | $494.13 |
| E1841 | | Multidirectional static progressive stretch shoulder device, with range of motion adjustability, includes cuffs | BR |
| E1902 | | Communication board, nonelectronic augmentative or alternative communication device | BR |
| E2000 | RR | Gastric suction pump, home model, portable or stationary, electric | $66.93 |
| E2100 | NU | Blood glucose monitor with integrated voice synthesizer | $830.45 |
| E2100 | RR | Blood glucose monitor with integrated voice synthesizer | $83.04 |
| E2100 | UE | Blood glucose monitor with integrated voice synthesizer | $622.85 |
| E2101 | NU | Blood glucose monitor with integrated lancing/blood sample | $243.47 |
| E2101 | RR | Blood glucose monitor with integrated lancing/blood sample | $24.35 |
| E2101 | UE | Blood glucose monitor with integrated lancing/blood sample | $182.60 |
| E2120 | RR | Pulse generator system for tympanic treatment of inner ear endolymphatic fluid | $366.06 |
| E2201 | NU | Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches | $481.74 |
| E2201 | RR | Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches | $48.17 |
| E2201 | UE | Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches | $361.31 |
| E2202 | NU | Manual wheelchair accessory, nonstandard seat frame width, 24–27 in. | $611.97 |
| E2202 | RR | Manual wheelchair accessory, nonstandard seat frame width, 24–27 in. | $61.20 |
| E2202 | UE | Manual wheelchair accessory, nonstandard seat frame width, 24–27 in. | $459.01 |
| E2203 | NU | Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches | $618.52 |
| E2203 | RR | Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches | $61.84 |
| E2203 | UE | Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches | $463.89 |
| E2204 | NU | Manual wheelchair accessory, nonstandard seat frame depth, 22–25 in. | $1,050.22 |
| E2204 | RR | Manual wheelchair accessory, nonstandard seat frame depth, 22–25 in. | $105.04 |
| E2204 | UE | Manual wheelchair accessory, nonstandard seat frame depth, 22–25 in. | $787.66 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E2205 | | Manual wheelchair accessory, handrim without projections, any type, replacement only, each | BR |
| E2206 | | Manual wheelchair accessory, wheel Lock assembly, complete, each | BR |
| E2207 | NU | Wheelchair accessory, crutch and cane holder, each | $65.85 |
| E2207 | RR | Wheelchair accessory, crutch and cane holder, each | $6.59 |
| E2207 | UE | Wheelchair accessory, crutch and cane holder, each | $49.38 |
| E2208 | NU | Wheelchair accessory, cylinder tank carrier, each | $180.43 |
| E2208 | RR | Wheelchair accessory, cylinder tank carrier, each | $18.03 |
| E2208 | UE | Wheelchair accessory, cylinder tank carrier, each | $135.33 |
| E2209 | NU | Accessory, arm trough, with or without hand support, each | $162.78 |
| E2209 | RR | Accessory, arm trough, with or without hand support, each | $16.31 |
| E2209 | UE | Accessory, arm trough, with or without hand support, each | $122.10 |
| E2210 | NU | Wheelchair accessory, bearings, any type, replacement only, each | $9.95 |
| E2210 | RR | Wheelchair accessory, bearings, any type, replacement only, each | $1.00 |
| E2210 | UE | Wheelchair accessory, bearings, any type, replacement only, each | $7.47 |
| E2211 | NU | Manual wheelchair accessory, pneumatic propulsion tire, any size, each | $62.14 |
| E2211 | RR | Manual wheelchair accessory, pneumatic propulsion tire, any size, each | $6.09 |
| E2211 | UE | Manual wheelchair accessory, pneumatic propulsion tire, any size, each | $44.51 |
| E2212 | NU | Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each | $8.93 |
| E2212 | RR | Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each | $0.93 |
| E2212 | UE | Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each | $6.71 |
| E2213 | NU | Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each | $46.19 |
| E2213 | RR | Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each | $4.63 |
| E2213 | UE | Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each | $34.62 |
| E2214 | NU | Manual wheelchair accessory, pneumatic caster tire, any size, each | $54.68 |
| E2214 | RR | Manual wheelchair accessory, pneumatic caster tire, any size, each | $6.02 |
| E2214 | UE | Manual wheelchair accessory, pneumatic caster tire, any size, each | $41.00 |
| E2215 | NU | Manual wheelchair accessory, tube for pneumatic caster tire, any size, each | $14.58 |
| E2215 | RR | Manual wheelchair accessory, tube for pneumatic caster tire, any size, each | $1.44 |
| E2215 | UE | Manual wheelchair accessory, tube for pneumatic caster tire, any size, each | $10.91 |
| E2216 | NU | Manual wheelchair accessory, foam filled propulsion tire, any size, each | BR |
| E2216 | RR | Manual wheelchair accessory, foam filled propulsion tire, any size, each | BR |
| E2216 | UE | Manual wheelchair accessory, foam filled propulsion tire, any size, each | BR |
| E2217 | NU | Manual wheelchair accessory, foam filled caster tire, any size, each | BR |
| E2217 | RR | Manual wheelchair accessory, foam filled caster tire, any size, each | BR |
| E2217 | UE | Manual wheelchair accessory, foam filled caster tire, any size, each | BR |
| E2218 | NU | Manual wheelchair accessory, foam propulsion tire, any size, each | BR |
| E2218 | RR | Manual wheelchair accessory, foam propulsion tire, any size, each | BR |
| E2218 | UE | Manual wheelchair accessory, foam propulsion tire, any size, each | BR |
| E2219 | NU | Manual wheelchair accessory, foam caster tire, any size, each | $63.57 |
| E2219 | RR | Manual wheelchair accessory, foam caster tire, any size, each | $7.17 |
| E2219 | UE | Manual wheelchair accessory, foam caster tire, any size, each | $47.68 |
| E2220 | NU | Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each | $43.32 |
| E2220 | RR | Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each | $4.18 |
| E2220 | UE | Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each | $33.13 |
| E2221 | NU | Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each | $38.81 |
| E2221 | RR | Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each | $3.92 |
| E2221 | UE | Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each | $29.13 |
| E2222 | NU | Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, each | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E2222 | RR | Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, each | BR |
| E2222 | UE | Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, each | BR |
| E2223 | NU | Manual wheelchair accessory, valve, any type, replacement only, each | BR |
| E2223 | RR | Manual wheelchair accessory, valve, any type, replacement only, each | BR |
| E2223 | UE | Manual wheelchair accessory, valve, any type, replacement only, each | BR |
| E2224 | NU | Manual wheelchair accessory, propulsion wheel excludes tire, any size, each | $148.95 |
| E2224 | RR | Manual wheelchair accessory, propulsion wheel excludes tire, any size, each | $15.63 |
| E2224 | UE | Manual wheelchair accessory, propulsion wheel excludes tire, any size, each | $111.72 |
| E2225 | NU | Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each | BR |
| E2225 | RR | Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each | BR |
| E2225 | UE | Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each | BR |
| E2226 | NU | Manual wheelchair accessory, caster fork, any size, replacement only, each | BR |
| E2226 | RR | Manual wheelchair accessory, caster fork, any size, replacement only, each | BR |
| E2226 | UE | Manual wheelchair accessory, caster fork, any size, replacement only, each | BR |
| E2291 | | Back, planar, for pediatric size wheelchair including fixed attaching hardware | BR |
| E2292 | | Seat, planar, for pediatric size wheelchair including fixed attaching hardware | BR |
| E2293 | | Back, contoured, for pediatric size wheelchair including fixed attaching hardware | BR |
| E2294 | | Seat, contoured, for pediatric size wheelchair including fixed attaching hardware | BR |
| E2300 | | Power wheelchair accessory, power seat elevation system | BR |
| E2301 | | Power wheelchair accessory, power standing system | BR |
| E2310 | NU | Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware | $1,510.95 |
| E2310 | RR | Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware | $151.09 |
| E2310 | UE | Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware | $1,133.22 |
| E2311 | NU | Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware | $3,058.99 |
| E2311 | RR | Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware | $305.91 |
| E2311 | UE | Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware | $2,294.25 |
| E2321 | NU | Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware | $1,979.21 |
| E2321 | RR | Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware | $197.91 |
| E2321 | UE | Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware | $1,484.41 |
| E2322 | NU | Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware | $1,820.99 |
| E2322 | RR | Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware | $182.10 |
| E2322 | UE | Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware | $1,365.75 |
| E2323 | NU | Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated | $83.45 |
| E2323 | RR | Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated | $8.35 |
| E2323 | UE | Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated | $62.60 |
| E2324 | NU | Power wheelchair accessory, chin cup for chin control interface | $57.45 |
| E2324 | RR | Power wheelchair accessory, chin cup for chin control interface | $5.74 |
| E2324 | UE | Power wheelchair accessory, chin cup for chin control interface | $43.08 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E2325 | NU | Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware | $1,738.97 |
| E2325 | RR | Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware | $173.93 |
| E2325 | UE | Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware | $1,304.23 |
| E2326 | NU | Power wheelchair accessory, breath tube kit for sip and puff interface | $412.65 |
| E2326 | RR | Power wheelchair accessory, breath tube kit for sip and puff interface | $41.27 |
| E2326 | UE | Power wheelchair accessory, breath tube kit for sip and puff interface | $309.51 |
| E2327 | NU | Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware | $2,977.57 |
| E2327 | RR | Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware | $297.77 |
| E2327 | UE | Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware | $2,233.14 |
| E2328 | NU | Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware | $5,006.20 |
| E2328 | RR | Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware | $500.63 |
| E2328 | UE | Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware | $3,754.68 |
| E2329 | NU | Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware | $2,234.08 |
| E2329 | RR | Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware | $223.41 |
| E2329 | UE | Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware | $1,675.55 |
| E2330 | NU | Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware | $4,303.75 |
| E2330 | RR | Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware | $430.36 |
| E2330 | UE | Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware | $3,227.83 |
| E2331 | | Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware | BR |
| E2340 | NU | Power wheelchair accessory, nonstandard seat frame width, 20–23 in. | $405.71 |
| E2340 | RR | Power wheelchair accessory, nonstandard seat frame width, 20–23 in. | $40.57 |
| E2340 | UE | Power wheelchair accessory, nonstandard seat frame width, 20–23 in. | $304.29 |
| E2341 | NU | Power wheelchair accessory, nonstandard seat frame width, 24–27 in. | $597.76 |
| E2341 | RR | Power wheelchair accessory, nonstandard seat frame width, 24–27 in. | $59.79 |
| E2341 | UE | Power wheelchair accessory, nonstandard seat frame width, 24–27 in. | $448.33 |
| E2342 | NU | Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 in. | $578.48 |
| E2342 | RR | Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 in. | $57.84 |
| E2342 | UE | Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 in. | $433.87 |
| E2343 | NU | Power wheelchair accessory, nonstandard seat frame depth, 22–25 in. | $334.76 |
| E2343 | RR | Power wheelchair accessory, nonstandard seat frame depth, 22–25 in. | $33.48 |
| E2343 | UE | Power wheelchair accessory, nonstandard seat frame depth, 22–25 in. | $251.05 |
| E2351 | NU | Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface | $902.04 |
| E2351 | RR | Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface | $90.23 |
| E2351 | UE | Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface | $676.52 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E2360 | NU | Power wheelchair accessory, 22 NF nonsealed lead acid battery, each | $145.05 |
| E2360 | RR | Power wheelchair accessory, 22 NF nonsealed lead acid battery, each | $14.58 |
| E2360 | UE | Power wheelchair accessory, 22 NF nonsealed lead acid battery, each | $108.79 |
| E2361 | NU | Power wheelchair accessory, 22 NF sealed lead acid battery, each, (e.g., gel cell, absorbed glassmat) | $180.08 |
| E2361 | RR | Power wheelchair accessory, 22 NF sealed lead acid battery, each, (e.g., gel cell, absorbed glassmat) | $18.02 |
| E2361 | UE | Power wheelchair accessory, 22 NF sealed lead acid battery, each, (e.g., gel cell, absorbed glassmat) | $135.08 |
| E2362 | NU | Power wheelchair accessory, group 24 nonsealed lead acid battery, each | $118.76 |
| E2362 | RR | Power wheelchair accessory, group 24 nonsealed lead acid battery, each | $11.88 |
| E2362 | UE | Power wheelchair accessory, group 24 nonsealed lead acid battery, each | $89.06 |
| E2363 | NU | Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) | $240.15 |
| E2363 | RR | Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) | $24.03 |
| E2363 | UE | Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) | $180.12 |
| E2364 | NU | Power wheelchair accessory, U-1 nonsealed lead acid battery, each | $145.05 |
| E2364 | RR | Power wheelchair accessory, U-1 nonsealed lead acid battery, each | $14.58 |
| E2364 | UE | Power wheelchair accessory, U-1 nonsealed lead acid battery, each | $108.79 |
| E2365 | NU | Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) | $144.82 |
| E2365 | RR | Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) | $14.49 |
| E2365 | UE | Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) | $108.65 |
| E2366 | NU | Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or nonsealed, each | $340.38 |
| E2366 | RR | Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or nonsealed, each | $34.13 |
| E2366 | UE | Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or nonsealed, each | $255.28 |
| E2367 | NU | Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or nonsealed, each | $541.10 |
| E2367 | RR | Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or nonsealed, each | $54.11 |
| E2367 | UE | Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or nonsealed, each | $405.82 |
| E2368 | | Power wheelchair component, motor, replacement only | BR |
| E2369 | | Power wheelchair component, gear box, replacement only | BR |
| E2370 | | Power wheelchair component, motor and gear box combination, replacement only | BR |
| E2371 | NU | Power wheelchair accessory, group 27 sealed lead acid battery, (e.g., gel cell, absorbed glassmat), each | BR |
| E2371 | RR | Power wheelchair accessory, group 27 sealed lead acid battery, (e.g., gel cell, absorbed glassmat), each | BR |
| E2371 | UE | Power wheelchair accessory, group 27 sealed lead acid battery, (e.g., gel cell, absorbed glassmat), each | BR |
| E2372 | NU | Power wheelchair accessory, group 27 nonsealed lead acid battery, each | BR |
| E2372 | RR | Power wheelchair accessory, group 27 nonsealed lead acid battery, each | BR |
| E2372 | UE | Power wheelchair accessory, group 27 nonsealed lead acid battery, each | BR |
| E2373 | | Power wheelchair accessory, hand or chin control interface, mini-proportional, compact, or short throw remote joystick or touchpad, proportional, including all related electronics and fixed mounting hardware | BR |
| E2374 | | Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only | BR |
| E2375 | | Power wheelchair accessory, nonexpandable controller, including all related electronics and mounting hardware, replacement only | BR |
| E2376 | | Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only | BR |
| E2377 | | Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E2381 | | Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each | BR |
| E2382 | | Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each | BR |
| E2383 | | Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each | BR |
| E2384 | | Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each | BR |
| E2385 | | Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each | BR |
| E2386 | | Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each | BR |
| E2387 | | Power wheelchair accessory, foam filled caster tire, any size, replacement only, each | BR |
| E2388 | | Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each | BR |
| E2389 | | Power wheelchair accessory, foam caster tire, any size, replacement only, each | BR |
| E2390 | | Power wheelchair accessory, solid (rubber/plastic) drive wheel tire, any size, replacement only, each | BR |
| E2391 | | Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each | BR |
| E2392 | | Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each | BR |
| E2393 | | Power wheelchair accessory, valve for pneumatic tire tube, any type, replacement only, each | BR |
| E2394 | | Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each | BR |
| E2395 | | Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each | BR |
| E2396 | | Power wheelchair accessory, caster fork, any size, replacement only, each | BR |
| E2399 | | Power wheelchair accessory, not otherwise classified interface, including all related electronics and any type mounting hardware | BR |
| E2402 | RR | Negative pressure wound therapy electrical pump, stationary or portable | $2,216.21 |
| E2500 | NU | Speech generating device, digitized speech, using prerecorded messages, less than or equal to 8 minutes recording time | $504.92 |
| E2500 | RR | Speech generating device, digitized speech, using prerecorded messages, less than or equal to 8 minutes recording time | $50.49 |
| E2500 | UE | Speech generating device, digitized speech, using prerecorded messages, less than or equal to 8 minutes recording time | $378.69 |
| E2502 | NU | Speech generating device, digitized speech, using prerecorded messages, greater than eight minutes but less than or equal to 20 minutes recording time | $1,543.96 |
| E2502 | RR | Speech generating device, digitized speech, using prerecorded messages, greater than eight minutes but less than or equal to 20 minutes recording time | $154.41 |
| E2502 | UE | Speech generating device, digitized speech, using prerecorded messages, greater than eight minutes but less than or equal to 20 minutes recording time | $1,157.98 |
| E2504 | NU | Speech generating device, digitized speech, using prerecorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time | $2,036.69 |
| E2504 | RR | Speech generating device, digitized speech, using prerecorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time | $203.70 |
| E2504 | UE | Speech generating device, digitized speech, using prerecorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time | $1,527.49 |
| E2506 | NU | Speech generating device, digitized speech, using prerecorded messages, greater than 40 minutes recording time | $2,986.38 |
| E2506 | RR | Speech generating device, digitized speech, using prerecorded messages, greater than 40 minutes recording time | $298.64 |
| E2506 | UE | Speech generating device, digitized speech, using prerecorded messages, greater than 40 minutes recording time | $2,239.75 |
| E2508 | NU | Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device | $4,617.94 |
| E2508 | RR | Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device | $461.81 |
| E2508 | UE | Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device | $3,463.47 |
| E2510 | NU | Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access | $8,738.82 |
| E2510 | RR | Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access | $873.88 |
| E2510 | UE | Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access | $6,554.11 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| E2511 | NU | Speech generating software program, for personal computer or personal digital assistant | BR |
| E2511 | RR | Speech generating software program, for personal computer or personal digital assistant | BR |
| E2511 | UE | Speech generating software program, for personal computer or personal digital assistant | BR |
| E2512 | NU | Accessory for speech generating device, mounting system | BR |
| E2512 | RR | Accessory for speech generating device, mounting system | BR |
| E2512 | UE | Accessory for speech generating device, mounting system | BR |
| E2599 | | Accessory for speech generating device, not otherwise classified | BR |
| E2601 | | General use wheelchair seat cushion, width less than 22 in., any depth | BR |
| E2602 | | General use wheelchair seat cushion, width 22 in. or greater, any depth | BR |
| E2603 | | Skin protection wheelchair seat cushion, width less than 22 in., any depth | BR |
| E2604 | | Skin protection wheelchair seat cushion, width 22 in. or greater, any depth | BR |
| E2605 | | Positioning wheelchair seat cushion, width less than 22 in., any depth | BR |
| E2606 | | Positioning wheelchair seat cushion, width 22 in. or greater, any depth | BR |
| E2607 | | Skin protection and positioning wheelchair seat cushion, width less than 22 in., any depth | BR |
| E2608 | | Skin protection and positioning wheelchair seat cushion, width 22 in. or greater, any depth | BR |
| E2609 | | Custom fabricated wheelchair seat cushion, any size | BR |
| E2610 | | Wheelchair seat cushion, powered | BR |
| E2611 | | General use wheelchair back cushion, width less than 22 in., any height, including any type mounting hardware | BR |
| E2612 | | General use wheelchair back cushion, width 22 in. or greater, any height, including any type mounting hardware | BR |
| E2613 | | Positioning wheelchair back cushion, posterior, width less than 22 in., any height, including any type mounting hardware | BR |
| E2614 | | Positioning wheelchair back cushion, posterior, width 22 in. or greater, any height, including any type mounting hardware | BR |
| E2615 | | Positioning wheelchair back cushion, posterior-lateral, width less than 22 in., any height, including any type mounting hardware | BR |
| E2616 | | Positioning wheelchair back cushion, posterior-lateral, width 22 in. or greater, any height, including any type mounting hardware | BR |
| E2617 | | Custom fabricated wheelchair back cushion, any size, including any type mounting hardware | BR |
| E2618 | | Wheelchair accessory, solid seat support base (replaces sling seat), for use with manual wheelchair or lightweight power wheelchair, includes any type mounting hardware | BR |
| E2619 | | Replacement cover for wheelchair seat cushion or back cushion, each | BR |
| E2620 | | Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 in., any height, including any type mounting hardware | BR |
| E2621 | | Positioning wheelchair back cushion, planar back with lateral supports, width 22 in. or greater, any height, including any type mounting hardware | BR |
| E8000 | | Gait trainer, pediatric size, posterior support, includes all accessories and components | BR |
| E8001 | | Gait trainer, pediatric size, upright support, includes all accessories and components | BR |
| E8002 | | Gait trainer, pediatric size, anterior support, includes all accessories and components | BR |
| G0008 | | Administration of influenza virus vaccine | $10.44 |
| G0009 | | Administration of pneumococcal vaccine | $10.44 |
| G0010 | | Administration of hepatitis B vaccine | $10.44 |
| G0027 | | Semen analysis; presence and/or motility of sperm excluding huhner | $23.49 |
| G0101 | | Cervical or vaginal cancer screening; pelvic and clinical breast examination | $56.12 |
| G0102 | | Prostate cancer screening; digital rectal examination | BR |
| G0103 | | Prostate cancer screening; prostate specific antigen test (PSA) | $65.25 |
| G0104 | | Colorectal cancer screening; flexible sigmoidoscopy | $185.31 |
| G0105 | | Colorectal cancer screening; colonoscopy on individual at high risk | $674.69 |
| G0106 | | Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema | $276.66 |
| G0108 | | Diabetes outpatient self-management training services, individual, per 30 minutes | BR |
| G0109 | | Diabetes self-management training services, group session (2 or more), per 30 minutes | BR |
| G0117 | | Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| G0118 | | Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist | BR |
| G0120 | | Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema | $276.66 |
| G0121 | | Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk | $674.69 |
| G0122 | | Colorectal cancer screening; barium enema | $276.66 |
| G0123 | | Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision | $16.64 |
| G0124 | | Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician | $4.24 |
| G0127 | | Trimming of dystrophic nails, any number | $26.10 |
| G0128 | | Direct (face-to-face with patient) skilled nursing services of a registered nurse provided in a comprehensive outpatient rehabilitation facility, each 10 minutes beyond the first 5 minutes | BR |
| G0129 | | Occupational therapy requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day | BR |
| G0130 | | Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel) | BR |
| G0141 | | Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician | BR |
| G0143 | | Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision | $23.16 |
| G0144 | | Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision | $22.19 |
| G0145 | | Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision | $24.14 |
| G0147 | | Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision | $22.19 |
| G0148 | | Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening | $23.16 |
| G0151 | | Services of physical therapist in home health setting, each 15 minutes | BR |
| G0152 | | Services of occupational therapist in home health setting, each 15 minutes | BR |
| G0153 | | Services of speech and language pathologist in home health setting, each 15 minutes | BR |
| G0154 | | Services of skilled nurse in home health setting, each 15 minutes | BR |
| G0155 | | Services of clinical social worker in home health setting, each 15 minutes | BR |
| G0156 | | Services of home health aide in home health setting, each 15 minutes | BR |
| G0166 | | External counterpulsation, per treatment session | BR |
| G0168 | | Wound closure utilizing tissue adhesive(s) only | BR |
| G0173 | | Linear accelerator based stereotactic radiosurgery, complete course of therapy In one session | BR |
| G0175 | | Scheduled interdisciplinary team conference (minimum of three exclusive of patient care nursing staff) with patient present | BR |
| G0176 | | Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more) | BR |
| G0177 | | Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more) | BR |
| G0179 | | Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period | BR |
| G0180 | | Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period | BR |
| G0181 | | Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| G0182 | | Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more | BR |
| G0186 | | Destruction of localized lesion of choroid (for example, choroidal neovascularization); photocoagulation, feeder vessel technique (one or more sessions) | BR |
| G0202 | | Screening mammography, producing direct digital image, bilateral, all views | BR |
| G0204 | | Diagnostic mammography, producing direct digital image, bilateral, all views | BR |
| G0206 | | Diagnostic mammography, producing direct digital image, unilateral, all views | BR |
| G0219 | | PET imaging whole body; melanoma for noncovered indications | BR |
| G0235 | | PET imaging, any site, not otherwise specified | BR |
| G0237 | | Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes (includes monitoring) | BR |
| G0238 | | Therapeutic procedures to improve respiratory function, other than described by G0237, one-on-one, face-to-face, per 15 minutes (includes monitoring) | BR |
| G0239 | | Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring) | BR |
| G0245 | | Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include: (1) the diagnosis of LOPS, (2) a patient history, (3) a physical examination that consists of at least the following elements: (a) visual inspection of the forefoot, hindfoot, and toe web spaces, (b) evaluation of a protective sensation, (c) evaluation of foot structure and biomechanics, (d) evaluation of vascular status and skin integrity, and (e) evaluation and recommendation of footwear, and (4) patient education | BR |
| G0246 | | Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following: (1) a patient history, (2) a physical examination that includes: (a) visual inspection of the forefoot, hindfoot, and toe web spaces, (b) evaluation of protective sensation, (c) evaluation of foot structure and biomechanics, (d) evaluation of vascular status and skin integrity, and (e) evaluation and recommendation of footwear, and (3) patient education | BR |
| G0247 | | Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include, the local care of superficial wounds (i.e., superficial to muscle and fascia) and at least the following if present: (1) local care of superficial wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails | BR |
| G0248 | | Demonstration, at initial use, of home INR monitoring for patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician; includes: demonstrating use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient ability to perform testing | BR |
| G0249 | | Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting of test results to physician; per four tests | BR |
| G0250 | | Physician review, interpretation and patient management of home INR testing for a patient with mechanical heart valve(s) who meets other coverage criteria; per four tests (does not require face-to-face service) | BR |
| G0251 | | Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum five sessions per course of treatment | BR |
| G0252 | | PET imaging, full and partial-ring PET scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes) | BR |
| G0255 | | Current perception threshold/sensory nerve conduction test, (SNCT) per limb, any nerve | BR |
| G0257 | | Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility | BR |
| G0259 | | Injection procedure for sacroiliac joint; arthrography | BR |
| G0260 | | Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography | BR |
| G0265 | | Cryopreservation, freezing and storage of cells for therapeutic use, each cell line | BR |
| G0266 | | Thawing and expansion of frozen cells for therapeutic use, each aliquot | BR |
| G0267 | | Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (e.g., T-cells, metastatic carcinoma) | BR |
| G0268 | | Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| G0269 | | Placement of occlusive device into either a venous or arterial access site, post surgical or interventional procedure (e.g., angioseal plug, vascular plug) | BR |
| G0270 | | Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes | BR |
| G0271 | | Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes | BR |
| G0275 | | Renal artery angiography (unilateral or bilateral) performed at the time of cardiac catheterization, includes catheter placement, injection of dye, flush aortogram and radiologic supervision and interpretation and production of images (list separately in addition to primary procedure) | BR |
| G0278 | | Iliac artery angiography performed at the same time of cardiac catheterization, includes catheter placement, injection of dye, radiologic supervision and interpretation and production of images (list separately in addition to primary procedure) | BR |
| G0281 | | Electrical stimulation, (unattended), to one or more areas, for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care | BR |
| G0282 | | Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281 | BR |
| G0283 | | Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care | BR |
| G0288 | | Reconstruction, computed tomographic angiography of aorta for surgical planning for vascular surgery | BR |
| G0289 | | Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee | BR |
| G0290 | | Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel | BR |
| G0291 | | Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel | BR |
| G0293 | | Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a medicare qualifying clinical trial, per day | BR |
| G0294 | | Noncovered procedure(s) using either no anesthesia or local anesthesia only, in a medicare qualifying clinical trial, per day | BR |
| G0295 | | Electromagnetic therapy, to one or more areas, for wound care other than described In G0329 or for other uses | BR |
| G0297 | | Insertion of single chamber pacing cardioverter defibrillator pulse generator | BR |
| G0298 | | Insertion of dual chamber pacing cardioverter defibrillator pulse generator | BR |
| G0299 | | Insertion or repositioning of electrode lead for single chamber pacing cardioverter defibrillator and insertion of pulse generator | BR |
| G0300 | | Insertion or repositioning of electrode lead(s) for dual chamber pacing cardioverter defibrillator and insertion of pulse generator | BR |
| G0302 | | Preoperative pulmonary surgery services for preparation for LVRS, complete course of services, to include a minimum of 16 days of services | BR |
| G0303 | | Preoperative pulmonary surgery services for preparation for LVRS, 10 to 15 days of services | BR |
| G0304 | | Preoperative pulmonary surgery services for preparation for LVRS, 1 to 9 days of services | BR |
| G0305 | | Postdischarge pulmonary surgery services after LVRS, minimum of 6 days of services | BR |
| G0306 | | Complete CBC, automated (HgB, HCT, RBC, WBC, without platelet count) and automated WBC differential count | BR |
| G0307 | | Complete CBC, automated (HgB, HCT, RBC, WBC; without platelet count) | BR |
| G0308 | | ESRD related services during the course of treatment, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month. | BR |
| G0309 | | ESRD related services during the course of treatment, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month. | BR |
| G0310 | | ESRD related services during the course of treatment, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month | BR |
| G0311 | | ESRD related services during the course of treatment, 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; with 4 or more face-to-face physician visits per month | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| G0312 | | ESRD related services during the course of treatment, 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; with 2 or 3 face-to-face physician visits per month | BR |
| G0313 | | ESRD related services during the course of treatment, 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; with 1 face-to-face physician visit per month | BR |
| G0314 | | ESRD related services during the course of treatment, 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; with 4 or more face-to-face physician visits per month | BR |
| G0315 | | ESRD related services during the course of treatment, 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; with 2 or 3 face-to-face physician visits per month | BR |
| G0316 | | ESRD related services during the course of treatment, 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; with 1 face-to-face physician visit per month | BR |
| G0317 | | ESRD related services during the course of treatment, for patients 20 years of age and over; with 4 or more face-to-face physician visits per month | BR |
| G0318 | | ESRD related services during the course of treatment, for patients 20 years of age and over; with 2 or 3 face-to-face physician visits per month | BR |
| G0319 | | ESRD related services during the course of treatment, for patients 20 years of age and over; with 1 face-to-face physician visit per month | BR |
| G0320 | | ESRD related services for home dialysis patients per full month; for patients under 2 years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents | BR |
| G0321 | | ESRD related services for home dialysis patients per full month; for patients 2 to 11 years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents | BR |
| G0322 | | ESRD related services for home dialysis patients per full month; for patients 12 to 19 years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents | BR |
| G0323 | | ESRD related services for home dialysis patients per full month; for patients 20 years of age and older | BR |
| G0324 | | End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients under two years of age | BR |
| G0325 | | End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between two and 11 years of age | BR |
| G0326 | | End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between 12 and 19 years of age | BR |
| G0327 | | End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients 20 years of age and over | BR |
| G0328 | | Colorectalcancer screening; fecal-occult blood test, immunoassay, 1–3 simultaneous determinations. | BR |
| G0329 | | Electromagnetic therapy, to one or more areas for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapay plan of care | BR |
| G0332 | | Services for intravenous infusion of immunoglobulin prior to administration (this service is to be billed in conjunction with administration of immunoglobulin) | BR |
| G0333 | | Pharmacy dispensing fee for inhalation drug(s); initial 30-day supply as a beneficiary | BR |
| G0337 | | Hospice evaluation and counseling services, pre-election | BR |
| G0339 | | Image guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment | BR |
| G0340 | | Image guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment | BR |
| G0341 | | Percutaneous islet cell transplant, includes portal vein catherization and infusion | BR |
| G0342 | | Laparoscopy for islet cell transplant, includes portal vein catherization and infusion | BR |
| G0343 | | Laparotomy for islet cell transplant, includes portal vein catherization and infusion | BR |
| G0344 | | Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment | BR |
| G0364 | | Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| G0365 | | Vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow) | BR |
| G0366 | | Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report, performed as a component of the initial preventive physical examination | BR |
| G0367 | | Tracing only, without interpretation and report, performed as a component of the initial preventive examination | BR |
| G0368 | | Interpretation and report only, performed as a component of the initial preventive examination | BR |
| G0372 | | Physician service required to establish and document the need for a power mobility device | BR |
| G0375 | | Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes | BR |
| G0376 | | Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes | BR |
| G0377 | | Administration of vaccine for Part D drug | BR |
| G0378 | | Hospital observation service, per hour | BR |
| G0379 | | Direct admission of patient for hospital observation care | BR |
| G0380 | | Level 1 hospital emergency visit provided in a type B department or facility of the hospital (the department or facility must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment) | BR |
| G0381 | | Level 2 hospital emergency visit provided in a type B department or facility of the hospital (the department or facility must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment) | BR |
| G0382 | | Level 3 hospital emergency visit provided in a type B department or facility of the hospital (the department or facility must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment) | BR |
| G0383 | | Level 4 hospital emergency visit provided in a type B department or facility of the hospital (the department or facility must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment) | BR |
| G0384 | | Level 5 hospital emergency visit provided in a type B department or facility of the hospital (the department or facility must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment) | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| G0389 | | Ultrasound B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening | BR |
| G0390 | | Trauma response team associated with hospital critical care service | BR |
| G0392 | | Transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; arterial | BR |
| G0393 | | Transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; venous | BR |
| G0394 | | Blood occult test (e.g., guaiac), feces, for single determination for colorectal neoplasm (e.g., patient was provided three cards or single triple card for consecutive collection) | BR |
| G3001 | | Administration and supply of tositumomab, 450 mg | BR |
| G8348 | | Internal carotid stenosis patient in the 30-99% range documented to have reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement | BR |
| G8349 | | Patient was not an eligible candidate for documentation of presence or absence of alarm symptoms | BR |
| G8350 | | Patient documented to have had 12-lead ECG performed | BR |
| G8351 | | Patient not documented to have had ECG | BR |
| G8352 | | Clinician documented that patient was not an eligible candidate for ECG | BR |
| G8353 | | Patient documented to have received or taken aspirin 24 hours before emergency department arrival or during emergency department stay | BR |
| G8354 | | Patient not documented to have received or taken aspirin 24 hours before emergency department arrival or during emergency department stay | BR |
| G8355 | | Clinician documented that patient was not an eligible candidate to receive aspirin | BR |
| G8356 | | Patient documented to have had ECG performed | BR |
| G8357 | | Patient not documented to have had ECG | BR |
| G8358 | | Clinician documented that patient was not an eligible candidate for ECG | BR |
| G8359 | | Patient documented to have had vital signs recorded and reviewed | BR |
| G8360 | | Patient not documented to have vital signs recorded and reviewed | BR |
| G8361 | | Patient documented to have oxygen saturation assessed | BR |
| G8362 | | Patient not documented to have oxygen saturation assessed | BR |
| G8363 | | Clinician documented that patient was not an eligible candidate for oxygen saturation assessment | BR |
| G8364 | | Patient documented to have mental status assessed | BR |
| G8365 | | Patient not documented to have mental status assessed | BR |
| G8366 | | Patient documented to have appropriate empiric antibiotic prescribed | BR |
| G8367 | | Patient not documented to have appropriate empiric antibiotic prescribed | BR |
| G8368 | | Clinician documented that patient was not an eligible candidate for appropriate empiric antibiotic | BR |
| J0120 | | Injection, tetracycline, up to 250 mg | BR |
| J0128 | | Injection, abarelix, 10 mg | BR |
| J0129 | | Injection, abatacept, 10 mg | $34.80 |
| J0130 | | Injection abciximab, 10 mg | $756.88 |
| J0132 | | Injection, acetylcysteine, 100 mg | $0.23 |
| J0133 | | Injection, acyclovir, 5 mg | $1,265.63 |
| J0135 | | Injection, adalimumab, 20 mg | BR |
| J0150 | | Injection, adenosine for therapeutic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use A9270) | $55.63 |
| J0152 | | Injection, adenosine for diagnostic use, 30 mg (not to be used to report any adenosine phosphate compounds; instead use A9270) | $117.64 |
| J0170 | | Injection, adrenalin, epinephrine, up to 1 ml ampule | $3.35 |
| J0180 | | Injection, agalsidase beta, 1 mg | $182.59 |
| J0190 | | Injection, biperiden lactate, per 5 mg | BR |
| J0200 | | Injection, alatrofloxacin mesylate, 100 mg | $26.86 |
| J0205 | | Injection, alglucerase, per 10 units | $59.61 |
| J0207 | | Injection, amifostine, 500 mg | $637.55 |
| J0210 | | Injection, methyldopate HCl, up to 250 mg | $16.71 |
| J0215 | | Injection, alefacept, 0.5 mg | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| J0256 | | Injection, alpha 1-proteinase inhibitor — human, 10 mg | $0.37 |
| J0270 | | Injection, alprostadil, 1.25 mcg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) | $3.53 |
| J0275 | | Alprostadil urethral suppository (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) | BR |
| J0278 | | Injection, amikacin sulfate, 100 mg | $251.19 |
| J0280 | | Injection, aminophyllin, up to 250 mg | $3.14 |
| J0282 | | Injection, amiodarone HCl, 30 mg | BR |
| J0285 | | Injection, amphotericin B, 50 mg | $14.47 |
| J0287 | | Injection, amphotericin B lipid complex, 10 mg | $36.01 |
| J0288 | | Injection, amphotericin B cholesteryl sulfate complex, 10 mg | $24.95 |
| J0289 | | Injection, amphotericin B liposome, 10 mg | $50.38 |
| J0290 | | Injection, ampicillin sodium, 500 mg | $2.95 |
| J0295 | | Injection, ampicillin sodium/sulbactam sodium, per 1.5 g | $11.66 |
| J0300 | | Injection, amobarbital, up to 125 mg | $4.08 |
| J0330 | | Injection, succinylcholine chloride, up to 20 mg | $0.48 |
| J0348 | | Injection, anidulafungin, 1 mg | BR |
| J0350 | | Injection, anistreplase, per 30 units | BR |
| J0360 | | Injection, hydralazine HCl, up to 20 mg | $25.07 |
| J0364 | | Injection, apomorphine hydrochloride, 1 mg | $1.13 |
| J0365 | | Injection, aprotonin, 10,000 kiu | $4.49 |
| J0380 | | Injection, metaraminol bitartrate, per 10 mg | $1.85 |
| J0390 | | Injection, chloroquine HCl, up to 250 mg | BR |
| J0395 | | Injection, arbutamine HCl, 1 mg | BR |
| J0456 | | Injection, azithromycin, 500 mg | BR |
| J0460 | | Injection, atropine sulfate, up to 0.3 mg | $1.06 |
| J0470 | | Injection, dimercaprol, per 100 mg | BR |
| J0475 | | Injection, baclofen, 10 mg | $691.30 |
| J0476 | | Injection, baclofen, 50 mcg for intrathecal trial | $112.32 |
| J0480 | | Injection, basiliximab, 20 mg | $1,772.10 |
| J0500 | | Injection, dicyclomine HCl, up to 20 mg | $2.30 |
| J0515 | | Injection, benztropine mesylate, per 1 mg | $11.07 |
| J0520 | | Injection, bethanechol chloride, Mytonachol or Urecholine, up to 5 mg | BR |
| J0530 | | Injection, penicillin G benzathine and penicillin G procaine, up to 600,000 units | $16.77 |
| J0540 | | Injection, penicillin G benzathine and penicillin G procaine, up to 1,200,000 units | $32.93 |
| J0550 | | Injection, penicillin G benzathine and penicillin G procaine, up to 2,400,000 units | $70.53 |
| J0560 | | Injection, penicillin G benzathine, up to 600,000 units | $23.84 |
| J0570 | | Injection, penicillin G benzathine, up to 1,200,000 units | $41.31 |
| J0580 | | Injection, penicillin G benzathine, up to 2,400,000 units | $84.64 |
| J0583 | | Injection, bivalirudin, 1 mg | BR |
| J0585 | | Botulinum toxin type A, per unit | $7.27 |
| J0587 | | Botulinum toxin type B, per 100 units | $12.21 |
| J0592 | | Injection, buprenorphine HCl, 0.1 mg | $4.08 |
| J0594 | | Injection, busulfan, 1 mg | $10.13 |
| J0595 | | Injection, butorphanol tartrate, 1 mg | $10.04 |
| J0600 | | Injection, edetate calcium disodium, up to 1000 mg | $62.06 |
| J0610 | | Injection, calcium gluconate, per 10 ml | $1.88 |
| J0620 | | Injection, calcium glycerophosphate and calcium lactate, per 10 ml | $8.72 |
| J0630 | | Injection, calcitonin-salmon, up to 400 units | $54.05 |
| J0636 | | Injection, calcitriol, 0.1 mcg | $19.14 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| **J0637** | | Injection, caspofungin acetate, 5 mg | $50.39 |
| **J0640** | | Injection, leucovorin calcium, per 50 mg | $6.28 |
| **J0670** | | Injection, mepivacaine HCl, per 10 ml | BR |
| **J0690** | | Injection, cefazolin sodium, 500 mg | $3.83 |
| **J0692** | | Injection, cefepime HCl, 500 mg | $11.95 |
| **J0694** | | Injection, cefoxitin sodium, 1 g | $13.34 |
| **J0696** | | Injection, ceftriaxone sodium, per 250 mg | $21.57 |
| **J0697** | | Injection, sterile cefuroxime sodium, per 750 mg | $9.04 |
| **J0698** | | Cefotaxime sodium, per g | $16.85 |
| **J0702** | | Injection, betamethasone acetate and betamethasone sodium phosphate, per 3 mg | $7.72 |
| **J0704** | | Injection, betamethasone sodium phosphate, per 4 mg | BR |
| **J0706** | | Injection, caffeine citrate, 5 mg | $4.83 |
| **J0710** | | Injection, cephapirin sodium, up to 1 g | BR |
| **J0713** | | Injection, ceftazidime, per 500 mg | $9.39 |
| **J0715** | | Injection, ceftizoxime sodium, per 500 mg | $9.34 |
| **J0720** | | Injection, chloramphenicol sodium succinate, up to 1 g | $16.54 |
| **J0725** | | Injection, chorionic gonadotropin, per 1,000 USP units | $4.72 |
| **J0735** | | Injection, clonidine HCl, 1 mg | $77.63 |
| **J0740** | | Injection, cidofovir, 375 mg | $1,187.37 |
| **J0743** | | Injection, cilastatin sodium imipenem, per 250 mg | $22.75 |
| **J0744** | | Injection, ciprofloxacin for intravenous infusion, 200 mg | $21.02 |
| **J0745** | | Injection, codeine phosphate, per 30 mg | $1.55 |
| **J0760** | | Injection, colchicine, per 1 mg | $9.94 |
| **J0770** | | Injection, colistimethate sodium, up to 150 mg | $81.19 |
| **J0780** | | Injection, prochlorperazine, up to 10 mg | BR |
| **J0795** | | Injection, corticorelin ovine triflutate, 1 mcg | $8.33 |
| **J0800** | | Injection, corticotropin, up to 40 units | $130.80 |
| **J0835** | | Injection, cosyntropin, per 0.25 mg | $25.66 |
| **J0850** | | Injection, cytomegalovirus immune globulin intravenous (human), per vial | $988.53 |
| **J0878** | | Injection, daptomycin, 1 mg | $0.45 |
| **J0881** | | Injection, darbepoetin alfa, 1 mcg (non-ESRD use) | $8.26 |
| **J0882** | | Injection, darbepoetin alfa, 1 mcg (for ESRD on dialysis) | $8.26 |
| **J0885** | | Injection, epoetin alfa, (for non-ESRD use), 1000 units | $22.38 |
| **J0886** | | Injection, epoetin alfa, 1000 units (for ESRD on dialysis) | $22.38 |
| **J0894** | | Injection, decitabine, 1 mg | BR |
| **J0895** | | Injection, deferoxamine mesylate, 500 mg | $21.99 |
| **J0900** | | Injection, testosterone enanthate and estradiol valerate, up to 1 cc | $2.53 |
| **J0945** | | Injection, brompheniramine maleate, per 10 mg | $1.42 |
| **J0970** | | Injection, estradiol valerate, up to 40 mg | $2.24 |
| **J1000** | | Injection, depo-estradiol cypionate, up to 5 mg | BR |
| **J1020** | | Injection, methylprednisolone acetate, 20 mg | $3.77 |
| **J1030** | | Injection, methylprednisolone acetate, 40 mg | $6.38 |
| **J1040** | | Injection, methylprednisolone acetate, 80 mg | $11.63 |
| **J1051** | | Injection, medroxyprogesterone acetate, 50 mg | $8.43 |
| **J1055** | | Injection, medroxyprogesterone acetate for contraceptive use, 150 mg | $72.56 |
| **J1056** | | Injection, medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg | $36.20 |
| **J1060** | | Injection, testosterone cypionate and estradiol cypionate, up to 1 ml | BR |
| **J1070** | | Injection, testosterone cypionate, up to 100 mg | $6.96 |
| **J1080** | | Injection, testosterone cypionate, 1 cc, 200 mg | $13.92 |
| **J1094** | | Injection, dexamethasone acetate, 1 mg | $0.47 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| J1100 | | Injection, dexamethasone sodium phosphate, 1 mg | $0.37 |
| J1110 | | Injection, dihydroergotamine mesylate, per 1 mg | $50.79 |
| J1120 | | Injection, acetazolamide sodium, up to 500 mg | $28.87 |
| J1160 | | Injection, digoxin, up to 0.5 mg | $3.06 |
| J1162 | | Injection, digoxin immune fab (ovine), per vial | $1,069.62 |
| J1165 | | Injection, phenytoin sodium, per 50 mg | $1.80 |
| J1170 | | Injection, hydromorphone, up to 4 mg | $1.80 |
| J1180 | | Injection, dyphylline, up to 500 mg | $12.68 |
| J1190 | | Injection, dexrazoxane HCl, per 250 mg | $329.30 |
| J1200 | | Injection, diphenhydramine HCl, up to 50 mg | $3.37 |
| J1205 | | Injection, chlorothiazide sodium, per 500 mg | $14.76 |
| J1212 | | Injection, DMSO, dimethyl sulfoxide, 50%, 50 ml | $64.38 |
| J1230 | | Injection, methadone HCl, up to 10 mg | $1.05 |
| J1240 | | Injection, dimenhydrinate, up to 50 mg | $0.53 |
| J1245 | | Injection, dipyridamole, per 10 mg | $24.63 |
| J1250 | | Injection, dobutamine HCl, per 250 mg | $10.66 |
| J1260 | | Injection, dolasetron mesylate, 10 mg | $22.88 |
| J1265 | | Injection, dopamine HCl, 40 mg | $6.40 |
| J1270 | | Injection, doxercalciferol, 1 mcg | $9.31 |
| J1320 | | Injection, amitriptyline HCl, up to 20 mg | $3.38 |
| J1324 | | Injection, enfuvirtide, 1 mg | $39.79 |
| J1325 | | Injection, epoprostenol, 0.5 mg | $25.41 |
| J1327 | | Injection, eptifibatide, 5 mg | $21.65 |
| J1330 | | Injection, ergonovine maleate, up to 0.2 mg | BR |
| J1335 | | Injection, ertapenem sodium, 500 mg | BR |
| J1364 | | Injection, erythromycin lactobionate, per 500 mg | $5.17 |
| J1380 | | Injection, estradiol valerate, up to 10 mg | $1.13 |
| J1390 | | Injection, estradiol valerate, up to 20 mg | $2.19 |
| J1410 | | Injection, estrogen conjugated, per 25 mg | $86.58 |
| J1430 | | Injection, ethanolamine oleate, 100 mg | $134.52 |
| J1435 | | Injection, estrone, per 1 mg | $0.98 |
| J1436 | | Injection, etidronate disodium, per 300 mg | $108.31 |
| J1438 | | Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered) | $218.39 |
| J1440 | | Injection, filgrastim (G-CSF), 300 mcg | $281.14 |
| J1441 | | Injection, filgrastim (G-CSF), 480 mcg | $463.44 |
| J1450 | | Injection, fluconazole, 200 mg | $135.00 |
| J1451 | | Injection, fomepizole, 15 mg | $85.58 |
| J1452 | | Injection, fomivirsen sodium, intraocular, 1.65 mg | $1,337.13 |
| J1455 | | Injection, foscarnet sodium, per 1,000 mg | $18.48 |
| J1457 | | Injection, gallium nitrate, 1 mg | $2.01 |
| J1458 | | Injection, galsulfase, 1 mg | $583.83 |
| J1460 | | Injection, gamma globulin, intramuscular, 1 cc | BR |
| J1470 | | Injection, gamma globulin, intramuscular, 2 cc | BR |
| J1480 | | Injection, gamma globulin, intramuscular, 3 cc | BR |
| J1490 | | Injection, gamma globulin, intramuscular, 4 cc | BR |
| J1500 | | Injection, gamma globulin, intramuscular, 5 cc | BR |
| J1510 | | Injection, gamma globulin, intramuscular, 6 cc | BR |
| J1520 | | Injection, gamma globulin, intramuscular, 7 cc | BR |
| J1530 | | Injection, gamma globulin, intramuscular, 8 cc | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| J1540 | | Injection, gamma globulin, intramuscular, 9 cc | BR |
| J1550 | | Injection, gamma globulin, intramuscular, 10 cc | BR |
| J1560 | | Injection, gamma globulin, intramuscular, over 10 cc | BR |
| J1562 | | Injection, immune globulin, subcutaneous, 100 mg | BR |
| J1565 | | Injection, respiratory syncytial virus immune globulin, intravenous, 50 mg | BR |
| J1566 | | Injection, immune globulin, intravenous, lyophilized (e.g., powder), 500 mg | $83.13 |
| J1567 | | Injection, immune globulin, intravenous, non-lyophilized (e.g., liquid), 500 mg | $78.29 |
| J1570 | | Injection, ganciclovir sodium, 500 mg | $48.67 |
| J1580 | | Injection, garamycin, gentamicin, up to 80 mg | $8.49 |
| J1590 | | Injection, gatifloxacin, 10 mg | $1.22 |
| J1595 | | Injection, glatiramer acetate, 20 mg | $1,421.88 |
| J1600 | | Injection, gold sodium thiomalate, up to 50 mg | $17.83 |
| J1610 | | Injection, glucagon HCl, per 1 mg | $95.45 |
| J1620 | | Injection, gonadorelin HCl, per 100 mcg | $284.28 |
| J1626 | | Injection, granisetron HCl, 100 mcg | $26.10 |
| J1630 | | Injection, haloperidol, up to 5 mg | $12.52 |
| J1631 | | Injection, haloperidol decanoate, per 50 mg | $53.58 |
| J1640 | | Injection, hemin, 1 mg | $12.34 |
| J1642 | | Injection, heparin sodium, (heparin lock flush), per 10 units | $1.50 |
| J1644 | | Injection, heparin sodium, per 1,000 units | $1.39 |
| J1645 | | Injection, dalteparin sodium, per 2500 IU | $16.40 |
| J1650 | | Injection, enoxaparin sodium, 10 mg | $10.34 |
| J1652 | | Injection, fondaparinux sodium, 0.5 mg | $11.63 |
| J1655 | | Injection, tinzaparin sodium, 1000 IU | $5.88 |
| J1670 | | Injection, tetanus immune globulin, human, up to 250 units | $168.48 |
| J1675 | | Injection, histrelin acetate, 10 mcg | $1.93 |
| J1700 | | Injection, hydrocortisone acetate, up to 25 mg | $0.47 |
| J1710 | | Injection, hydrocortisone sodium phosphate, up to 50 mg | BR |
| J1720 | | Injection, hydrocortisone sodium succinate, up to 100 mg | $3.71 |
| J1730 | | Injection, diazoxide, up to 300 mg | $173.04 |
| J1740 | | Injection, ibandronate sodium, 1 mg | BR |
| J1742 | | Injection, ibutilide fumarate, 1 mg | $353.78 |
| J1745 | | Injection, infliximab, 10 mg | $92.47 |
| J1751 | | Injection, iron dextran 165, 50 mg | $30.37 |
| J1752 | | Injection, iron dextran 267, 50 mg | $30.37 |
| J1756 | | Injection, iron sucrose, 1 mg | $1.10 |
| J1785 | | Injection, imiglucerase, per unit | $5.27 |
| J1790 | | Injection, droperidol, up to 5 mg | $2.56 |
| J1800 | | Injection, propranolol HCl, up to 1 mg | $16.16 |
| J1810 | | Injection, droperidol and fentanyl citrate, up to 2 ml ampule | BR |
| J1815 | | Injection, insulin, per 5 units | BR |
| J1817 | | Insulin for administration through DME (i.e., insulin pump) per 50 units | BR |
| J1825 | | Injection, interferon beta-1a, 33 mcg | $359.77 |
| J1830 | | Injection interferon beta-1b, 0.25 mg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) | BR |
| J1835 | | Injection, itraconazole, 50 mg | $1,296.53 |
| J1840 | | Injection, kanamycin sulfate, up to 500 mg | $4.58 |
| J1850 | | Injection, kanamycin sulfate, up to 75 mg | $3.04 |
| J1885 | | Injection, ketorolac tromethamine, per 15 mg | $11.87 |
| J1890 | | Injection, cephalothin sodium, up to 1 g | $14.43 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| J1931 | | Injection, laronidase, 0.1 mg | BR |
| J1940 | | Injection, furosemide, up to 20 mg | $1.32 |
| J1945 | | Injection, lepirudin, 50 mg | $279.15 |
| J1950 | | Injection, leuprolide acetate (for depot suspension), per 3.75 mg | $713.85 |
| J1955 | | Injection, levocarnitine, per 1 g | $39.63 |
| J1956 | | Injection, levofloxacin, 250 mg | $29.29 |
| J1960 | | Injection, levorphanol tartrate, up to 2 mg | $5.67 |
| J1980 | | Injection, hyoscyamine sulfate, up to 0.25 mg | $24.07 |
| J1990 | | Injection, chlordiazepoxide HCl, up to 100 mg | $36.41 |
| J2001 | | Injection, lidocaine HCl for intravenous infusion, 10 mg | BR |
| J2010 | | Injection, lincomycin HCl, up to 300 mg | $5.28 |
| J2020 | | Injection, linezolid, 200 mg | $50.36 |
| J2060 | | Injection, lorazepam, 2 mg | $8.10 |
| J2150 | | Injection, mannitol, 25% in 50 ml | $3.24 |
| J2170 | | Injection, mecasermin, 1 mg | BR |
| J2175 | | Injection, meperidine HCl, per 100 mg | $1.35 |
| J2180 | | Injection, meperidine and promethazine HCl, up to 50 mg | $13.27 |
| J2185 | | Injection, meropenem, 100 mg | BR |
| J2210 | | Injection, methylergonovine maleate, up to 0.2 mg | $5.38 |
| J2248 | | Injection, micafungin sodium, 1 mg | $3.61 |
| J2250 | | Injection, midazolam HCl, per 1 mg | $2.32 |
| J2260 | | Injection, milrinone lactate, 5 mg | $72.59 |
| J2270 | | Injection, morphine sulfate, up to 10 mg | $1.27 |
| J2271 | | Injection, morphine sulfate, 100 mg | $12.37 |
| J2275 | | Injection, morphine sulfate (preservative-free sterile solution), per 10 mg | $9.23 |
| J2278 | | Injection, ziconotide, 1 mcg | $11.76 |
| J2280 | | Injection, moxifloxacin, 100 mg | $14.63 |
| J2300 | | Injection, nalbuphine HCl, per 10 mg | $1.51 |
| J2310 | | Injection, naloxone HCl, per 1 mg | $5.85 |
| J2315 | | Injection, naltrexone, depot form, 1 mg | BR |
| J2320 | | Injection, nandrolone decanoate, up to 50 mg | $7.31 |
| J2321 | | Injection, nandrolone decanoate, up to 100 mg | $14.63 |
| J2322 | | Injection, nandrolone decanoate, up to 200 mg | $23.71 |
| J2325 | | Injection, nesiritide, 0.1 mg | $57.00 |
| J2353 | | Injection, octreotide, depot form for intramuscular injection, 1 mg | $255.99 |
| J2354 | | Injection, octreotide, nondepot form for subcutaneous or intravenous injection, 25 mcg | $12.79 |
| J2355 | | Injection, oprelvekin, 5 mg | $376.97 |
| J2357 | | Injection, omalizumab, 5 mg | $25.28 |
| J2360 | | Injection, orphenadrine citrate, up to 60 mg | $2.66 |
| J2370 | | Injection, phenylephrine HCl, up to 1 ml | $1.69 |
| J2400 | | Injection, chloroprocaine HCl, per 30 ml | $8.99 |
| J2405 | | Injection, ondansetron HCl, per 1 mg | $8.57 |
| J2410 | | Injection, oxymorphone HCl, up to 1 mg | $4.14 |
| J2425 | | Injection, palifermin, 50 mcg | $201.38 |
| J2430 | | Injection, pamidronate disodium, per 30 mg | $387.77 |
| J2440 | | Injection, papaverine HCl, up to 60 mg | $5.22 |
| J2460 | | Injection, oxytetracycline HCl, up to 50 mg | BR |
| J2469 | | Injection, palonosetron HCl, 25 mcg | $45.41 |
| J2501 | | Injection, paricalcitol, 1 mcg | $8.51 |
| J2503 | | Injection, pegaptanib sodium, 0.3 mg | $192.35 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| J2504 | | Injection, pegademase bovine, 25 IU | $24.17 |
| J2505 | | Injection, pegfilgrastim, 6 mg | $3,944.53 |
| J2510 | | Injection, penicillin G procaine, aqueous, up to 600,000 units | $13.48 |
| J2513 | | Injection, pentastarch, 10% solution, 100 ml | BR |
| J2515 | | Injection, pentobarbital sodium, per 50 mg | $1.00 |
| J2540 | | Injection, penicillin G potassium, up to 600,000 units | BR |
| J2543 | | Injection, piperacillin sodium/tazobactam sodium, 1 g/0.125 g (1.125 g) | BR |
| J2545 | | Pentamidine isethionate, inhalation solution, per 300 mg, administered through a DME | $119.00 |
| J2550 | | Injection, promethazine HCl, up to 50 mg | $3.46 |
| J2560 | | Injection, phenobarbital sodium, up to 120 mg | BR |
| J2590 | | Injection, oxytocin, up to 10 units | $2.88 |
| J2597 | | Injection, desmopressin acetate, per 1 mcg | $7.64 |
| J2650 | | Injection, prednisolone acetate, up to 1 ml | BR |
| J2670 | | Injection, tolazoline HCl, up to 25 mg | BR |
| J2675 | | Injection, progesterone, per 50 mg | $5.11 |
| J2680 | | Injection, fluphenazine decanoate, up to 25 mg | $13.60 |
| J2690 | | Injection, procainamide HCl, up to 1 g | $2.17 |
| J2700 | | Injection, oxacillin sodium, up to 250 mg | $7.41 |
| J2710 | | Injection, neostigmine methylsulfate, up to 0.5 mg | $0.61 |
| J2720 | | Injection, protamine sulfate, per 10 mg | $1.24 |
| J2725 | | Injection, protirelin, per 250 mcg | $68.68 |
| J2730 | | Injection, pralidoxime chloride, up to 1 g | $144.91 |
| J2760 | | Injection, phentolamine mesylate, up to 5 mg | $46.01 |
| J2765 | | Injection, metoclopramide HCl, up to 10 mg | $2.09 |
| J2770 | | Injection, quinupristin/dalfopristin, 500 mg (150/350) | $161.26 |
| J2780 | | Injection, ranitidine HCl, 25 mg | $2.03 |
| J2783 | | Injection, rasburicase, 0.5 mg | BR |
| J2788 | | Injection, Rho D immune globulin, human, minidose, 50 mcg | $86.83 |
| J2790 | | Injection, Rho D immune globulin, human, full dose, 300 mcg | $168.66 |
| J2792 | | Injection, Rho D immune globulin, intravenous, human, solvent detergent, 100 IU | $30.27 |
| J2794 | | Injection, risperidone, long acting, 0.5 mg | $7.46 |
| J2795 | | Injection, ropivacaine HCl, 1 mg | $0.13 |
| J2800 | | Injection, methocarbamol, up to 10 ml | $21.07 |
| J2805 | | Injection, sincalide, 5 mcg | $88.43 |
| J2810 | | Injection, theophylline, per 40 mg | BR |
| J2820 | | Injection, sargramostim (GM-CSF), 50 mcg | $40.40 |
| J2850 | | Injection, secretin, synthetic, human, 1 mcg | $39.26 |
| J2910 | | Injection, aurothioglucose, up to 50 mg | $24.36 |
| J2916 | | Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg | $13.85 |
| J2920 | | Injection, methylprednisolone sodium succinate, up to 40 mg | $3.83 |
| J2930 | | Injection, methylprednisolone sodium succinate, up to 125 mg | $5.98 |
| J2940 | | Injection, somatrem, 1 mg | $63.34 |
| J2941 | | Injection, somatropin, 1 mg | $64.63 |
| J2950 | | Injection, promazine HCl, up to 25 mg | $0.63 |
| J2993 | | Injection, reteplase, 18.1 mg | $1,816.40 |
| J2995 | | Injection, streptokinase, per 250,000 IU | $125.35 |
| J2997 | | Injection, alteplase recombinant, 1 mg | BR |
| J3000 | | Injection, streptomycin, up to 1 g | $9.59 |
| J3010 | | Injection, fentanyl citrate, 0.1 mg | $2.38 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| J3030 | | Injection, sumatriptan succinate, 6 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered) | $57.46 |
| J3070 | | Injection, pentazocine, 30 mg | $5.43 |
| J3100 | | Injection, tenecteplase, 50 mg | $3,784.24 |
| J3105 | | Injection, terbutaline sulfate, up to 1 mg | $43.35 |
| J3110 | | Injection, teriparatide, 10 mcg | $11.20 |
| J3120 | | Injection, testosterone enanthate, up to 100 mg | $12.61 |
| J3130 | | Injection, testosterone enanthate, up to 200 mg | $21.62 |
| J3140 | | Injection, testosterone suspension, up to 50 mg | BR |
| J3150 | | Injection, testosterone propionate, up to 100 mg | $1.61 |
| J3230 | | Injection, chlorpromazine HCl, up to 50 mg | $2.64 |
| J3240 | | Injection, thyrotropin alpha, 0.9 mg, provided in 1.1 mg vial | $869.13 |
| J3243 | | Injection, tigecycline, 1 mg | BR |
| J3246 | | Injection, tirofiban HCl, 0.25mg | $13.90 |
| J3250 | | Injection, trimethobenzamide HCl, up to 200 mg | $3.75 |
| J3260 | | Injection, tobramycin sulfate, up to 80 mg | $11.44 |
| J3265 | | Injection, torsemide, 10 mg/ml | $6.70 |
| J3280 | | Injection, thiethylperazine maleate, up to 10 mg | $6.88 |
| J3285 | | Injection, treprostinil, 1 mg | $104.72 |
| J3301 | | Injection, triamcinolone acetonide, per 10 mg | $2.48 |
| J3302 | | Injection, triamcinolone diacetate, per 5 mg | $0.92 |
| J3303 | | Injection, triamcinolone hexacetonide, per 5 mg | $4.20 |
| J3305 | | Injection, trimetrexate glucoronate, per 25 mg | $200.57 |
| J3310 | | Injection, perphenazine, up to 5 mg | BR |
| J3315 | | Injection, triptorelin pamoate, 3.75 mg | $561.05 |
| J3320 | | Injection, spectinomycin dihydrochloride, up to 2 g | $39.79 |
| J3350 | | Injection, urea, up to 40 g | BR |
| J3355 | | Injection, urofollitropin, 75 IU | $125.66 |
| J3360 | | Injection, diazepam, up to 5 mg | $3.80 |
| J3364 | | Injection, urokinase, 5,000 IU vial | $14.39 |
| J3365 | | Injection, IV, urokinase, 250,000 IU vial | $719.92 |
| J3370 | | Injection, vancomycin HCl, 500 mg | $12.03 |
| J3396 | | Injection, verteporfin, 0.1 mg | $15.76 |
| J3400 | | Injection, trifluprom azine HCl, up to 20 mg | BR |
| J3410 | | Injection, hydroxyzine HCl, up to 25 mg | $1.37 |
| J3411 | | Injection, thiamine HCl, 100 mg | $1.27 |
| J3415 | | Injection, pyridoxine HCl, 100 mg | $2.22 |
| J3420 | | Injection, vitamin B-12 cyanocobalamin, up to 1,000 mcg | $0.32 |
| J3430 | | Injection, phytonadione (vitamin K), per 1 mg | $3.66 |
| J3465 | | Injection, voriconazole, 10 mg | BR |
| J3470 | | Injection, hyaluronidase, up to 150 units | BR |
| J3471 | | Injection, hyaluronidase, ovine, preservative free, per 1 USP unit (up to 999 USP units) | $0.32 |
| J3472 | | Injection, hyaluronidase, ovine, preservative free, per 1000 USP units | $322.20 |
| J3473 | | Injection, hyaluronidase, recombinant, 1 USP unit | BR |
| J3475 | | Injection, magnesium sulphate, per 500 mg | $0.58 |
| J3480 | | Injection, potassium chloride, per 2 meq | $0.79 |
| J3485 | | Injection, zidovudine, 10 mg | $1.42 |
| J3486 | | Injection, ziprasidone mesylate, 10 mg | BR |
| J3487 | | Injection, zoledronic acid, 1 mg | $306.03 |
| J3490 | | Unclassified drugs | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| J3520 | | Edetate disodium, per 150 mg | $0.64 |
| J3530 | | Nasal vaccine inhalation | BR |
| J3535 | | Drug administered through a metered dose inhaler | BR |
| J3570 | | Laetrile, amygdalin, vitamin B-17 | BR |
| J3590 | | Unclassified biologics | BR |
| J7030 | | Infusion, normal saline solution, 1,000 cc | $13.10 |
| J7040 | | Infusion, normal saline solution, sterile (500 ml = 1 unit) | $15.42 |
| J7042 | | 5% dextrose/normal saline (500 ml = 1 unit) | BR |
| J7050 | | Infusion, normal saline solution, 250 cc | $15.77 |
| J7060 | | 5% dextrose/water (500 ml = 1 unit) | $14.00 |
| J7070 | | Infusion, D-5-W, 1,000 cc | $17.41 |
| J7100 | | Infusion, dextran 40, 500 ml | $195.61 |
| J7110 | | Infusion, dextran 75, 500 ml | $19.99 |
| J7120 | | Ringer's lactate infusion, up to 1,000 cc | $17.03 |
| J7130 | | Hypertonic saline solution, 50 or 100 meq, 20 cc vial | BR |
| J7187 | | Injection, von Willebrand Factor complex, human, ristocetin cofactor, per IU VWF:RC0 | BR |
| J7189 | | Factor VIIa (antihemophilic Factor, recombinant), per 1 mcg | $2.37 |
| J7190 | | Factor VIII (antihemophilic factor, human) per IU | $1.19 |
| J7191 | | Factor VIII (antihemophilic factor (porcine)), per IU | $3.01 |
| J7192 | | Factor VIII (antihemophilic factor, recombinant) per IU | $1.90 |
| J7193 | | Factor IX (antihemophilic factor, purified, nonrecombinant) per IU | $1.45 |
| J7194 | | Factor IX complex, per IU | $0.69 |
| J7195 | | Factor IX (antihemophilic factor, recombinant) per IU | $1.55 |
| J7197 | | Antithrombin III (human), per IU | $1.76 |
| J7198 | | Antiinhibitor, per IU | $2.00 |
| J7199 | | Hemophilia clotting factor, not otherwise classified | BR |
| J7300 | | Intrauterine copper contraceptive | $458.41 |
| J7302 | | Levonorgestrel-releasing intrauterine contraceptive system, 52 mg | $521.80 |
| J7303 | | Contraceptive supply, hormone containing vaginal ring, each | BR |
| J7304 | | Contraceptive supply, hormone containing patch, each | BR |
| J7306 | | Levonorgestrel (contraceptive) implant system, including implants and supplies | $729.78 |
| J7308 | | Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg) | $175.34 |
| J7310 | | Ganciclovir, 4.5 mg, long-acting implant | $6,685.65 |
| J7311 | | Fluocinolone acetonide, intravitreal implant | BR |
| J7330 | | Autologous cultured chondrocytes, implant | BR |
| J7340 | | Dermal and epidermal, (substitute) tissue of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter | BR |
| J7341 | | Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, with metabolically active elements, per square centimeter | BR |
| J7342 | | Dermal (substitute) tissue of human origin, with or without other bioengineered or processed elements, with metabolically active elements, per square centimeter | BR |
| J7343 | | Dermal and epidermal, (substitute) tissue of non-human origin, with or without other bioengineered or processed elements, without metabolically active elements, per square centimeter | BR |
| J7344 | | Dermal (substitute) tissue of human origin, with or without other bioengineered or processed elements, without metabolically active elements, per square centimeter | BR |
| J7345 | | Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements, per square centimeter | BR |
| J7346 | | Dermal (substitute) tissue of human origin, injectable, with or without other bioengineered or processed elements, but without metabolically active elements, 1 cc | BR |
| J7500 | | Azathioprine, oral, 50 mg | $1.68 |
| J7501 | | Azathioprine, parenteral, 100 mg | $107.79 |
| J7502 | | Cyclosporine, oral, 100 mg | $9.26 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| J7504 | | Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg | $392.26 |
| J7505 | | Muromonab-CD3, parenteral, 5 mg | $1,203.90 |
| J7506 | | Prednisone, oral, per 5 mg | $0.05 |
| J7507 | | Tacrolimus, oral, per 1 mg | $4.96 |
| J7509 | | Methylprednisolone, oral, per 4 mg | $0.77 |
| J7510 | | Prednisolone, oral, per 5 mg | $0.18 |
| J7511 | | Lymphocyte immune globulin, antithymocyte globulin, rabbit, parenteral, 25 mg | BR |
| J7513 | | Daclizumab, parenteral, 25 mg | $598.33 |
| J7515 | | Cyclosporine, oral, 25 mg | $1.82 |
| J7516 | | Cyclosporine, parenteral, 250 mg | $35.30 |
| J7517 | | Mycophenolate mofetil, oral, 250 mg | $3.95 |
| J7518 | | Mycophenolic acid, oral, 180 mg | BR |
| J7520 | | Sirolimus, oral, 1 mg | $10.02 |
| J7525 | | Tacrolimus, parenteral, 5 mg | $162.05 |
| J7599 | | Immunosuppressive drug, NOC | BR |
| J7607 | | Levalbuterol, inhalation solution, compounded product, administered through DME, concentrated form, 0.5 mg | $4.00 |
| J7608 | | Acetylcysteine, inhalation solution administered through DME, unit dose form, per g | BR |
| J7609 | | Albuterol, inhalation solution, compounded product, administered through DME, unit dose, 1 mg | $0.81 |
| J7610 | | Albuterol, inhalation solution, compounded product, administered through DME, concentrated form, 1 mg | $0.81 |
| J7611 | | Albuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, 1 mg | $0.81 |
| J7612 | | Levalbuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, 0.5 mg | $4.00 |
| J7613 | | Albuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose, 1 mg | $0.81 |
| J7614 | | Levalbuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose, 0.5 mg | $4.00 |
| J7615 | | Levalbuterol, inhalation solution, compounded product, administered through DME, unit dose, 0.5 mg | $4.00 |
| J7620 | | Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, FDA-approved final product, noncompounded, administered through DME | $3.48 |
| J7622 | | Beclomethasone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram | BR |
| J7624 | | Betamethasone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram | BR |
| J7626 | | Budesonide, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, up to 0.5 mg | $4.83 |
| J7627 | | Budesonide, inhalation solution, compounded product, administered through DME, unit dose form, up to 0.5 mg | $6.44 |
| J7628 | | Bitolterol mesylate, inhalation solution, compounded product, administered through DME, concentrated form, per milligram | BR |
| J7629 | | Bitolterol mesylate, inhalation solution, compounded product, administered through DME, unit dose form, per milligram | BR |
| J7631 | | Cromolyn sodium, inhalation solution administered through DME, unit dose form, per 10 mg | $0.56 |
| J7633 | | Budesonide, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, per 0.25 milligram | $8.36 |
| J7634 | | Budesonide, inhalation solution, compounded product, administered through DME, concentrated form, per 0.25 milligram | $4.03 |
| J7635 | | Atropine, inhalation solution, compounded product, administered through DME, concentrated form, per milligram | BR |
| J7636 | | Atropine, inhalation solution, compounded product, administered through DME, unit dose form, per milligram | BR |
| J7637 | | Dexamethasone, inhalation solution, compounded product, administered through DME, concentrated form, per milligram | BR |
| J7638 | | Dexamethasone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| J7639 | | Dornase alpha, inhalation solution administered through DME, unit dose form, per mg | $58.66 |
| J7640 | | Formoterol, inhalation solution, compounded product, administered through DME, unit dose form, 12 micrograms | $2.01 |
| J7641 | | Flunisolide, inhalation solution, compounded product, administered through DME, unit dose, per milligram | BR |
| J7642 | | Glycopyrrolate, inhalation solution, compounded product, administered through DME, concentrated form, per milligram | $4.43 |
| J7643 | | Glycopyrrolate, inhalation solution, compounded product, administered through DME, unit dose form, per milligram | $4.67 |
| J7644 | | Ipratropium bromide, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per milligram | $6.04 |
| J7645 | | Ipratropium bromide, inhalation solution, compounded product, administered through DME, unit dose form, per milligram | $6.04 |
| J7647 | | Isoetharine HCl, inhalation solution, compounded product, administered through DME, concentrated form, per milligram | BR |
| J7648 | | Isoetharine HCl, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, per milligram | BR |
| J7649 | | Isoetharine HCl, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per milligram | BR |
| J7650 | | Isoetharine HCl, inhalation solution, compounded product, administered through DME, unit dose form, per milligram | BR |
| J7657 | | Isoproterenol HCl, inhalation solution, compounded product, administered through DME, concentrated form, per milligram | BR |
| J7658 | | Isoproterenol HCl, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, per milligram | $6.48 |
| J7659 | | Isoproterenol HCl, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per milligram | $6.48 |
| J7660 | | Isoproterenol HCl, inhalation solution, compounded product, administered through DME, unit dose form, per milligram | BR |
| J7667 | | Metaproterenol sulfate, inhalation solution, compounded product, concentrated form, per 10 milligrams | $2.11 |
| J7668 | | Metaproterenol sulfate, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, per 10 milligrams | $2.11 |
| J7669 | | Metaproterenol sulfate, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per 10 milligrams | $2.11 |
| J7670 | | Metaproterenol sulfate, inhalation solution, compounded product, administered through DME, unit dose form, per 10 milligrams | $2.11 |
| J7674 | | Methacholine chloride administered as inhalation solution through a nebulizer, per 1 mg | $0.68 |
| J7680 | | Terbutaline sulfate, inhalation solution, compounded product, administered through DME, concentrated form, per milligram | BR |
| J7681 | | Terbutaline sulfate, inhalation solution, compounded product, administered through DME, unit dose form, per milligram | BR |
| J7682 | | Tobramycin, inhalation solution, FDA-approved final product, noncompounded, unit dose form, administered through DME, per 300 milligrams | BR |
| J7683 | | Triamcinolone, inhalation solution, compounded product, administered through DME, concentrated form, per milligram | BR |
| J7684 | | Triamcinolone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram | BR |
| J7685 | | Tobramycin, inhalation solution, compounded product, administered through DME, unit dose form, per 300 milligrams | BR |
| J7699 | | NOC drugs, inhalation solution administered through DME | BR |
| J7799 | | NOC drugs, other than inhalation drugs, administered through DME | BR |
| J8498 | | Antiemetic drug, rectal/suppository, not otherwise specified | BR |
| J8499 | | Prescription drug, oral, nonchemotherapeutic, NOS | BR |
| J8501 | | Aprepitant, oral, 5 mg | $145.99 |
| J8510 | | Bulsulfan; oral, 2 mg | $2.75 |
| J8515 | | Cabergoline, oral, 0.25 mg | $29.74 |
| J8520 | | Capecitabine, oral, 150 mg | $4.75 |
| J8521 | | Capecitabine, oral, 500 mg | $15.88 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| J8530 | | Cyclophosphamide, oral, 25 mg | $3.14 |
| J8540 | | Dexamethasone, oral, 0.25 mg | $0.18 |
| J8560 | | Etoposide, oral, 50 mg | $63.68 |
| J8565 | | Gefitinib, oral, 250 mg | $87.45 |
| J8597 | | Antiemetic drug, oral, not otherwise specified | BR |
| J8600 | | Melphalan, oral 2 mg | $3.30 |
| J8610 | | Methotrexate, oral, 2.5 mg | $3.06 |
| J8650 | | Nabilone, oral, 1 mg | BR |
| J8700 | | Temozolomide, oral, 5 mg | $10.34 |
| J8999 | | Prescription drug, oral, chemotherapeutic, NOS | BR |
| J9000 | | Doxorubicin HCl, 10 mg | $22.39 |
| J9001 | | Doxorubicin HCl, all lipid formulations, 10 mg | $553.81 |
| J9010 | | Alemtuzumab, 10 mg | $866.91 |
| J9015 | | Aldesleukin, per single use vial | $1,033.75 |
| J9017 | | Arsenic trioxide, 1 mg | $521.48 |
| J9020 | | Asparaginase, 10,000 units | $87.07 |
| J9025 | | Injection, azacitidine, 1 mg | $7.67 |
| J9027 | | Injection, clofarabine, 1 mg | $217.49 |
| J9031 | | BCG live (intravesical), per instillation | $225.38 |
| J9035 | | Injection, bevacizumab, 10 mg | $110.76 |
| J9040 | | Bleomycin sulfate, 15 units | $359.58 |
| J9041 | | Injection, bortezomib, 0.1 mg | $43.82 |
| J9045 | | Carboplatin, 50 mg | $209.37 |
| J9050 | | Carmustine, 100 mg | $191.66 |
| J9055 | | Injection, cetuximab, 10 mg | $92.79 |
| J9060 | | Cisplatin, powder or solution, per 10 mg | $44.35 |
| J9062 | | Cisplatin, 50 mg | $221.80 |
| J9065 | | Injection, cladribine, per 1 mg | $77.33 |
| J9070 | | Cyclophosphamide, 100 mg | $8.55 |
| J9080 | | Cyclophosphamide, 200 mg | $15.97 |
| J9090 | | Cyclophosphamide, 500 mg | $34.22 |
| J9091 | | Cyclophosphamide, 1 g | $67.05 |
| J9092 | | Cyclophosphamide, 2 g | $137.32 |
| J9093 | | Cyclophosphamide, lyophilized, 100 mg | BR |
| J9094 | | Cyclophosphamide, lyophilized, 200 mg | $16.77 |
| J9095 | | Cyclophosphamide, lyophilized, 500 mg | $35.20 |
| J9096 | | Cyclophosphamide, lyophilized, 1 g | $70.43 |
| J9097 | | Cyclophosphamide, lyophilized, 2 g | $140.90 |
| J9098 | | Cytarabine liposome, 10 mg | $522.82 |
| J9100 | | Cytarabine, 100 mg | $4.80 |
| J9110 | | Cytarabine, 500 mg | $13.63 |
| J9120 | | Dactinomycin, 0.5 mg | $19.51 |
| J9130 | | Dacarbazine, 100 mg | $17.85 |
| J9140 | | Dacarbazine, 200 mg | $34.10 |
| J9150 | | Daunorubicin HCl, 10 mg | $112.64 |
| J9151 | | Daunorubicin citrate, liposomal formulation, 10 mg | $90.92 |
| J9160 | | Denileukin diftitox, 300 mcg | $1,873.32 |
| J9165 | | Diethylstilbestrol diphosphate, 250 mg | $20.17 |
| J9170 | | Docetaxel, 20 mg | $503.76 |
| J9175 | | Injection, Elliotts B Solution, 1 ml | $5.72 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| **J9178** | | Injection, epirubicin HCl, 2 mg | $38.91 |
| **J9181** | | Etoposide, 10 mg | $9.78 |
| **J9182** | | Etoposide, 100 mg | $83.48 |
| **J9185** | | Fludarabine phosphate, 50 mg | $501.17 |
| **J9190** | | Fluorouracil, 500 mg | $3.72 |
| **J9200** | | Floxuridine, 500 mg | $198.15 |
| **J9201** | | Gemcitabine HCl, 200 mg | $170.31 |
| **J9202** | | Goserelin acetate implant, per 3.6 mg | $628.43 |
| **J9206** | | Irinotecan, 20 mg | $195.64 |
| **J9208** | | Ifosfamide, per 1 g | $224.35 |
| **J9209** | | Mesna, 200 mg | $50.73 |
| **J9211** | | Idarubicin HCl, 5 mg | $601.87 |
| **J9212** | | Injection, interferon alfacon-1, recombinant, 1 mcg | BR |
| **J9213** | | Interferon alfa-2A, recombinant, 3 million units | $48.12 |
| **J9214** | | Interferon alfa-2B, recombinant, 1 million units | $20.93 |
| **J9215** | | Interferon alfa-N3, (human leukocyte derived), 250,000 IU | $12.82 |
| **J9216** | | Interferon gamma-1B, 3 million units | $442.25 |
| **J9217** | | Leuprolide acetate (for depot suspension), 7.5 mg | $860.77 |
| **J9218** | | Leuprolide acetate, per 1 mg | BR |
| **J9219** | | Leuprolide acetate implant, 65 mg | $7,600.25 |
| **J9225** | | Histrelin implant, 50 mg | $9,666.00 |
| **J9230** | | Mechlorethamine HCl, (nitrogen mustard), 10 mg | $16.11 |
| **J9245** | | Injection, melphalan HCl, 50 mg | $591.29 |
| **J9250** | | Methotrexate sodium, 5 mg | $0.43 |
| **J9260** | | Methotrexate sodium, 50 mg | $9.21 |
| **J9261** | | Injection, nelarabine, 50 mg | $154.66 |
| **J9263** | | Injection, oxaliplatin, 0.5 mg | BR |
| **J9264** | | Injection, paclitaxel protein-bound particles, 1 mg | $16.01 |
| **J9265** | | Paclitaxel, 30 mg | $244.20 |
| **J9266** | | Pegaspargase, per single dose vial | $2,009.03 |
| **J9268** | | Pentostatin, per 10 mg | $2,711.70 |
| **J9270** | | Plicamycin, 2.5 mg | $130.43 |
| **J9280** | | Mitomycin, 5 mg | $146.26 |
| **J9290** | | Mitomycin, 20 mg | $400.61 |
| **J9291** | | Mitomycin, 40 mg | $401.14 |
| **J9293** | | Injection, mitoxantrone HCl, per 5 mg | $505.77 |
| **J9300** | | Gemtuzumab ozogamicin, 5 mg | $3,073.72 |
| **J9305** | | Injection, pemetrexed, 10 mg | $68.32 |
| **J9310** | | Rituximab, 100 mg | $705.33 |
| **J9320** | | Streptozocin, 1 g | $199.12 |
| **J9340** | | Thiotepa, 15 mg | $179.37 |
| **J9350** | | Topotecan, 4 mg | $1,124.09 |
| **J9355** | | Trastuzumab, 10 mg | $107.13 |
| **J9357** | | Valrubicin, intravesical, 200 mg | $741.30 |
| **J9360** | | Vinblastine sulfate, 1 mg | $5.77 |
| **J9370** | | Vincristine sulfate, 1 mg | $48.91 |
| **J9375** | | Vincristine sulfate, 2 mg | $73.40 |
| **J9380** | | Vincristine sulfate, 5 mg | BR |
| **J9390** | | Vinorelbine tartrate, per 10 mg | $153.42 |
| **J9395** | | Injection, fulvestrant, 25 mg | $123.27 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| J9600 | | Porfimer sodium, 75 mg | $3,664.67 |
| J9999 | | NOC, antineoplastic drug | BR |
| K0001 | NU | Standard wheelchair | BR |
| K0001 | RR | Standard wheelchair | $58.36 |
| K0001 | UE | Standard wheelchair | BR |
| K0002 | NU | Standard hemi (low seat) wheelchair | $874.37 |
| K0002 | RR | Standard hemi (low seat) wheelchair | $87.44 |
| K0002 | UE | Standard hemi (low seat) wheelchair | $655.78 |
| K0003 | NU | Lightweight wheelchair | $957.21 |
| K0003 | RR | Lightweight wheelchair | $95.72 |
| K0003 | UE | Lightweight wheelchair | $717.91 |
| K0004 | NU | High strength, lightweight wheelchair | $1,427.83 |
| K0004 | RR | High strength, lightweight wheelchair | $142.78 |
| K0004 | UE | High strength, lightweight wheelchair | $1,070.88 |
| K0005 | NU | Ultralightweight wheelchair | $1,975.31 |
| K0005 | RR | Ultralightweight wheelchair | $197.51 |
| K0005 | UE | Ultralightweight wheelchair | $1,481.46 |
| K0006 | NU | Heavy-duty wheelchair | $1,339.96 |
| K0006 | RR | Heavy-duty wheelchair | $134.00 |
| K0006 | UE | Heavy-duty wheelchair | $1,004.97 |
| K0007 | NU | Extra heavy-duty wheelchair | $1,907.25 |
| K0007 | RR | Extra heavy-duty wheelchair | $190.72 |
| K0007 | UE | Extra heavy-duty wheelchair | $1,430.44 |
| K0009 | | Other manual wheelchair/base | BR |
| K0010 | NU | Standard-weight frame motorized/power wheelchair | $4,551.47 |
| K0010 | RR | Standard-weight frame motorized/power wheelchair | $455.15 |
| K0010 | UE | Standard-weight frame motorized/power wheelchair | $3,413.61 |
| K0011 | NU | Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking | BR |
| K0011 | RR | Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking | $565.90 |
| K0011 | UE | Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking | BR |
| K0012 | RR | Lightweight portable motorized/power wheelchair | $347.16 |
| K0014 | | Other motorized/power wheelchair base | BR |
| K0015 | NU | Detachable, nonadjustable height armrest, each | $194.14 |
| K0015 | RR | Detachable, nonadjustable height armrest, each | $19.42 |
| K0015 | UE | Detachable, nonadjustable height armrest, each | $145.60 |
| K0017 | NU | Detachable, adjustable height armrest, base, each | $54.60 |
| K0017 | RR | Detachable, adjustable height armrest, base, each | $5.46 |
| K0017 | UE | Detachable, adjustable height armrest, base, each | $40.95 |
| K0018 | NU | Detachable, adjustable height armrest, upper portion, each | $30.51 |
| K0018 | RR | Detachable, adjustable height armrest, upper portion, each | $3.03 |
| K0018 | UE | Detachable, adjustable height armrest, upper portion, each | $22.90 |
| K0019 | NU | Arm pad, each | $18.42 |
| K0019 | RR | Arm pad, each | $1.84 |
| K0019 | UE | Arm pad, each | $13.81 |
| K0020 | NU | Fixed, adjustable height armrest, pair | $49.64 |
| K0020 | RR | Fixed, adjustable height armrest, pair | $4.97 |
| K0020 | UE | Fixed, adjustable height armrest, pair | $37.22 |
| K0037 | NU | High mount flip-up footrest, each | $51.46 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| K0037 | RR | High mount flip-up footrest, each | $4.60 |
| K0037 | UE | High mount flip-up footrest, each | $38.60 |
| K0038 | NU | Leg strap, each | $25.92 |
| K0038 | RR | Leg strap, each | $2.60 |
| K0038 | UE | Leg strap, each | $19.45 |
| K0039 | NU | Leg strap, H style, each | $57.57 |
| K0039 | RR | Leg strap, H style, each | $5.77 |
| K0039 | UE | Leg strap, H style, each | $43.18 |
| K0040 | NU | Adjustable angle footplate, each | $79.78 |
| K0040 | RR | Adjustable angle footplate, each | $7.96 |
| K0040 | UE | Adjustable angle footplate, each | $59.82 |
| K0041 | NU | Large size footplate, each | $56.54 |
| K0041 | RR | Large size footplate, each | $5.67 |
| K0041 | UE | Large size footplate, each | $42.41 |
| K0042 | NU | Standard size footplate, each | $38.93 |
| K0042 | RR | Standard size footplate, each | $3.88 |
| K0042 | UE | Standard size footplate, each | $29.19 |
| K0043 | NU | Footrest, lower extension tube, each | $20.87 |
| K0043 | RR | Footrest, lower extension tube, each | $2.09 |
| K0043 | UE | Footrest, lower extension tube, each | $15.66 |
| K0044 | NU | Footrest, upper hanger bracket, each | $17.77 |
| K0044 | RR | Footrest, upper hanger bracket, each | $1.78 |
| K0044 | UE | Footrest, upper hanger bracket, each | $13.34 |
| K0045 | NU | Footrest, complete assembly | $60.50 |
| K0045 | RR | Footrest, complete assembly | $6.23 |
| K0045 | UE | Footrest, complete assembly | $45.38 |
| K0046 | NU | Elevating legrest, lower extension tube, each | $20.87 |
| K0046 | RR | Elevating legrest, lower extension tube, each | $2.09 |
| K0046 | UE | Elevating legrest, lower extension tube, each | $15.66 |
| K0047 | NU | Elevating legrest, upper hanger bracket, each | $81.72 |
| K0047 | RR | Elevating legrest, upper hanger bracket, each | $8.20 |
| K0047 | UE | Elevating legrest, upper hanger bracket, each | $61.27 |
| K0050 | NU | Ratchet assembly | $34.73 |
| K0050 | RR | Ratchet assembly | $3.46 |
| K0050 | UE | Ratchet assembly | $26.06 |
| K0051 | NU | Cam release assembly, footrest or legrest, each | $56.21 |
| K0051 | RR | Cam release assembly, footrest or legrest, each | $5.66 |
| K0051 | UE | Cam release assembly, footrest or legrest, each | $42.13 |
| K0052 | NU | Swingaway, detachable footrests, each | $98.76 |
| K0052 | RR | Swingaway, detachable footrests, each | $9.87 |
| K0052 | UE | Swingaway, detachable footrests, each | $74.06 |
| K0053 | NU | Elevating footrests, articulating (telescoping), each | $108.99 |
| K0053 | RR | Elevating footrests, articulating (telescoping), each | $10.89 |
| K0053 | UE | Elevating footrests, articulating (telescoping), each | $81.74 |
| K0056 | NU | Seat height less than 17 in. or equal to or greater than 21 in. for a high strength, lightweight, or ultralightweight wheelchair | $101.62 |
| K0056 | RR | Seat height less than 17 in. or equal to or greater than 21 in. for a high strength, lightweight, or ultralightweight wheelchair | $10.16 |
| K0056 | UE | Seat height less than 17 in. or equal to or greater than 21 in. for a high strength, lightweight, or ultralightweight wheelchair | $76.22 |
| K0065 | NU | Spoke protectors, each | $47.50 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| K0065 | RR | Spoke protectors, each | $4.75 |
| K0065 | UE | Spoke protectors, each | $35.62 |
| K0069 | NU | Rear wheel assembly, complete, with solid tire, spokes or molded, each | $106.76 |
| K0069 | UE | Rear wheel assembly, complete, with solid tire, spokes or molded, each | $80.07 |
| K0070 | NU | Rear wheel assembly, complete with pneumatic tire, spokes or molded, each | $195.70 |
| K0070 | UE | Rear wheel assembly, complete with pneumatic tire, spokes or molded, each | $146.77 |
| K0071 | NU | Front caster assembly, complete, with pneumatic tire, each | $116.73 |
| K0071 | UE | Front caster assembly, complete, with pneumatic tire, each | $87.52 |
| K0072 | NU | Front caster assembly, complete, with semipneumatic tire, each | $70.27 |
| K0072 | UE | Front caster assembly, complete, with semipneumatic tire, each | $52.69 |
| K0073 | NU | Caster pin lock, each | $37.18 |
| K0073 | RR | Caster pin lock, each | $3.72 |
| K0073 | UE | Caster pin lock, each | $27.89 |
| K0077 | NU | Front caster assembly, complete, with solid tire, each | $62.88 |
| K0077 | RR | Front caster assembly, complete, with solid tire, each | $6.29 |
| K0077 | UE | Front caster assembly, complete, with solid tire, each | $47.15 |
| K0098 | NU | Drive belt for power wheelchair | $29.07 |
| K0098 | RR | Drive belt for power wheelchair | $2.90 |
| K0098 | UE | Drive belt for power wheelchair | $21.78 |
| K0105 | NU | IV hanger, each | $106.24 |
| K0105 | RR | IV hanger, each | $10.61 |
| K0105 | UE | IV hanger, each | $79.67 |
| K0108 | | Wheelchair component or accessory, not otherwise specified | BR |
| K0195 | RR | Elevating legrest, pair (for use with capped rental wheelchair base) | $22.51 |
| K0455 | RR | Infusion pump used for uninterrupted parenteral administration of medication, (e.g., epoprostenol or treprostinol) | $283.00 |
| K0462 | | Temporary replacement for patient owned equipment being repaired, any type | BR |
| K0552 | | Supplies for external drug infusion pump, syringe type cartridge, sterile, each | $2.83 |
| K0601 | | Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each | $1.18 |
| K0602 | | Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each | $6.80 |
| K0603 | | Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each | $0.60 |
| K0604 | | Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each | $6.51 |
| K0605 | | Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each | $15.60 |
| K0606 | RR | Automatic external defibrillator, with integrated electrocardiogram analysis, garment type | BR |
| K0607 | NU | Replacement battery for automated external defibrillator, garment type only, each | $207.53 |
| K0607 | RR | Replacement battery for automated external defibrillator, garment type only, each | $20.77 |
| K0607 | UE | Replacement battery for automated external defibrillator, garment type only, each | $155.64 |
| K0608 | NU | Replacement garment for use with automated external defibrillator, each | $136.59 |
| K0608 | RR | Replacement garment for use with automated external defibrillator, each | $13.68 |
| K0608 | UE | Replacement garment for use with automated external defibrillator, each | $102.45 |
| K0609 | | Replacement electrodes for use with automated external defibrillator, garment type only, each | $861.27 |
| K0669 | | Wheelchair accessory, wheelchair seat or back cushion, does not meet specific code criteria or no written coding verification from SADMERC | BR |
| K0730 | | Controlled dose inhalation drug delivery system | BR |
| K0733 | | Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g. gel cell, absorbed glassmat) | BR |
| K0734 | | Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth | BR |
| K0735 | | Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth | BR |
| K0736 | | Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth | BR |
| K0737 | | Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| K0738 | | Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing | BR |
| K0800 | | Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds | BR |
| K0801 | | Power operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 pounds | BR |
| K0802 | | Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds | BR |
| K0806 | | Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds | BR |
| K0807 | | Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450 pounds | BR |
| K0808 | | Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds | BR |
| K0812 | | Power operated vehicle, not otherwise classified | BR |
| K0813 | | Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds | BR |
| K0814 | | Power wheelchair, group 1 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds | BR |
| K0815 | | Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds | BR |
| K0816 | | Power wheelchair, group 1 standard, captain's chair, patient weight capacity up to and including 300 pounds | BR |
| K0820 | | Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds | BR |
| K0821 | | Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds | BR |
| K0822 | | Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds | BR |
| K0823 | | Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds | BR |
| K0824 | | Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds | BR |
| K0825 | | Power wheelchair, group 2 heavy duty, captain's chair, patient weight capacity 301 to 450 pounds | BR |
| K0826 | | Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds | BR |
| K0827 | | Power wheelchair, group 2 very heavy duty, captain's chair, patient weight capacity 451 to 600 pounds | BR |
| K0828 | | Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more | BR |
| K0829 | | Power wheelchair, group 2 extra heavy duty, captain's chair, patient weight capacity 601 pounds or more | BR |
| K0830 | | Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds | BR |
| K0831 | | Power wheelchair, group 2 standard, seat elevator, captain's chair, patient weight capacity up to and including 300 pounds | BR |
| K0835 | | Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | BR |
| K0836 | | Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds | BR |
| K0837 | | Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | BR |
| K0838 | | Power wheelchair, group 2 heavy duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds | BR |
| K0839 | | Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds | BR |
| K0840 | | Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more | BR |
| K0841 | | Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | BR |
| K0842 | | Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds | BR |
| K0843 | | Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | BR |
| K0848 | | Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| K0849 | | Power wheelchair, group 3 standard, captain's chair, patient weight capacity up to and including 300 pounds | BR |
| K0850 | | Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds | BR |
| K0851 | | Power wheelchair, group 3 heavy duty, captain's chair, patient weight capacity 301 to 450 pounds | BR |
| K0852 | | Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds | BR |
| K0853 | | Power wheelchair, group 3 very heavy duty, captain's chair, patient weight capacity, 451 to 600 pounds | BR |
| K0854 | | Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more | BR |
| K0855 | | Power wheelchair, group 3 extra heavy duty, captain's chair, patient weight 601 pounds or more | BR |
| K0856 | | Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | BR |
| K0857 | | Power wheelchair, group 3 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds | BR |
| K0858 | | Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | BR |
| K0859 | | Power wheelchair, group 3 heavy duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds | BR |
| K0860 | | Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds | BR |
| K0861 | | Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | BR |
| K0862 | | Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | BR |
| K0863 | | Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds | BR |
| K0864 | | Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more | BR |
| K0868 | | Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds | BR |
| K0869 | | Power wheelchair, group 4 standard, captain's chair, patient weight capacity up to and including 300 pounds | BR |
| K0870 | | Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds | BR |
| K0871 | | Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds | BR |
| K0877 | | Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | BR |
| K0878 | | Power wheelchair, group 4 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds | BR |
| K0879 | | Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | BR |
| K0880 | | Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds | BR |
| K0884 | | Power wheelchair, group 4 standard multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | BR |
| K0885 | | Power wheelchair, group 4 standard, multiple power option, captain's chair, weight capacity up to and including 300 pounds | BR |
| K0886 | | Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | BR |
| K0890 | | Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds | BR |
| K0891 | | Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds | BR |
| K0898 | | Power wheelchair, not otherwise classified | BR |
| K0899 | | Power mobility device, not coded by SADMERC or does not meet criteria | BR |
| L0112 | | Cranial cervical orthosis, congenital torticollis type, with or without soft interface material, adjustable range of motion joint, custom fabricated | $1,265.27 |
| L0120 | | Cervical, flexible, nonadjustable (foam collar) | $25.10 |
| L0130 | | Cervical, flexible, thermoplastic collar, molded to patient | $154.37 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L0140 | | Cervical, semi-rigid, adjustable (plastic collar) | $60.57 |
| L0150 | | Cervical, semi-rigid, adjustable molded chin cup (plastic collar with mandibular/occipital piece) | $102.26 |
| L0160 | | Cervical, semi-rigid, wire frame occipital/mandibular support | $148.20 |
| L0170 | | Cervical, collar, molded to patient model | $610.22 |
| L0172 | | Cervical, collar, semi-rigid thermoplastic foam, two piece | $120.13 |
| L0174 | | Cervical, collar, semi-rigid, thermoplastic foam, two piece with thoracic extension | $259.94 |
| L0180 | | Cervical, multiple post collar, occipital/mandibular supports, adjustable | $350.60 |
| L0190 | | Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars (SOMI, Guilford, Taylor types) | $468.72 |
| L0200 | | Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars, and thoracic extension | $488.63 |
| L0210 | | Thoracic, rib belt | $41.90 |
| L0220 | | Thoracic, rib belt, custom fabricated | $115.88 |
| L0430 | | Spinal orthosis, anterior-posterior-lateral control, with interface material, custom fitted (DeWall Posture Protector only) | $1,267.86 |
| L0450 | | TLSO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, includes fitting and adjustment | $164.45 |
| L0452 | | TLSO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, custom fabricated | BR |
| L0454 | | TLSO flexible, provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, includes fitting and adjustment | $313.53 |
| L0456 | | TLSO, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated, includes fitting and adjustment | $899.11 |
| L0458 | | TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment | $806.23 |
| L0460 | | TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment | $907.47 |
| L0462 | | TLSO, triplanar control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment | $1,128.72 |
| L0464 | | TLSO, triplanar control, modular segmented spinal system, four rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment | $1,343.75 |
| L0466 | | TLSO, sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment | $353.52 |
| L0468 | | TLSO, sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal, and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment | $433.73 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L0470 | | TLSO, triplanar control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction to scapula, lateral strength provided by pelvic, thoracic, and lateral frame pieces, rotational strength provided by subclavicular extensions, restricts gross trunk motion in sagittal, coronal, and transverse planes, produces intracavitary pressure to reduce load on the intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment | $603.26 |
| L0472 | | TLSO, triplanar control, hyperextension, rigid anterior and lateral frame extends from symphysis pubis to sternal notch with two anterior components (one pubic and one sternal), posterior and lateral pads with straps and closures, limits spinal flexion, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment | $382.59 |
| L0480 | | TLSO, triplanar control, one piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated | $1,347.35 |
| L0482 | | TLSO, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated | $1,467.31 |
| L0484 | | TLSO, triplanar control, two piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated | $1,681.55 |
| L0486 | | TLSO, triplanar control, two piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated | $1,784.03 |
| L0488 | | TLSO, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, prefabricated, includes fitting and adjustment | $907.47 |
| L0490 | | TLSO, sagittal-coronal control, one piece rigid plastic shell, with overlapping reinforced anterior, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates at or before the T-9 vertebra, anterior extends from symphysis pubis to xiphoid, anterior opening, restricts gross trunk motion in sagittal and coronal planes, prefabricated, includes fitting and adjustment | $255.72 |
| L0491 | | TLSO, sagittal-coronal control, modular segmented spinal sytem, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment | $925.71 |
| L0492 | | TLSO, sagittal-coronal control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment | $601.08 |
| L0621 | | Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment | $116.34 |
| L0622 | | Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated | $325.93 |
| L0623 | | Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment | BR |
| L0624 | | Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels placed over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated | BR |
| L0625 | | Lumbar orthosis, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, includes fitting and adjustment | $66.41 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L0626 | | Lumbar orthosis, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment | $93.99 |
| L0627 | | Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment | $495.57 |
| L0628 | | Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment | $101.14 |
| L0629 | | Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated | BR |
| L0630 | | Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment | $195.25 |
| L0631 | | Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment | $1,237.68 |
| L0632 | | LSO, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated | BR |
| L0633 | | LSO, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment | $345.71 |
| L0634 | | LSO, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated | BR |
| L0635 | | LSO, sagittal-coronal control, lumbar flexion, rigid posterior frame/panel(s), lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, prefabricated, includes fitting and adjustment | $1,207.63 |
| L0636 | | LSO, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, custom fabricated | $1,787.72 |
| L0637 | | LSO, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment | $1,414.75 |
| L0638 | | LSO, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated | $1,589.75 |
| L0639 | | LSO, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated, includes fitting and adjustment | $1,414.75 |
| L0640 | | LSO, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated | $1,261.26 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L0700 | | CTLSO, anterior-posterior-lateral control, molded to patient model (Minerva type) | $1,912.97 |
| L0710 | | CTLSO, anterior-posterior-lateral control, molded to patient model, with interface material (Minerva type) | $1,976.17 |
| L0810 | | Halo procedure, cervical halo incorporated into jacket vest | $2,440.68 |
| L0820 | | Halo procedure, cervical halo incorporated into plaster body jacket | $2,043.89 |
| L0830 | | Halo procedure, cervical halo incorporated into Milwaukee type orthosis | $2,967.12 |
| L0859 | | Addition to halo procedure, magnetic resonance image compatible systems, rings and pins, any material | $1,536.95 |
| L0861 | | Addition to halo procedure, replacement liner/interface material | $194.85 |
| L0960 | | Torso support, postsurgical support, pads for postsurgical support | $65.36 |
| L0970 | | TLSO, corset front | $108.14 |
| L0972 | | LSO, corset front | $97.38 |
| L0974 | | TLSO, full corset | $169.41 |
| L0976 | | LSO, full corset | $151.29 |
| L0978 | | Axillary crutch extension | $182.14 |
| L0980 | | Peroneal straps, pair | $16.52 |
| L0982 | | Stocking supporter grips, set of four (4) | $15.40 |
| L0984 | | Protective body sock, each | $56.64 |
| L0999 | | Addition to spinal orthosis, NOS | BR |
| L1000 | | CTLSO (Milwaukee), inclusive of furnishing initial orthosis, including model | $1,921.04 |
| L1001 | | Cervical thoracic lumbar sacral orthosis, immobilizer, infant size, prefabricated, includes fitting and adjustment | BR |
| L1005 | | Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment | $2,893.40 |
| L1010 | | Addition to CTLSO or scoliosis orthosis, axilla sling | $63.50 |
| L1020 | | Addition to CTLSO or scoliosis orthosis, kyphosis pad | $81.78 |
| L1025 | | Addition to CTLSO or scoliosis orthosis, kyphosis pad, floating | $117.99 |
| L1030 | | Addition to CTLSO or scoliosis orthosis, lumbar bolster pad | $60.20 |
| L1040 | | Addition to CTLSO or scoliosis orthosis, lumbar or lumbar rib pad | $73.82 |
| L1050 | | Addition to CTLSO or scoliosis orthosis, sternal pad | $78.78 |
| L1060 | | Addition to CTLSO or scoliosis orthosis, thoracic pad | $90.49 |
| L1070 | | Addition to CTLSO or scoliosis orthosis, trapezius sling | $85.14 |
| L1080 | | Addition to CTLSO or scoliosis orthosis, outrigger | $52.37 |
| L1085 | | Addition to CTLSO or scoliosis orthosis, outrigger, bilateral with vertical extensions | $145.65 |
| L1090 | | Addition to CTLSO or scoliosis orthosis, lumbar sling | $86.73 |
| L1100 | | Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather | $150.48 |
| L1110 | | Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather, molded to patient model | $241.66 |
| L1120 | | Addition to CTLSO, scoliosis orthosis, cover for upright, each | $37.58 |
| L1200 | | TLSO, inclusive of furnishing initial orthosis only | $1,482.56 |
| L1210 | | Addition to TLSO, (low profile), lateral thoracic extension | $247.59 |
| L1220 | | Addition to TLSO, (low profile), anterior thoracic extension | $209.63 |
| L1230 | | Addition to TLSO, (low profile), Milwaukee type superstructure | $537.88 |
| L1240 | | Addition to TLSO, (low profile), lumbar derotation pad | $73.47 |
| L1250 | | Addition to TLSO, (low profile), anterior asis pad | $68.36 |
| L1260 | | Addition to TLSO, (low profile), anterior thoracic derotation pad | $71.59 |
| L1270 | | Addition to TLSO, (low profile), abdominal pad | $73.31 |
| L1280 | | Addition to TLSO, (low profile), rib gusset (elastic), each | $81.63 |
| L1290 | | Addition to TLSO, (low profile), lateral trochanteric pad | $74.38 |
| L1300 | | Other scoliosis procedure, body jacket molded to patient model | $1,580.59 |
| L1310 | | Other scoliosis procedure, postoperative body jacket | $1,626.43 |
| L1499 | | Spinal orthosis, not otherwise specified | BR |
| L1500 | | THKAO, mobility frame (Newington, Parapodium types) | $1,797.31 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L1510 | | THKAO, standing frame, with or without tray and accessories | $1,137.06 |
| L1520 | | THKAO, swivel walker | $2,158.66 |
| L1600 | | HO, abduction control of hip joints, flexible, Frejka type with cover, prefabricated, includes fitting and adjustment | $121.93 |
| L1610 | | HO, abduction control of hip joints, flexible, (Frejka cover only), prefabricated, includes fitting and adjustment | $41.54 |
| L1620 | | HO, abduction control of hip joints, flexible, (Pavlik harness), prefabricated, includes fitting and adjustment | $126.78 |
| L1630 | | HO, abduction control of hip joints, semi-flexible (Von Rosen type), custom fabricated | $160.34 |
| L1640 | | HO, abduction control of hip joints, static, pelvic band or spreader bar, thigh cuffs, custom fabricated | $436.61 |
| L1650 | | HO, abduction control of hip joints, static, adjustable (Ilfled type), prefabricated, includes fitting and adjustment | $219.07 |
| L1652 | | Hip orthosis, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, includes fitting and adjustment, any type | $322.26 |
| L1660 | | HO, abduction control of hip joints, static, plastic, prefabricated, includes fitting and adjustment | $161.93 |
| L1680 | | HO, abduction control of hip joints, dynamic, pelvic control, adjustable hip motion control, thigh cuffs (Rancho hip action type), custom fabricated | $1,152.90 |
| L1685 | | HO, abduction control of hip joint, postoperative hip abduction type, custom fabricated | $1,125.51 |
| L1686 | | HO, abduction control of hip joint, postoperative hip abduction type, prefabricated, includes fitting and adjustments | $863.13 |
| L1690 | | Combination, bilateral, lumbo-sacral, hip, femur orthosis providing adduction and internal rotation control, prefabricated, includes fitting and adjustment | $1,748.11 |
| L1700 | | Legg Perthes orthosis, (Toronto type), custom fabricated | $1,444.97 |
| L1710 | | Legg Perthes orthosis, (Newington type), custom fabricated | $1,691.49 |
| L1720 | | Legg Perthes orthosis, trilateral, (Tachdijan type), custom fabricated | $1,246.84 |
| L1730 | | Legg Perthes orthosis, (Scottish Rite type), custom fabricated | $1,070.91 |
| L1755 | | Legg Perthes orthosis, (Patten bottom type), custom fabricated | $1,498.09 |
| L1800 | | KO, elastic with stays, prefabricated, includes fitting and adjustment | $62.94 |
| L1810 | | KO, elastic with joints, prefabricated, includes fitting and adjustment | $93.18 |
| L1815 | | KO, elastic or other elastic type material with condylar pad(s), prefabricated, includes fitting and adjustment | $91.66 |
| L1820 | | Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment | $122.68 |
| L1825 | | KO, elastic knee cap, prefabricated, includes fitting and adjustment | $52.03 |
| L1830 | | KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment | $82.77 |
| L1831 | | Knee orthosis, locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment | $266.07 |
| L1832 | | Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, includes fitting and adjustment | $575.27 |
| L1834 | | KO, without knee joint, rigid, custom fabricated | $734.50 |
| L1836 | | Knee orthosis, rigid, without joint(s), includes soft interface material, prefabricated, includes fitting and adjustment | $120.62 |
| L1840 | | KO, derotation, medial-lateral, anterior cruciate ligament, custom fabricated | $870.02 |
| L1843 | | Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, includes fitting and adjustment | $811.13 |
| L1844 | | Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated | $1,504.54 |
| L1845 | | Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, includes fitting and adjustment | $773.39 |
| L1846 | | Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated | $1,004.59 |
| L1847 | | KO, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated, includes fitting and adjustment | $519.96 |
| L1850 | | KO, Swedish type, prefabricated, includes fitting and adjustment | $272.35 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L1855 | | KO, molded plastic, thigh and calf sections, with double upright knee joints, custom fabricated | $1,039.78 |
| L1858 | | KO, molded plastic, polycentric knee joints, pneumatic knee pads (CTI), custom fabricated | $1,133.80 |
| L1860 | | KO, modification of supracondylar prosthetic socket, custom fabricated (SK) | $1,015.34 |
| L1870 | | KO, double upright, thigh and calf lacers, with knee joints, custom fabricated | $990.23 |
| L1880 | | KO, double upright, nonmolded thigh and calf cuffs/lacers with knee joints, custom fabricated | $669.73 |
| L1900 | | AFO, spring wire, dorsiflexion assist calf band, custom fabricated | $255.26 |
| L1901 | | Ankle orthosis, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra) | $15.99 |
| L1902 | | AFO, ankle gauntlet, prefabricated, includes fitting and adjustment | $75.53 |
| L1904 | | AFO, molded ankle gauntlet, custom fabricated | $444.95 |
| L1906 | | AFO, multiligamentus ankle support, prefabricated, includes fitting and adjustment | $113.80 |
| L1907 | | AFO, supramalleolar with straps, with or without interface/pads, custom fabricated | $508.67 |
| L1910 | | AFO, posterior, single bar, clasp attachment to shoe counter, prefabricated, includes fitting and adjustment | $253.03 |
| L1920 | | AFO, single upright with static or adjustable stop (Phelps or Perlstein type), custom fabricated | $330.79 |
| L1930 | | AFO, plastic or other material, prefabricated, includes fitting and adjustment | $223.85 |
| L1932 | | AFO, rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment | BR |
| L1940 | | AFO, plastic or other material, custom-fabricated | $467.94 |
| L1945 | | AFO, molded to patient model, plastic, rigid anterior tibial section (floor reaction), custom fabricated | $875.90 |
| L1950 | | Ankle foot orthosis, spiral, (Institute of Rehabilitative Medicine type), plastic, custom-fabricated | $704.79 |
| L1951 | | Ankle foot orthosis, spiral, (Institute of Rehabilitative Medicine type), plastic or other material, prefabricated, includes fitting and adjustment | $759.22 |
| L1960 | | AFO, posterior solid ankle, plastic, custom fabricated | $524.47 |
| L1970 | | AFO, plastic, with ankle joint, custom fabricated | $673.30 |
| L1971 | | Ankle foot orthosis, plastic or other material with ankle joint, prefabricated, includes fitting and adjustment | $423.73 |
| L1980 | | AFO, single upright free plantar dorsiflexion, solid stirrup, calf band/cuff (single bar BK orthosis), custom fabricated | $347.27 |
| L1990 | | AFO, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff (double bar BK orthosis), custom fabricated | $421.77 |
| L2000 | | KAFO, single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar AK orthosis), custom fabricated | $959.73 |
| L2005 | | Knee ankle foot orthosis, any material, single or double upright, stance control, automatic lock and swing phase release, mechanical activation, includes ankle joint, any type, custom fabricated | BR |
| L2010 | | KAFO, single upright, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar AK orthosis), without knee joint, custom fabricated | $874.88 |
| L2020 | | KAFO, double upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar AK orthosis), custom fabricated | $1,104.85 |
| L2030 | | KAFO, double upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar AK orthosis), without knee joint, custom fabricated | $958.55 |
| L2034 | | Knee ankle foot orthosis, full plastic, single upright, with or without free motion knee, medial lateral rotation control, with or without free motion ankle, custom fabricated | BR |
| L2035 | | Knee ankle foot orthosis, full plastic, static (pediatric size), without free motion ankle, prefabricated, includes fitting and adjustment | $157.59 |
| L2036 | | Knee ankle foot orthosis, full plastic, double upright, with or without free motion knee, with or without free motion ankle, custom fabricated | $1,755.54 |
| L2037 | | Knee ankle foot orthosis, full plastic, single upright, with or without free motion knee, with or without free motion ankle, custom fabricated | $1,576.01 |
| L2038 | | Knee ankle foot orthosis, full plastic, with or without free motion knee, multi-axis ankle, custom fabricated | $1,352.83 |
| L2040 | | HKAFO, torsion control, bilateral rotation straps, pelvic band/belt, custom fabricated | $168.00 |
| L2050 | | HKAFO, torsion control, bilateral torsion cables, hip joint, pelvic band/belt, custom fabricated | $450.75 |
| L2060 | | HKAFO, torsion control, bilateral torsion cables, ball bearing hip joint, pelvic band/ belt, custom fabricated | $549.36 |
| L2070 | | HKAFO, torsion control, unilateral rotation straps, pelvic band/belt, custom fabricated | $127.25 |
| L2080 | | HKAFO, torsion control, unilateral torsion cable, hip joint, pelvic band/belt, custom fabricated | $340.33 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L2090 | | HKAFO, torsion control, unilateral torsion cable, ball bearing hip joint, pelvic band/belt, custom fabricated | $414.91 |
| L2106 | | AFO, fracture orthosis, tibial fracture cast orthosis, thermoplastic type casting material, custom fabricated | $643.35 |
| L2108 | | AFO, fracture orthosis, tibial fracture cast orthosis, custom fabricated | $1,010.99 |
| L2112 | | AFO, fracture orthosis, tibial fracture orthosis, soft, prefabricated, includes fitting and adjustment | $441.46 |
| L2114 | | AFO, fracture orthosis, tibial fracture orthosis, semi-rigid, prefabricated, includes fitting and adjustment | $549.21 |
| L2116 | | AFO, fracture orthosis, tibial fracture orthosis, rigid, prefabricated, includes fitting and adjustment | $673.61 |
| L2126 | | KAFO, fracture orthosis, femoral fracture cast orthosis, thermoplastic type casting material, custom fabricated | $1,133.05 |
| L2128 | | KAFO, fracture orthosis, femoral fracture cast orthosis, custom fabricated | $1,622.50 |
| L2132 | | KAFO, fracture orthosis, femoral fracture cast orthosis, soft, prefabricated, includes fitting and adjustment | $763.29 |
| L2134 | | KAFO, fracture orthosis, femoral fracture cast orthosis, semi-rigid, prefabricated, includes fitting and adjustment | $915.16 |
| L2136 | | KAFO, fracture orthosis, femoral fracture cast orthosis, rigid, prefabricated, includes fitting and adjustment | $1,118.99 |
| L2180 | | Addition to lower extremity fracture orthosis, plastic shoe insert with ankle joints | $110.80 |
| L2182 | | Addition to lower extremity fracture orthosis, drop lock knee joint | $86.72 |
| L2184 | | Addition to lower extremity fracture orthosis, limited motion knee joint | $117.22 |
| L2186 | | Addition to lower extremity fracture orthosis, adjustable motion knee joint, Lerman type | $142.46 |
| L2188 | | Addition to lower extremity fracture orthosis, quadrilateral brim | $283.38 |
| L2190 | | Addition to lower extremity fracture orthosis, waist belt | $82.64 |
| L2192 | | Addition to lower extremity fracture orthosis, hip joint, pelvic band, thigh flange, and pelvic belt | $337.38 |
| L2200 | | Addition to lower extremity, limited ankle motion, each joint | $44.99 |
| L2210 | | Addition to lower extremity, dorsiflexion assist (plantar flexion resist), each joint | $63.60 |
| L2220 | | Addition to lower extremity, dorsiflexion and plantar flexion assist/resist, each joint | $77.49 |
| L2230 | | Addition to lower extremity, split flat caliper stirrups and plate attachment | $72.60 |
| L2232 | | Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only | BR |
| L2240 | | Addition to lower extremity, round caliper and plate attachment | $79.13 |
| L2250 | | Addition to lower extremity, foot plate, molded to patient model, stirrup attachment | $336.22 |
| L2260 | | Addition to lower extremity, reinforced solid stirrup (Scott-Craig type) | $189.68 |
| L2265 | | Addition to lower extremity, long tongue stirrup | $111.43 |
| L2270 | | Addition to lower extremity, varus/valgus correction (T) strap, padded/lined or malleolus pad | $50.82 |
| L2275 | | Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined | $118.67 |
| L2280 | | Addition to lower extremity, molded inner boot | $428.46 |
| L2300 | | Addition to lower extremity, abduction bar (bilateral hip involvement), jointed, adjustable | $254.76 |
| L2310 | | Addition to lower extremity, abduction bar, straight | $116.40 |
| L2320 | | Addition to lower extremity, nonmolded lacer, for custom fabricated orthosis only | $194.68 |
| L2330 | | Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only | $371.54 |
| L2335 | | Addition to lower extremity, anterior swing band | $214.96 |
| L2340 | | Addition to lower extremity, pretibial shell, molded to patient model | $422.89 |
| L2350 | | Addition to lower extremity, prosthetic type, (BK) socket, molded to patient model, (used for PTB, AFO orthoses) | $843.12 |
| L2360 | | Addition to lower extremity, extended steel shank | $48.96 |
| L2370 | | Addition to lower extremity, patten bottom | $242.90 |
| L2375 | | Addition to lower extremity, torsion control, ankle joint and half solid stirrup | $106.91 |
| L2380 | | Addition to lower extremity, torsion control, straight knee joint, each joint | $116.49 |
| L2385 | | Addition to lower extremity, straight knee joint, heavy duty, each joint | $126.74 |
| L2387 | | Addition to lower extremity, polycentric knee joint, for custom fabricated knee ankle foot orthosis, each joint | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L2390 | | Addition to lower extremity, offset knee joint, each joint | $103.58 |
| L2395 | | Addition to lower extremity, offset knee joint, heavy duty, each joint | $148.05 |
| L2397 | | Addition to lower extremity orthosis, suspension sleeve | $106.34 |
| L2405 | | Addition to knee joint, drop lock, each | $78.81 |
| L2415 | | Addition to knee lock with integrated release mechanism (bail, cable, or equal), any material, each joint | $109.81 |
| L2425 | | Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint | $129.58 |
| L2430 | | Addition to knee joint, ratchet lock for active and progressive knee extension, each joint | $129.58 |
| L2492 | | Addition to knee joint, lift loop for drop lock ring | $96.49 |
| L2500 | | Addition to lower extremity, thigh/weight bearing, gluteal/ischial weight bearing, ring | $298.50 |
| L2510 | | Addition to lower extremity, thigh/weight bearing, quadri-lateral brim, molded to patient model | $687.32 |
| L2520 | | Addition to lower extremity, thigh/weight bearing, quadri-lateral brim, custom fitted | $435.90 |
| L2525 | | Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M–L brim molded to patient model | $1,153.42 |
| L2526 | | Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M–L brim, custom fitted | $648.11 |
| L2530 | | Addition to lower extremity, thigh/weight bearing, lacer, nonmolded | $222.33 |
| L2540 | | Addition to lower extremity, thigh/weight bearing, lacer, molded to patient model | $400.04 |
| L2550 | | Addition to lower extremity, thigh/weight bearing, high roll cuff | $271.75 |
| L2570 | | Addition to lower extremity, pelvic control, hip joint, Clevis type, two position joint, each | $450.70 |
| L2580 | | Addition to lower extremity, pelvic control, pelvic sling | $439.15 |
| L2600 | | Addition to lower extremity, pelvic control, hip joint, Clevis type, or thrust bearing, free, each | $194.33 |
| L2610 | | Addition to lower extremity, pelvic control, hip joint, Clevis or thrust bearing, lock, each | $229.79 |
| L2620 | | Addition to lower extremity, pelvic control, hip joint, heavy-duty, each | $253.00 |
| L2622 | | Addition to lower extremity, pelvic control, hip joint, adjustable flexion, each | $290.17 |
| L2624 | | Addition to lower extremity, pelvic control, hip joint, adjustable flexion, extension, abduction control, each | $313.33 |
| L2627 | | Addition to lower extremity, pelvic control, plastic, molded to patient model, reciprocating hip joint and cables | $1,622.08 |
| L2628 | | Addition to lower extremity, pelvic control, metal frame, reciprocating hip joint and cables | $1,585.28 |
| L2630 | | Addition to lower extremity, pelvic control, band and belt, unilateral | $234.30 |
| L2640 | | Addition to lower extremity, pelvic control, band and belt, bilateral | $317.98 |
| L2650 | | Addition to lower extremity, pelvic and thoracic control, gluteal pad, each | $113.56 |
| L2660 | | Addition to lower extremity, thoracic control, thoracic band | $176.36 |
| L2670 | | Addition to lower extremity, thoracic control, paraspinal uprights | $161.41 |
| L2680 | | Addition to lower extremity, thoracic control, lateral support uprights | $148.07 |
| L2750 | | Addition to lower extremity orthosis, plating chrome or nickel, per bar | $79.09 |
| L2755 | | Addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, per segment, for custom fabricated orthosis only | $118.12 |
| L2760 | | Addition to lower extremity orthosis, extension, per extension, per bar (for lineal adjustment for growth) | $57.48 |
| L2768 | | Orthotic side bar disconnect device, per bar | $117.79 |
| L2770 | | Addition to lower extremity orthosis, any material, per bar or joint | $58.43 |
| L2780 | | Addition to lower extremity orthosis, noncorrosive finish, per bar | $64.03 |
| L2785 | | Addition to lower extremity orthosis, drop lock retainer, each | $29.99 |
| L2795 | | Addition to lower extremity orthosis, knee control, full kneecap | $80.40 |
| L2800 | | Addition to lower extremity orthosis, knee control, knee cap, medial or lateral pull, for use with custom fabricated orthosis only | $100.92 |
| L2810 | | Addition to lower extremity orthosis, knee control, condylar pad | $73.90 |
| L2820 | | Addition to lower extremity orthosis, soft interface for molded plastic, below knee section | $82.17 |
| L2830 | | Addition to lower extremity orthosis, soft interface for molded plastic, above knee section | $88.90 |
| L2840 | | Addition to lower extremity orthosis, tibial length sock, fracture or equal, each | $41.34 |
| L2850 | | Addition to lower extremity orthosis, femoral length sock, fracture or equal, each | $58.59 |
| L2860 | | Addition to lower extremity joint, knee or ankle, concentric adjustable torsion style mechanism, each | BR |
| L2999 | | Lower extremity orthoses, NOS | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L3000 | | Foot insert, removable, molded to patient model, UCB type, Berkeley shell, each | $247.63 |
| L3001 | | Foot insert, removable, molded to patient model, Spenco, each | $145.81 |
| L3002 | | Foot insert, removable, molded to patient model, Plastazote or equal, each | $120.67 |
| L3003 | | Foot insert, removable, molded to patient model, silicone gel, each | $148.33 |
| L3010 | | Foot insert, removable, molded to patient model, longitudinal arch support, each | $192.32 |
| L3020 | | Foot insert, removable, molded to patient model, longitudinal/metatarsal support, each | $243.86 |
| L3030 | | Foot insert, removable, formed to patient foot, each | $243.86 |
| L3031 | | Foot, insert/plate, removable, addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, each | BR |
| L3040 | | Foot, arch support, removable, premolded, longitudinal, each | $43.37 |
| L3050 | | Foot, arch support, removable, premolded, metatarsal, each | $40.22 |
| L3060 | | Foot, arch support, removable, premolded, longitudinal/metatarsal, each | $77.93 |
| L3070 | | Foot, arch support, nonremovable, attached to shoe, longitudinal, each | $23.88 |
| L3080 | | Foot, arch support, nonremovable, attached to shoe, metatarsal, each | $9.74 |
| L3090 | | Foot, arch support, nonremovable, attached to shoe, longitudinal/metatarsal, each | $15.08 |
| L3100 | | Hallus-valgus night dynamic splint | $25.14 |
| L3140 | | Foot, abduction rotation bar, including shoes | $72.91 |
| L3150 | | Foot, abduction rotation bar, without shoes | $60.96 |
| L3160 | | Foot, adjustable shoe-styled positioning device | $18.86 |
| L3170 | | Foot, plastic, silicone or equal, heel stabilizer, each | $32.05 |
| L3201 | | Orthopedic shoe, Oxford with supinator or pronator, infant | $72.28 |
| L3202 | | Orthopedic shoe, Oxford with supinator or pronator, child | $71.02 |
| L3203 | | Orthopedic shoe, Oxford with supinator or pronator, junior | $69.14 |
| L3204 | | Orthopedic shoe, hightop with supinator or pronator, infant | $69.14 |
| L3206 | | Orthopedic shoe, hightop with supinator or pronator, child | $71.96 |
| L3207 | | Orthopedic shoe, hightop with supinator or pronator, junior | $73.22 |
| L3208 | | Surgical boot, each, infant | $38.34 |
| L3209 | | Surgical boot, each, child | $54.37 |
| L3211 | | Surgical boot, each, junior | $57.82 |
| L3212 | | Benesch boot, pair, infant | $80.76 |
| L3213 | | Benesch boot, pair, child | $97.42 |
| L3214 | | Benesch boot, pair, junior | $103.70 |
| L3215 | | Orthopedic footwear, ladies shoe, oxford, each | $131.99 |
| L3216 | | Orthopedic footwear, ladies shoe, depth inlay, each | $159.64 |
| L3217 | | Orthopedic footwear, ladies shoe, hightop, depth inlay, each | $173.15 |
| L3219 | | Orthopedic footwear, mens shoe, oxford, each | $148.33 |
| L3221 | | Orthopedic footwear, mens shoe, depth inlay, each | $177.87 |
| L3222 | | Orthopedic footwear, mens shoe, hightop, depth inlay, each | $196.41 |
| L3224 | | Orthopedic footwear, woman's shoe, Oxford, used as an integral part of a brace (orthosis) | $55.63 |
| L3225 | | Orthopedic footwear, man's shoe, Oxford, used as an integral part of a brace (orthosis) | $64.01 |
| L3230 | | Orthopedic footwear, custom shoe, depth inlay, each | $231.29 |
| L3250 | | Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each | $450.01 |
| L3251 | | Foot, shoe molded to patient model, silicone shoe, each | $61.91 |
| L3252 | | Foot, shoe molded to patient model, Plastazote (or similar), custom fabricated, each | $246.37 |
| L3253 | | Foot, molded shoe Plastazote (or similar), custom fitted, each | $61.59 |
| L3254 | | Nonstandard size or width | BR |
| L3255 | | Nonstandard size or length | BR |
| L3257 | | Orthopedic footwear, additional charge for split size | $44.62 |
| L3260 | | Surgical boot/shoe, each | $25.14 |
| L3265 | | Plastazote sandal, each | $27.34 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L3300 | | Lift, elevation, heel, tapered to metatarsals, per in. | $31.43 |
| L3310 | | Lift, elevation, heel and sole, neoprene, per in. | $62.85 |
| L3320 | | Lift, elevation, heel and sole, cork, per in. | $166.55 |
| L3330 | | Lift, elevation, metal extension (skate) | $269.41 |
| L3332 | | Lift, elevation, inside shoe, tapered, up to one-half in. | $18.86 |
| L3334 | | Lift, elevation, heel, per in. | $18.54 |
| L3340 | | Heel wedge, SACH | $45.25 |
| L3350 | | Heel wedge | $28.60 |
| L3360 | | Sole wedge, outside sole | $21.37 |
| L3370 | | Sole wedge, between sole | $25.77 |
| L3380 | | Clubfoot wedge | $44.31 |
| L3390 | | Outflare wedge | $61.59 |
| L3400 | | Metatarsal bar wedge, rocker | $59.08 |
| L3410 | | Metatarsal bar wedge, between sole | $99.93 |
| L3420 | | Full sole and heel wedge, between sole | $32.05 |
| L3430 | | Heel, counter, plastic reinforced | $80.45 |
| L3440 | | Heel, counter, leather reinforced | $54.05 |
| L3450 | | Heel, SACH cushion type | $44.00 |
| L3455 | | Heel, new leather, standard | $18.44 |
| L3460 | | Heel, new rubber, standard | $31.74 |
| L3465 | | Heel, Thomas with wedge | $22.63 |
| L3470 | | Heel, Thomas extended to ball | $55.31 |
| L3480 | | Heel, pad and depression for spur | $37.71 |
| L3485 | | Heel, pad, removable for spur | $25.14 |
| L3500 | | Orthopedic shoe addition, insole, leather | $27.65 |
| L3510 | | Orthopedic shoe addition, insole, rubber | $25.77 |
| L3520 | | Orthopedic shoe addition, insole, felt covered with leather | $42.11 |
| L3530 | | Orthopedic shoe addition, sole, half | $12.57 |
| L3540 | | Orthopedic shoe addition, sole, full | $46.51 |
| L3550 | | Orthopedic shoe addition, toe tap, standard | $7.54 |
| L3560 | | Orthopedic shoe addition, toe tap, horseshoe | $10.06 |
| L3570 | | Orthopedic shoe addition, special extension to instep (leather with eyelets) | $41.48 |
| L3580 | | Orthopedic shoe addition, convert instep to Velcro closure | $61.59 |
| L3590 | | Orthopedic shoe addition, convert firm shoe counter to soft counter | $47.77 |
| L3595 | | Orthopedic shoe addition, March bar | $13.83 |
| L3600 | | Transfer of an orthosis from one shoe to another, caliper plate, existing | $77.93 |
| L3610 | | Transfer of an orthosis from one shoe to another, caliper plate, new | $125.70 |
| L3620 | | Transfer of an orthosis from one shoe to another, solid stirrup, existing | $77.93 |
| L3630 | | Transfer of an orthosis from one shoe to another, solid stirrup, new | $95.53 |
| L3640 | | Transfer of an orthosis from one shoe to another, Dennis Browne splint (Riveton), both shoes | $31.43 |
| L3649 | | Orthopedic shoe, modification, addition or transfer, NOS | BR |
| L3650 | | SO, figure of eight design abduction restrainer, prefabricated, includes fitting and adjustment | $54.91 |
| L3651 | | SO, single shoulder, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra) | $54.16 |
| L3652 | | SO, double shoulder, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra) | $163.26 |
| L3660 | | SO, figure of eight design abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment | $95.17 |
| L3670 | | SO, acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and adjustment | $104.71 |
| L3671 | | Shoulder orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3672 | | Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L3673 | | Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, includes nontorsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3675 | | SO, vest type abduction restrainer, canvas webbing type, or equal, prefabricated, includes fitting and adjustment | $144.38 |
| L3677 | | Shoulder orthosis, hard plastic, shoulder stabilizer, prefabricated, includes fitting and adjustment | $182.27 |
| L3700 | | EO, elastic with stays, prefabricated, includes fitting and adjustment | $64.63 |
| L3701 | | EO, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra) | $16.76 |
| L3702 | | Elbow orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3710 | | EO, elastic with metal joints, prefabricated, includes fitting and adjustment | $114.46 |
| L3720 | | EO, double upright with forearm/arm cuffs, free motion, custom fabricated | $605.62 |
| L3730 | | EO, double upright with forearm/arm cuffs, extension/flexion assist, custom fabricated | $834.67 |
| L3740 | | EO, double upright with forearm/arm cuffs, adjustable position lock with active control, custom fabricated | $989.57 |
| L3760 | | Elbow orthosis, with adjustable position locking joint(s), prefabricated, includes fitting and adjustments, any type | $411.44 |
| L3762 | | Elbow orthosis, rigid, without joints, includes soft interface material, prefabricated, includes fitting and adjustment | $88.47 |
| L3763 | | Elbow wrist hand orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3764 | | Elbow wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3765 | | Elbow wrist hand finger orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3766 | | Elbow wrist hand finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3800 | | WHFO, short opponens, no attachments, custom fabricated | $185.14 |
| L3805 | | WHFO, long opponens, no attachment, custom fabricated | $296.24 |
| L3806 | | Wrist hand finger orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface material, straps, custom fabricated, includes fitting and adjustment | BR |
| L3807 | | WHFO, without joint(s), prefabricated, includes fitting and adjustments, any type | $205.72 |
| L3808 | | Wrist hand finger orthosis, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment | BR |
| L3810 | | WHFO, addition to short and long opponens, thumb abduction (C) bar | $60.01 |
| L3815 | | WHFO, addition to short and long opponens, second M.P. abduction assist | $55.71 |
| L3820 | | WHFO, addition to short and long opponens, I.P. extension assist, with M.P. extension stop | $95.68 |
| L3825 | | WHFO, addition to short and long opponens, M.P. extension stop | $60.05 |
| L3830 | | WHFO, addition to short and long opponens, M.P. extension assist | $78.39 |
| L3835 | | WHFO, addition to short and long opponens, M.P. spring extension assist | $84.97 |
| L3840 | | WHFO, addition to short and long opponens, spring swivel thumb | $58.20 |
| L3845 | | WHFO, addition to short and long opponens, thumb I.P. extension assist, with M.P. stop | $75.17 |
| L3850 | | WHFO, addition to short and long opponens, action wrist, with dorsiflexion assist | $107.36 |
| L3855 | | WHFO, addition to short and long opponens, adjustable M.P. flexion control | $108.23 |
| L3860 | | WHFO, addition to short and long opponens, adjustable M.P. flexion control and I.P. | $148.15 |
| L3890 | | Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism, each | BR |
| L3900 | | WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven, custom fabricated | $1,198.10 |
| L3901 | | WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, cable driven, custom fabricated | $1,487.97 |
| L3904 | | WHFO, external powered, electric, custom fabricated | $2,711.50 |
| L3905 | | Wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3906 | | Wrist hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | $365.86 |
| L3907 | | WHFO, wrist gauntlet with thumb spica, molded to patient model, custom fabricated | $470.34 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L3908 | | WHO, wrist extension control cock-up, nonmolded, prefabricated, includes fitting and adjustment | $55.48 |
| L3909 | | WO, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra) | $11.63 |
| L3910 | | WHFO, Swanson design, prefabricated, includes fitting and adjustment | $347.31 |
| L3911 | | WHFO, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra) | $20.39 |
| L3912 | | HFO, flexion glove with elastic finger control, prefabricated, includes fitting and adjustment | $87.81 |
| L3913 | | Hand finger orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3915 | | Wrist hand orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, includes fitting and adjustment | BR |
| L3916 | | WHFO, wrist extension cock-up, with outrigger, prefabricated, includes fitting and adjustment | $117.59 |
| L3917 | | Hand orthosis, metacarpal fracture orthosis, prefabricated, includes fitting and adjustment | $86.90 |
| L3918 | | HFO, knuckle bender, prefabricated, includes fitting and adjustment | $72.57 |
| L3919 | | Hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3920 | | HFO, knuckle bender, with outrigger, prefabricated, includes fitting and adjustment | $90.68 |
| L3921 | | Hand finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3922 | | HFO, knuckle bender, two segment to flex joints, prefabricated, includes fitting and adjustment | $90.54 |
| L3923 | | Hand finger orthosis, without joints, may include soft interface, straps, prefabricated, includes fitting and adjustment | $32.02 |
| L3924 | | WHFO, Oppenheimer, prefabricated, includes fitting and adjustment | $98.72 |
| L3926 | | WHFO, Thomas suspension, prefabricated, includes fitting and adjustment | $85.95 |
| L3928 | | HFO, finger extension, with clock spring, prefabricated, includes fitting and adjustment | $53.89 |
| L3930 | | WHFO, finger extension, with wrist support, prefabricated, includes fitting and adjustment | $56.97 |
| L3932 | | FO, safety pin, spring wire, prefabricated, includes fitting and adjustment | $43.52 |
| L3933 | | Finger orthosis, without joints, may include soft interface, custom fabricated, includes fitting and adjustment | BR |
| L3934 | | FO, safety pin, modified, prefabricated, includes fitting and adjustment | $44.61 |
| L3935 | | Finger orthosis, nontorsion joint, may include soft interface, custom fabricated, includes fitting and adjustment | BR |
| L3936 | | WHFO, Palmer, prefabricated, includes fitting and adjustment | $82.47 |
| L3938 | | WHFO, dorsal wrist, prefabricated, includes fitting and adjustment | $86.37 |
| L3940 | | WHFO, dorsal wrist, with outrigger attachment, prefabricated, includes fitting and adjustment | $99.54 |
| L3942 | | HFO, reverse knuckle bender, prefabricated, includes fitting and adjustment | $68.85 |
| L3944 | | HFO, reverse knuckle bender, with outrigger, prefabricated, includes fitting and adjustment | $90.93 |
| L3946 | | HFO, composite elastic, prefabricated, includes fitting and adjustment | $82.06 |
| L3948 | | FO, finger knuckle bender, prefabricated, includes fitting and adjustment | $51.02 |
| L3950 | | WHFO, combination Oppenheimer, with knuckle bender and two attachments, prefabricated, includes fitting and adjustment | $138.85 |
| L3952 | | WHFO, combination Oppenheimer, with reverse knuckle and two attachments, prefabricated, includes fitting and adjustment | $154.11 |
| L3954 | | HFO, spreading hand, prefabricated, includes fitting and adjustment | $102.26 |
| L3956 | | Addition of joint to upper extremity orthosis, any material; per joint | BR |
| L3960 | | SEWHO, abduction positioning, airplane design, prefabricated, includes fitting and adjustment | $680.48 |
| L3961 | | Shoulder elbow wrist hand orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3962 | | SEWHO, abduction positioning, Erb's palsy design, prefabricated, includes fitting and adjustment | $664.34 |
| L3964 | NU | SEO, mobile arm support attached to wheelchair, balanced, adjustable, prefabricated, includes fitting and adjustment | $663.62 |
| L3964 | RR | SEO, mobile arm support attached to wheelchair, balanced, adjustable, prefabricated, includes fitting and adjustment | $66.36 |
| L3964 | UE | SEO, mobile arm support attached to wheelchair, balanced, adjustable, prefabricated, includes fitting and adjustment | $497.68 |
| L3965 | NU | SEO, mobile arm support attached to wheelchair, balanced, adjustable Rancho type, prefabricated, includes fitting and adjustment | $1,058.95 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L3965 | RR | SEO, mobile arm support attached to wheelchair, balanced, adjustable Rancho type, prefabricated, includes fitting and adjustment | $105.91 |
| L3965 | UE | SEO, mobile arm support attached to wheelchair, balanced, adjustable Rancho type, prefabricated, includes fitting and adjustment | $794.21 |
| L3966 | NU | SEO, mobile arm support attached to wheelchair, balanced, reclining, prefabricated, includes fitting and adjustment | $797.74 |
| L3966 | RR | SEO, mobile arm support attached to wheelchair, balanced, reclining, prefabricated, includes fitting and adjustment | $79.78 |
| L3966 | UE | SEO, mobile arm support attached to wheelchair, balanced, reclining, prefabricated, includes fitting and adjustment | $598.31 |
| L3967 | | Shoulder elbow wrist hand orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3968 | NU | SEO, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints), prefabricated, includes fitting and adjustment | $1,009.53 |
| L3968 | RR | SEO, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints), prefabricated, includes fitting and adjustment | $100.95 |
| L3968 | UE | SEO, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints), prefabricated, includes fitting and adjustment | $757.15 |
| L3969 | NU | SEO, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type arm suspension support, prefabricated, includes fitting and adjustment | $705.97 |
| L3969 | RR | SEO, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type arm suspension support, prefabricated, includes fitting and adjustment | $70.61 |
| L3969 | UE | SEO, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type arm suspension support, prefabricated, includes fitting and adjustment | $529.46 |
| L3970 | NU | SEO, addition to mobile arm support, elevating proximal arm | $282.40 |
| L3970 | RR | SEO, addition to mobile arm support, elevating proximal arm | $28.24 |
| L3970 | UE | SEO, addition to mobile arm support, elevating proximal arm | $211.80 |
| L3971 | | Shoulder elbow wrist hand orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3972 | NU | SEO, addition to mobile arm support, offset or lateral rocker arm with elastic balance control | $179.58 |
| L3972 | RR | SEO, addition to mobile arm support, offset or lateral rocker arm with elastic balance control | $17.96 |
| L3972 | UE | SEO, addition to mobile arm support, offset or lateral rocker arm with elastic balance control | $134.67 |
| L3973 | | Shoulder elbow wrist hand orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3974 | NU | SEO, addition to mobile arm support, supinator | $152.31 |
| L3974 | RR | SEO, addition to mobile arm support, supinator | $15.25 |
| L3974 | UE | SEO, addition to mobile arm support, supinator | $114.22 |
| L3975 | | Shoulder elbow wrist hand finger orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3976 | | Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3977 | | Shoulder elbow wrist hand finger orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3978 | | Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | BR |
| L3980 | | Upper extremity fracture orthosis, humeral, prefabricated, includes fitting and adjustment | $286.24 |
| L3982 | | Upper extremity fracture orthosis, radius/ulnar, prefabricated, includes fitting and adjustment | $345.66 |
| L3984 | | Upper extremity fracture orthosis, wrist, prefabricated, includes fitting and adjustment | $318.69 |
| L3985 | | Upper extremity fracture orthosis, forearm, hand with wrist hinge, custom fabricated | $541.18 |
| L3986 | | Upper extremity fracture orthosis, combination of humeral, radius/ulnar, wrist (example: Colles' fracture), custom fabricated | $518.99 |
| L3995 | | Addition to upper extremity orthosis, sock, fracture or equal, each | $30.28 |
| L3999 | | Upper limb orthosis, NOS | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L4000 | | Replace girdle for spinal orthosis (CTLSO or SO) | $1,206.47 |
| L4002 | | Replacement strap, any orthosis, includes all components, any length, any type | BR |
| L4010 | | Replace trilateral socket brim | $635.02 |
| L4020 | | Replace quadrilateral socket brim, molded to patient model | $815.00 |
| L4030 | | Replace quadrilateral socket brim, custom fitted | $477.72 |
| L4040 | | Replace molded thigh lacer, for custom fabricated orthosis only | $386.24 |
| L4045 | | Replace nonmolded thigh lacer, for custom fabricated orthosis only | $310.39 |
| L4050 | | Replace molded calf lacer, for custom fabricated orthosis only | $390.64 |
| L4055 | | Replace nonmolded calf lacer, for custom fabricated orthosis only | $252.95 |
| L4060 | | Replace high roll cuff | $300.71 |
| L4070 | | Replace proximal and distal upright for KAFO | $266.30 |
| L4080 | | Replace metal bands KAFO, proximal thigh | $95.71 |
| L4090 | | Replace metal bands KAFO-AFO, calf or distal thigh | $85.45 |
| L4100 | | Replace leather cuff KAFO, proximal thigh | $98.69 |
| L4110 | | Replace leather cuff KAFO-AFO, calf or distal thigh | $80.25 |
| L4130 | | Replace pretibial shell | $469.45 |
| L4205 | | Repair of orthotic device, labor component, per 15 minutes | BR |
| L4210 | | Repair of orthotic device, repair or replace minor parts | BR |
| L4350 | | Ankle control orthosis, stirrup style, rigid, includes any type interface (e.g., pneumatic, gel), prefabricated, includes fitting and adjustment | $84.58 |
| L4360 | | Walking boot, pneumatic, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment | $262.00 |
| L4370 | | Pneumatic full leg splint, prefabricated, includes fitting and adjustment | $178.63 |
| L4380 | | Pneumatic knee splint, prefabricated, includes fitting and adjustment | $101.63 |
| L4386 | | Walking boot, nonpneumatic, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment | $143.34 |
| L4392 | | Replacement soft interface material, static AFO | $21.24 |
| L4394 | | Replace soft interface material, foot drop splint | $15.50 |
| L4396 | | Static ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, pressure reduction, may be used for minimal ambulation, prefabricated, includes fitting and adjustment | $151.44 |
| L4398 | | Foot drop splint, recumbent positioning device, prefabricated, includes fitting and adjustment | $69.71 |
| L5000 | | Partial foot, shoe insert with longitudinal arch, toe filler | $509.34 |
| L5010 | | Partial foot, molded socket, ankle height, with toe filler | $1,227.27 |
| L5020 | | Partial foot, molded socket, tibial tubercle height, with toe filler | $1,997.75 |
| L5050 | | Ankle, Symes, molded socket, SACH foot | $2,313.50 |
| L5060 | | Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot | $2,784.31 |
| L5100 | | Below knee, molded socket, shin, SACH foot | $2,342.92 |
| L5105 | | Below knee, plastic socket, joints and thigh lacer, SACH foot | $3,502.00 |
| L5150 | | Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot | $3,540.04 |
| L5160 | | Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, SACH foot | $3,850.43 |
| L5200 | | Above knee, molded socket, single axis constant friction knee, shin, SACH foot | $3,330.14 |
| L5210 | | Above knee, short prosthesis, no knee joint (stubbies), with foot blocks, no ankle joints, each | $2,446.17 |
| L5220 | | Above knee, short prosthesis, no knee joint (stubbies), with articulated ankle/foot, dynamically aligned, each | $2,780.52 |
| L5230 | | Above knee, for proximal femoral focal deficiency, constant friction knee, shin, sach foot | $3,834.89 |
| L5250 | | Hip disarticulation, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot | $5,230.44 |
| L5270 | | Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot | $5,184.62 |
| L5280 | | Hemipelvectomy, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot | $5,132.78 |
| L5301 | | Below knee, molded socket, shin, SACH foot, endoskeletal system | $2,314.58 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L5311 | | Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot, endoskeletal system | $3,325.13 |
| L5321 | | Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee | $3,313.24 |
| L5331 | | Hip disarticulation, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot | $4,688.36 |
| L5341 | | Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot | $5,094.76 |
| L5400 | | Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, and one cast change, below knee | $1,213.26 |
| L5410 | | Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, below knee, each additional cast change and realignment | $421.20 |
| L5420 | | Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension and one cast change AK or knee disarticulation | $1,532.30 |
| L5430 | | Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, AK or knee disarticulation, each additional cast change and realignment | $507.27 |
| L5450 | | Immediate postsurgical or early fitting, application of nonweight bearing rigid dressing, below knee | $410.70 |
| L5460 | | Immediate postsurgical or early fitting, application of nonweight bearing rigid dressing, above knee | $549.69 |
| L5500 | | Initial, below knee PTB type socket, nonalignable system, pylon, no cover, SACH foot, plaster socket, direct formed | $1,294.70 |
| L5505 | | Initial, above knee — knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot plaster socket, direct formed | $1,753.36 |
| L5510 | | Preparatory, below knee PTB type socket, nonalignable system, pylon, no cover, SACH foot, plaster socket, molded to model | $1,467.62 |
| L5520 | | Preparatory, below knee PTB type socket, nonalignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed | $1,449.66 |
| L5530 | | Preparatory, below knee PTB type socket, nonalignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model | $1,741.18 |
| L5535 | | Preparatory, below knee PTB type socket, nonalignable system, pylon, no cover, SACH foot, prefabricated, adjustable open end socket | $1,709.49 |
| L5540 | | Preparatory, below knee PTB type socket, nonalignable system, pylon, no cover, SACH foot, laminated socket, molded to model | $1,824.57 |
| L5560 | | Preparatory, above knee — knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, plaster socket, molded to model | $1,959.27 |
| L5570 | | Preparatory, above knee — knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed | $2,036.96 |
| L5580 | | Preparatory, above knee — knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model | $2,377.99 |
| L5585 | | Preparatory, above knee — knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, prefabricated adjustable open end socket | $2,579.23 |
| L5590 | | Preparatory, above knee — knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, laminated socket, molded to model | $2,423.35 |
| L5595 | | Preparatory, hip disarticulation — hemipelvectomy, pylon, no cover, SACH foot, thermoplastic or equal, molded to patient model | $4,059.02 |
| L5600 | | Preparatory, hip disarticulation — hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient model | $4,482.36 |
| L5610 | | Addition to lower extremity, endoskeletal system, above knee, hydracadence system | $2,087.11 |
| L5611 | | Addition to lower extremity, endoskeletal system, above knee — knee disarticulation, 4-bar linkage, with friction swing phase control | $1,624.18 |
| L5613 | | Addition to lower extremity, endoskeletal system, above knee — knee disarticulation, 4-bar linkage, with hydraulic swing phase control | $2,470.48 |
| L5614 | | Addition to lower extremity, endoskeletal system, above knee — knee disarticulation, 4-bar linkage, with pneumatic swing phase control | $1,528.45 |
| L5616 | | Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control | $1,369.12 |
| L5617 | | Addition to lower extremity, quick change self-aligning unit, above or below knee, each | $510.04 |
| L5618 | | Addition to lower extremity, test socket, Symes | $283.50 |
| L5620 | | Addition to lower extremity, test socket, below knee | $280.26 |
| L5622 | | Addition to lower extremity, test socket, knee disarticulation | $365.45 |
| L5624 | | Addition to lower extremity, test socket, above knee | $366.49 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L5626 | | Addition to lower extremity, test socket, hip disarticulation | $480.64 |
| L5628 | | Addition to lower extremity, test socket, hemipelvectomy | $486.72 |
| L5629 | | Addition to lower extremity, below knee, acrylic socket | $320.37 |
| L5630 | | Addition to lower extremity, Symes type, expandable wall socket | $452.42 |
| L5631 | | Addition to lower extremity, above knee or knee disarticulation, acrylic socket | $442.93 |
| L5632 | | Addition to lower extremity, Symes type, PTB brim design socket | $223.83 |
| L5634 | | Addition to lower extremity, Symes type, posterior opening (Canadian) socket | $306.65 |
| L5636 | | Addition to lower extremity, Symes type, medial opening socket | $256.86 |
| L5637 | | Addition to lower extremity, below knee, total contact | $291.22 |
| L5638 | | Addition to lower extremity, below knee, leather socket | $490.59 |
| L5639 | | Addition to lower extremity, below knee, wood socket | $1,130.23 |
| L5640 | | Addition to lower extremity, knee disarticulation, leather socket | $644.60 |
| L5642 | | Addition to lower extremity, above knee, leather socket | $624.57 |
| L5643 | | Addition to lower extremity, hip disarticulation, flexible inner socket, external frame | $1,569.01 |
| L5644 | | Addition to lower extremity, above knee, wood socket | $595.42 |
| L5645 | | Addition to lower extremity, below knee, flexible inner socket, external frame | $804.33 |
| L5646 | | Addition to lower extremity, below knee, air, fluid, gel or equal, cushion socket | $552.34 |
| L5647 | | Addition to lower extremity, below knee, suction socket | $801.88 |
| L5648 | | Addition to lower extremity, above knee, air, fluid, gel or equal, cushion socket | $663.70 |
| L5649 | | Addition to lower extremity, ischial containment/narrow M-L socket | $1,919.31 |
| L5650 | | Addition to lower extremity, total contact, above knee or knee disarticulation socket | $492.13 |
| L5651 | | Addition to lower extremity, above knee, flexible inner socket, external frame | $1,210.62 |
| L5652 | | Addition to lower extremity, suction suspension, above knee or knee disarticulation socket | $439.50 |
| L5653 | | Addition to lower extremity, knee disarticulation, expandable wall socket | $586.69 |
| L5654 | | Addition to lower extremity, socket insert, Symes (Kemblo, Pelite, Aliplast, Plastazote or equal) | $334.31 |
| L5655 | | Addition to lower extremity, socket insert, below knee (Kemblo, Pelite, Aliplast, Plastazote or equal) | $267.39 |
| L5656 | | Addition to lower extremity, socket insert, knee disarticulation (Kemblo, Pelite, Aliplast, Plastazote or equal) | $373.94 |
| L5658 | | Addition to lower extremity, socket insert, above knee (Kemblo, Pelite, Aliplast, Plastazote or equal) | $366.53 |
| L5661 | | Addition to lower extremity, socket insert, multidurometer, Symes | $613.45 |
| L5665 | | Addition to lower extremity, socket insert, multidurometer, below knee | $516.16 |
| L5666 | | Addition to lower extremity, below knee, cuff suspension | $70.57 |
| L5668 | | Addition to lower extremity, below knee, molded distal cushion | $101.79 |
| L5670 | | Addition to lower extremity, below knee, molded supracondylar suspension (PTS or similar) | $273.54 |
| L5671 | | Addition to lower extremity, below knee/above knee suspension locking mechanism (shuttle, lanyard or equal), excludes socket insert | $501.43 |
| L5672 | | Addition to lower extremity, below knee, removable medial brim suspension | $300.60 |
| L5673 | | Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism | $673.60 |
| L5676 | | Addition to lower extremity, below knee, knee joints, single axis, pair | $365.30 |
| L5677 | | Addition to lower extremity, below knee, knee joints, polycentric, pair | $497.04 |
| L5678 | | Addition to lower extremity, below knee joint covers, pair | $40.02 |
| L5679 | | Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism | $561.33 |
| L5680 | | Addition to lower extremity, below knee, thigh lacer, nonmolded | $306.83 |
| L5681 | | Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L5673 or L5679) | $1,191.74 |
| L5682 | | Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded | $630.45 |
| L5683 | | Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L5673 or L5679) | $1,191.74 |
| L5684 | | Addition to lower extremity, below knee, fork strap | $48.52 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L5685 | | Addition to lower extremity prosthesis, below knee, suspension/sealing sleeve, with or without valve, any material, each | BR |
| L5686 | | Addition to lower extremity, below knee, back check (extension control) | $51.50 |
| L5688 | | Addition to lower extremity, below knee, waist belt, webbing | $61.58 |
| L5690 | | Addition to lower extremity, below knee, waist belt, padded and lined | $98.64 |
| L5692 | | Addition to lower extremity, above knee, pelvic control belt, light | $133.95 |
| L5694 | | Addition to lower extremity, above knee, pelvic control belt, padded and lined | $182.88 |
| L5695 | | Addition to lower extremity, above knee, pelvic control, sleeve suspension, neoprene or equal, each | $164.40 |
| L5696 | | Addition to lower extremity, above knee or knee disarticulation, pelvic joint | $186.51 |
| L5697 | | Addition to lower extremity, above knee or knee disarticulation, pelvic band | $80.93 |
| L5698 | | Addition to lower extremity, above knee or knee disarticulation, Silesian bandage | $105.15 |
| L5699 | | All lower extremity prostheses, shoulder harness | $187.96 |
| L5700 | | Replacement, socket, below knee, molded to patient model | $2,760.66 |
| L5701 | | Replacement, socket, above knee/knee disarticulation, including attachment plate, molded to patient model | $3,427.58 |
| L5702 | | Replacement, socket, hip disarticulation, including hip joint, molded to patient model | $4,379.73 |
| L5703 | | Ankle, Symes, molded to patient model, socket without solid ankle cushion heel (SACH) foot, replacement only | BR |
| L5704 | | Custom shaped protective cover, below knee | $530.81 |
| L5705 | | Custom shaped protective cover, above knee | $936.41 |
| L5706 | | Custom shaped protective cover, knee disarticulation | $918.70 |
| L5707 | | Custom shaped protective cover, hip disarticulation | $1,247.03 |
| L5710 | | Addition, exoskeletal knee-shin system, single axis, manual lock | $362.57 |
| L5711 | | Addition, exoskeletal knee-shin system, single axis, manual lock, ultra-light material | $526.38 |
| L5712 | | Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee) | $434.38 |
| L5714 | | Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control | $421.65 |
| L5716 | | Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock | $734.73 |
| L5718 | | Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control | $918.33 |
| L5722 | | Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control | $910.17 |
| L5724 | | Addition, exoskeletal knee-shin system, single axis, fluid swing phase control | $1,521.60 |
| L5726 | | Addition, exoskeletal knee-shin system, single axis, external joints, fluid swing phase control | $1,753.62 |
| L5728 | | Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control | $2,398.71 |
| L5780 | | Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control | $1,154.15 |
| L5781 | | Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system | $3,624.14 |
| L5782 | | Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy duty | $3,820.68 |
| L5785 | | Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal) | $523.74 |
| L5790 | | Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal) | $724.82 |
| L5795 | | Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal) | $1,082.36 |
| L5810 | | Addition, endoskeletal knee-shin system, single axis, manual lock | $490.80 |
| L5811 | | Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material | $735.21 |
| L5812 | | Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee) | $569.86 |
| L5814 | | Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock | $3,363.92 |
| L5816 | | Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock | $857.31 |
| L5818 | | Addition, endoskeletal knee-shin system, polycentric, friction swing and stance phase control | $968.08 |
| L5822 | | Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control | $1,716.65 |
| L5824 | | Addition, endoskeletal knee-shin system, single axis, fluid swing phase control | $1,545.95 |
| L5826 | | Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame | $2,846.38 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L5828 | | Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control | $2,846.73 |
| L5830 | | Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control | $1,912.85 |
| L5840 | | Addition, endoskeletal knee-shin system, 4-bar linkage or multiaxial, pneumatic swing phase control | $3,416.76 |
| L5845 | | Addition, endoskeletal knee-shin system, stance flexion feature, adjustable | $1,623.48 |
| L5848 | | Addition to endoskeletal knee-shin system, fluid stance extension, dampening feature, with or without adjustability | $973.99 |
| L5850 | | Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist | $128.96 |
| L5855 | | Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist | $311.32 |
| L5856 | | Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type | BR |
| L5857 | | Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor(s), any type | BR |
| L5858 | | Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type | $22,445.24 |
| L5910 | | Addition, endoskeletal system, below knee, alignable system | $365.10 |
| L5920 | | Addition, endoskeletal system, above knee or hip disarticulation, alignable system | $534.87 |
| L5925 | | Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual lock | $338.72 |
| L5930 | | Addition, endoskeletal system, high activity knee control frame | $3,068.27 |
| L5940 | | Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal) | $505.65 |
| L5950 | | Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal) | $784.29 |
| L5960 | | Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal) | $971.82 |
| L5962 | | Addition, endoskeletal system, below knee, flexible protective outer surface covering system | $592.54 |
| L5964 | | Addition, endoskeletal system, above knee, flexible protective outer surface covering system | $944.08 |
| L5966 | | Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system | $1,202.99 |
| L5968 | | Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature | $3,291.49 |
| L5970 | | All lower extremity prostheses, foot, external keel, SACH foot | $204.74 |
| L5971 | | All lower extremity prosthesis, solid ankle cushion heel (SACH) foot, replacement only | BR |
| L5972 | | All lower extremity prostheses, flexible keel foot (SAFE, STEN, Bock Dynamic or equal) | $355.28 |
| L5974 | | All lower extremity prostheses, foot, single axis ankle/foot | $234.91 |
| L5975 | | All lower extremity prosthesis, combination single axis ankle and flexible keel foot | $419.91 |
| L5976 | | All lower extremity prostheses, energy storing foot (Seattle Carbon Copy II or equal) | $564.54 |
| L5978 | | All lower extremity prostheses, foot, multiaxial ankle/foot | $294.19 |
| L5979 | | All lower extremity prostheses, multiaxial ankle, dynamic response foot, one piece system | $2,300.18 |
| L5980 | | All lower extremity prostheses, flex-foot system | $3,737.65 |
| L5981 | | All lower extremity prostheses, flex-walk system or equal | $2,903.43 |
| L5982 | | All exoskeletal lower extremity prostheses, axial rotation unit | $582.78 |
| L5984 | | All endoskeletal lower extremity prosthesis, axial rotation unit, with or without adjustability | $574.27 |
| L5985 | | All endoskeletal lower extremity prostheses, dynamic prosthetic pylon | $257.41 |
| L5986 | | All lower extremity prostheses, multiaxial rotation unit (MCP or equal) | $638.79 |
| L5987 | | All lower extremity prosthesis, shank foot system with vertical loading pylon | $6,515.89 |
| L5988 | | Addition to lower limb prosthesis, vertical shock reducing pylon feature | $1,809.45 |
| L5990 | | Addition to lower extremity prosthesis, user adjustable heel height | $1,643.25 |
| L5993 | | Addition to lower extremity prosthesis, heavy duty feature, foot only, (for patient weight greater than 300 lbs) | BR |
| L5994 | | Addition to lower extremity prosthesis, heavy duty feature, knee only, (for patient weight greater than 300 lbs) | BR |
| L5995 | | Addition to lower extremity prosthesis, heavy duty feature, other than foot or knee, (for patient weight greater than 300 lbs) | BR |
| L5999 | | Lower extremity prosthesis, not otherwise specified | BR |
| L6000 | | Partial hand, Robin-Aids, thumb remaining (or equal) | $1,339.42 |
| L6010 | | Partial hand, Robin-Aids, little and/or ring finger remaining (or equal) | $1,490.55 |
| L6020 | | Partial hand, Robin-Aids, no finger remaining (or equal) | $1,389.70 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L6025 | | Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device | $7,248.31 |
| L6050 | | Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad | $1,914.96 |
| L6055 | | Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad | $2,668.96 |
| L6100 | | Below elbow, molded socket, flexible elbow hinge, triceps pad | $1,940.14 |
| L6110 | | Below elbow, molded socket (Muenster or Northwestern suspension types) | $2,057.86 |
| L6120 | | Below elbow, molded double wall split socket, step-up hinges, half cuff | $2,398.13 |
| L6130 | | Below elbow, molded double wall split socket, stump activated locking hinge, half cuff | $2,609.62 |
| L6200 | | Elbow disarticulation, molded socket, outside locking hinge, forearm | $2,750.11 |
| L6205 | | Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm | $3,670.97 |
| L6250 | | Above elbow, molded double wall socket, internal locking elbow, forearm | $2,707.02 |
| L6300 | | Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm | $3,755.70 |
| L6310 | | Shoulder disarticulation, passive restoration (complete prosthesis) | $3,059.10 |
| L6320 | | Shoulder disarticulation, passive restoration (shoulder cap only) | $1,722.73 |
| L6350 | | Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm | $3,948.55 |
| L6360 | | Interscapular thoracic, passive restoration (complete prosthesis) | $3,210.89 |
| L6370 | | Interscapular thoracic, passive restoration (shoulder cap only) | $2,047.48 |
| L6380 | | Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, wrist disarticulation or below elbow | $1,159.56 |
| L6382 | | Immediate postsurgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, elbow disarticulation or above elbow | $1,492.62 |
| L6384 | | Immediate postsurgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, shoulder disarticulation or interscapular thoracic | $1,922.00 |
| L6386 | | Immediate postsurgical or early fitting, each additional cast change and realignment | $404.83 |
| L6388 | | Immediate postsurgical or early fitting, application of rigid dressing only | $443.17 |
| L6400 | | Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping | $2,339.13 |
| L6450 | | Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping | $3,107.98 |
| L6500 | | Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping | $3,110.52 |
| L6550 | | Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping | $3,844.04 |
| L6570 | | Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping | $4,412.21 |
| L6580 | | Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, molded to patient model | $1,575.78 |
| L6582 | | Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, direct formed | $1,387.41 |
| L6584 | | Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, molded to patient model | $2,063.33 |
| L6586 | | Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, direct formed | $1,898.64 |
| L6588 | | Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC or equal pylon, no cover, molded to patient model | $2,849.34 |
| L6590 | | Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC or equal pylon, no cover, direct formed | $2,652.16 |
| L6600 | | Upper extremity additions, polycentric hinge, pair | $189.09 |
| L6605 | | Upper extremity additions, single pivot hinge, pair | $186.70 |
| L6610 | | Upper extremity additions, flexible metal hinge, pair | $167.83 |
| L6611 | | Addition to upper extremity prosthesis, external powered, additional switch, any type | BR |
| L6615 | | Upper extremity addition, disconnect locking wrist unit | $175.11 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L6616 | | Upper extremity addition, additional disconnect insert for locking wrist unit, each | $65.39 |
| L6620 | | Upper extremity addition, flexion/extension wrist unit, with or without friction | $305.65 |
| L6621 | | Upper extremity prosthesis addition, flexion/extension wrist with or without friction, for use with external powered terminal device | BR |
| L6623 | | Upper extremity addition, spring assisted rotational wrist unit with latch release | $646.64 |
| L6624 | | Upper extremity addition, flexion/extension and rotation wrist unit | BR |
| L6625 | | Upper extremity addition, rotation wrist unit with cable lock | $536.15 |
| L6628 | | Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal | $482.91 |
| L6629 | | Upper extremity addition, quick disconnect lamination collar with coupling piece, Otto Bock or equal | $147.48 |
| L6630 | | Upper extremity addition, stainless steel, any wrist | $217.26 |
| L6632 | | Upper extremity addition, latex suspension sleeve, each | $65.49 |
| L6635 | | Upper extremity addition, lift assist for elbow | $177.55 |
| L6637 | | Upper extremity addition, nudge control elbow lock | $370.15 |
| L6638 | | Upper extremity addition to prosthesis, electric locking feature, only for use with manually powered elbow | $2,265.09 |
| L6639 | | Upper extremity addition, heavy duty feature, any elbow | BR |
| L6640 | | Upper extremity additions, shoulder abduction joint, pair | $282.37 |
| L6641 | | Upper extremity addition, excursion amplifier, pulley type | $161.71 |
| L6642 | | Upper extremity addition, excursion amplifier, lever type | $219.20 |
| L6645 | | Upper extremity addition, shoulder flexion-abduction joint, each | $321.80 |
| L6646 | | Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction friction control, for use with body powered or external powered system | $2,856.78 |
| L6647 | | Upper extremity addition, shoulder lock mechanism, body powered actuator | $470.32 |
| L6648 | | Upper extremity addition, shoulder lock mechanism, external powered actuator | $2,946.38 |
| L6650 | | Upper extremity addition, shoulder universal joint, each | $341.23 |
| L6655 | | Upper extremity addition, standard control cable, extra | $75.72 |
| L6660 | | Upper extremity addition, heavy duty control cable | $92.53 |
| L6665 | | Upper extremity addition, Teflon, or equal, cable lining | $46.43 |
| L6670 | | Upper extremity addition, hook to hand, cable adapter | $48.34 |
| L6672 | | Upper extremity addition, harness, chest or shoulder, saddle type | $169.97 |
| L6675 | | Upper extremity addition, harness, (e.g., figure of eight type), single cable design | $121.06 |
| L6676 | | Upper extremity addition, harness, (e.g., figure of eight type), dual cable design | $122.26 |
| L6677 | | Upper extremity addition, harness, triple control, simultaneous operation of terminal device and elbow | BR |
| L6680 | | Upper extremity addition, test socket, wrist disarticulation or below elbow | $233.89 |
| L6682 | | Upper extremity addition, test socket, elbow disarticulation or above elbow | $258.59 |
| L6684 | | Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic | $351.38 |
| L6686 | | Upper extremity addition, suction socket | $595.13 |
| L6687 | | Upper extremity addition, frame type socket, below elbow or wrist disarticulation | $581.46 |
| L6688 | | Upper extremity addition, frame type socket, above elbow or elbow disarticulation | $534.02 |
| L6689 | | Upper extremity addition, frame type socket, shoulder disarticulation | $679.25 |
| L6690 | | Upper extremity addition, frame type socket, interscapular-thoracic | $693.16 |
| L6691 | | Upper extremity addition, removable insert, each | $347.98 |
| L6692 | | Upper extremity addition, silicone gel insert or equal, each | $563.75 |
| L6693 | | Upper extremity addition, locking elbow, forearm counterbalance | $2,571.48 |
| L6694 | | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism | BR |
| L6695 | | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism | BR |
| L6696 | | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695) | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L6697 | | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695) | BR |
| L6698 | | Addition to upper extremity prosthesis, below elbow/above elbow, lock mechanism, excludes socket insert | BR |
| L6703 | | Terminal device, passive hand/mitt, any material, any size | BR |
| L6704 | | Terminal device, sport/recreational/work attachment, any material, any size | BR |
| L6706 | | Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined | BR |
| L6707 | | Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined | BR |
| L6708 | | Terminal device, hand, mechanical, voluntary opening, any material, any size | BR |
| L6709 | | Terminal device, hand, mechanical, voluntary closing, any material, any size | BR |
| L6805 | | Addition to terminal device, modifier wrist unit | $342.99 |
| L6810 | | Addition to terminal device, precision pinch device | $188.03 |
| L6881 | | Automatic grasp feature, addition to upper limb electric prosthetic terminal device | $3,703.01 |
| L6882 | | Microprocessor control feature, addition to upper limb prosthetic terminal device | $2,808.92 |
| L6883 | | Replacement socket, below elbow/wrist disarticulation, molded to patient model, for use with or without external power | BR |
| L6884 | | Replacement socket, above elbow/elbow disarticulation, molded to patient model, for use with or without external power | BR |
| L6885 | | Replacement socket, shoulder disarticulation/interscapular thoracic, molded to patient model, for use with or without external power | BR |
| L6890 | | Addition to upper extremity prosthesis, glove for terminal device, any material, prefabricated, includes fitting and adjustment | $171.45 |
| L6895 | | Addition to upper extremity prosthesis, glove for terminal device, any material, custom fabricated | $562.90 |
| L6900 | | Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one finger remaining | $1,522.65 |
| L6905 | | Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining | $1,480.07 |
| L6910 | | Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining | $1,441.88 |
| L6915 | | Hand restoration (shading and measurements included), replacement glove for above | $631.08 |
| L6920 | | Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device | $6,727.61 |
| L6925 | | Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | $7,766.93 |
| L6930 | | Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device | $6,769.33 |
| L6935 | | Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | $7,912.34 |
| L6940 | | Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device | $8,844.58 |
| L6945 | | Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | $10,289.63 |
| L6950 | | Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device | $10,053.10 |
| L6955 | | Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | $12,039.96 |
| L6960 | | Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device | $12,143.21 |
| L6965 | | Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | $14,287.05 |
| L6970 | | Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device | $14,702.69 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L6975 | | Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | $16,109.49 |
| L7007 | | Electric hand, switch or myoelectric controlled, adult | BR |
| L7008 | | Electric hand, switch or myoelectric, controlled, pediatric | BR |
| L7009 | | Electric hook, switch or myoelectric controlled, adult | BR |
| L7040 | | Prehensile actuator, switch controlled | $2,841.94 |
| L7045 | | Electric hook, switch or myoelectric controlled, pediatric | $1,629.39 |
| L7170 | | Electronic elbow, Hosmer or equal, switch controlled | $5,910.85 |
| L7180 | | Electronic elbow, microprocessor sequential control of elbow and terminal device | $32,930.86 |
| L7181 | | Electronic elbow, microprocessor simultaneous control of elbow and terminal device | BR |
| L7185 | | Electronic elbow, adolescent, Variety Village or equal, switch controlled | $5,985.53 |
| L7186 | | Electronic elbow, child, Variety Village or equal, switch controlled | $8,916.97 |
| L7190 | | Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled | $7,615.45 |
| L7191 | | Electronic elbow, child, Variety Village or equal, myoelectronically controlled | $9,317.71 |
| L7260 | | Electronic wrist rotator, Otto Bock or equal | $1,983.92 |
| L7261 | | Electronic wrist rotator, for Utah arm | $3,611.49 |
| L7266 | | Servo control, Steeper or equal | $998.07 |
| L7272 | | Analogue control, UNB or equal | $2,035.06 |
| L7274 | | Proportional control, 6–12 volt, Liberty, Utah or equal | $5,789.97 |
| L7360 | | Six volt battery, Otto Bock or equal, each | $229.24 |
| L7362 | | Battery charger, six volt, Otto Bock or equal | $252.57 |
| L7364 | | Twelve volt battery, Utah or equal, each | $401.70 |
| L7366 | | Battery charger, twelve volt, Utah or equal | $541.10 |
| L7367 | | Lithium ion battery, replacement | $352.64 |
| L7368 | | Lithium ion battery charger | $457.13 |
| L7400 | | Addition to upper extremity prosthesis, below elbow/wrist disarticulation, ultralight material (titanium, carbon fiber or equal) | BR |
| L7401 | | Addition to upper extremity prosthesis, above elbow disarticulation, ultralight material (titanium, carbon fiber or equal) | BR |
| L7402 | | Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, ultralight material (titanium, carbon fiber or equal) | BR |
| L7403 | | Addition to upper extremity prosthesis, below elbow/wrist disarticulation, acrylic material | BR |
| L7404 | | Addition to upper extremity prosthesis, above elbow disarticulation, acrylic material | BR |
| L7405 | | Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, acrylic material | BR |
| L7499 | | Upper extremity prosthesis, NOS | BR |
| L7500 | | Repair of prosthetic device, hourly rate | BR |
| L7510 | | Repair of prosthetic device, repair or replace minor parts | BR |
| L7520 | | Repair prosthetic device, labor component, per 15 minutes | BR |
| L7600 | | Prosthetic donning sleeve, any material, each | BR |
| L7900 | | Male vacuum erection system | $485.76 |
| L8000 | | Breast prosthesis, mastectomy bra | $36.80 |
| L8001 | | Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral | $113.61 |
| L8002 | | Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral | $149.43 |
| L8010 | | Breast prosthesis, mastectomy sleeve | $56.57 |
| L8015 | | External breast prosthesis garment, with mastectomy form, post-mastectomy | $54.42 |
| L8020 | | Breast prosthesis, mastectomy form | $202.23 |
| L8030 | | Breast prosthesis, silicone or equal | $318.03 |
| L8035 | | Custom breast prosthesis, post mastectomy, molded to patient model | $3,318.40 |
| L8039 | | Breast prosthesis, NOS | BR |
| L8040 | | Nasal prosthesis, provided by a nonphysician | $2,243.38 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L8041 | | Midfacial prosthesis, provided by a nonphysician | $2,704.02 |
| L8042 | | Orbital prosthesis, provided by a nonphysician | $3,038.23 |
| L8043 | | Upper facial prosthesis, provided by a nonphysician | $3,402.82 |
| L8044 | | Hemi-facial prosthesis, provided by a nonphysician | $3,767.40 |
| L8045 | | Auricular prosthesis, provided by a nonphysician | $2,478.95 |
| L8046 | | Partial facial prosthesis, provided by a nonphysician | $2,430.59 |
| L8047 | | Nasal septal prosthesis, provided by a nonphysician | $1,245.67 |
| L8048 | | Unspecified maxillofacial prosthesis, by report, provided by a nonphysician | BR |
| L8049 | | Repair or modification of maxillofacial prosthesis, labor component, 15 minute increments, provided by a nonphysician | BR |
| L8300 | | Truss, single with standard pad | $85.04 |
| L8310 | | Truss, double with standard pads | $134.25 |
| L8320 | | Truss, addition to standard pad, water pad | $53.89 |
| L8330 | | Truss, addition to standard pad, scrotal pad | $49.76 |
| L8400 | | Prosthetic sheath, below knee, each | $15.86 |
| L8410 | | Prosthetic sheath, above knee, each | $20.88 |
| L8415 | | Prosthetic sheath, upper limb, each | $21.61 |
| L8417 | | Prosthetic sheath/sock, including a gel cushion layer, below knee or above knee, each | $68.09 |
| L8420 | | Prosthetic sock, multiple ply, below knee, each | $19.61 |
| L8430 | | Prosthetic sock, multiple ply, above knee, each | $22.31 |
| L8435 | | Prosthetic sock, multiple ply, upper limb, each | $21.19 |
| L8440 | | Prosthetic shrinker, below knee, each | $42.16 |
| L8460 | | Prosthetic shrinker, above knee, each | $67.19 |
| L8465 | | Prosthetic shrinker, upper limb, each | $49.17 |
| L8470 | | Prosthetic sock, single ply, fitting, below knee, each | $6.72 |
| L8480 | | Prosthetic sock, single ply, fitting, above knee, each | $9.28 |
| L8485 | | Prosthetic sock, single ply, fitting, upper limb, each | $11.21 |
| L8499 | | Unlisted procedure for miscellaneous prosthetic services | BR |
| L8500 | | Artificial larynx, any type | $665.29 |
| L8501 | | Tracheostomy speaking valve | $121.78 |
| L8505 | | Artificial larynx replacement battery/accessory, any type | BR |
| L8507 | | Tracheo-esophageal voice prosthesis, patient inserted, any type, each | $37.94 |
| L8509 | | Tracheo-esophageal voice prosthesis, inserted by a licensed health care provider, any type | $98.91 |
| L8510 | | Voice amplifier | $228.89 |
| L8511 | | Insert for indwelling tracheoesophageal prosthesis, with or without valve, replacement only, each | $65.88 |
| L8512 | | Gelatin capsules or equivalent, for use with tracheoesophageal voice prosthesis, replacement only, per 10 | $1.96 |
| L8513 | | Cleaning device used with tracheoesophageal voice prosthesis, pipet, brush, or equal, replacement only, each | $4.70 |
| L8514 | | Tracheoesophageal puncture dilator, replacement only, each | $85.43 |
| L8515 | | Gelatin capsule, application device for use with tracheoesophageal voice prosthesis, each | BR |
| L8600 | | Implantable breast prosthesis, silicone or equal | $629.49 |
| L8603 | | Injectable bulking agent, collagen implant, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies | $397.51 |
| L8606 | | Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe, includes shipping and necessary supplies | $199.34 |
| L8609 | | Artificial cornea | BR |
| L8610 | | Ocular implant | $590.04 |
| L8612 | | Aqueous shunt | $612.95 |
| L8613 | | Ossicular implant | $259.22 |
| L8614 | | Cochlear device, includes all internal and external components | $17,519.73 |
| L8615 | | Headset/headpiece for use with cochlear implant device, replacement | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| L8616 | | Microphone for use with cochlear implant device, replacement | BR |
| L8617 | | Transmitting coil for use with cochlear implant device, replacement | BR |
| L8618 | | Transmitter cable for use with cochlear implant device, replacement | BR |
| L8619 | | Cochlear implant external speech processor, replacement | $7,520.15 |
| L8621 | | Zinc air battery for use with cochlear implant device, replacement, each | BR |
| L8622 | | Alkaline battery for use with cochlear implant device, any size, replacement, each | BR |
| L8623 | | Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each | BR |
| L8624 | | Lithium ion battery for use with cochlear implant device speech processor, ear level, replacement, each | BR |
| L8630 | | Metacarpophalangeal joint implant | $339.63 |
| L8631 | | Metacarpal phalangeal joint replacement, two or more pieces, metal (e.g., stainless steel or cobalt chrome), ceramic-like material (e.g., pyrocarbon), for surgical implantation (all sizes, includes entire system) | $1,993.28 |
| L8641 | | Metatarsal joint implant | $352.87 |
| L8642 | | Hallux implant | $286.22 |
| L8658 | | Interphalangeal joint spacer, silicone or equal, each | $307.66 |
| L8659 | | Interphalangeal finger joint replacement, two or more pieces, metal (e.g., stainless steel or cobalt chrome), ceramic-like material (e.g., pyrocarbon) for surgical implantation, any size | $1,748.30 |
| L8670 | | Vascular graft material, synthetic, implant | $505.02 |
| L8680 | | Implantable neurostimulator electrode, each | BR |
| L8681 | | Patient programmer (external) for use with implantable programmable neurostimulator pulse generator | BR |
| L8682 | | Implantable neurostimulator radiofrequency receiver | BR |
| L8683 | | Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver | BR |
| L8684 | | Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement | BR |
| L8685 | | Implantable neurostimulator pulse generator, single array, rechargeable, includes extension | BR |
| L8686 | | Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension | BR |
| L8687 | | Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension | BR |
| L8688 | | Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension | BR |
| L8689 | | External recharging system for battery (internal) for use with implantable neurostimulator | BR |
| L8690 | | Auditory osseointegrated device, includes all internal and external components | BR |
| L8691 | | Auditory osseointegrated device, external sound processor, replacement | BR |
| L8695 | | External recharging system for battery (external) for use with implantable neurostimulator | BR |
| L8699 | | Prosthetic implant, not otherwise specified | BR |
| L9900 | | Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code | BR |
| M0064 | | Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders | $28.82 |
| M0075 | | Cellular therapy | BR |
| M0076 | | Prolotherapy | BR |
| M0100 | | Intragastric hypothermia using gastric freezing | BR |
| M0300 | | IV chelation therapy (chemical endarterectomy) | BR |
| M0301 | | Fabric wrapping of abdominal aneurysm | BR |
| P2028 | | Cephalin floculation, blood | BR |
| P2029 | | Congo red, blood | BR |
| P2031 | | Hair analysis (excluding arsenic) | BR |
| P2033 | | Thymol turbidity, blood | BR |
| P2038 | | Mucoprotein, blood (seromucoid) (medical necessity procedure) | $8.57 |
| P3000 | | Screening Papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision | $10.91 |
| P3001 | | Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician | $9.35 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| P7001 | | Culture, bacterial, urine; quantitative, sensitivity study | $21.03 |
| P9010 | | Blood (whole), for transfusion, per unit | $49.66 |
| P9011 | | Blood, split unit | $70.89 |
| P9012 | | Cryoprecipitate, each unit | BR |
| P9016 | | Red blood cells, leukocytes reduced, each unit | BR |
| P9017 | | Fresh frozen plasma (single donor), frozen within 8 hours of collection, each unit | BR |
| P9019 | | Platelets, each unit | BR |
| P9020 | | Platelet rich plasma, each unit | BR |
| P9021 | | Red blood cells, each unit | BR |
| P9022 | | Red blood cells, washed, each unit | BR |
| P9023 | | Plasma, pooled multiple donor, solvent/detergent treated, frozen, each unit | BR |
| P9031 | | Platelets, leukocytes reduced, each unit | BR |
| P9032 | | Platelets, irradiated, each unit | BR |
| P9033 | | Platelets, leukocytes reduced, irradiated, each unit | BR |
| P9034 | | Platelets, pheresis, each unit | BR |
| P9035 | | Platelets, pheresis, leukocytes reduced, each unit | BR |
| P9036 | | Platelets, pheresis, irradiated, each unit | BR |
| P9037 | | Platelets, pheresis, leukocytes reduced, irradiated, each unit | BR |
| P9038 | | Red blood cells, irradiated, each unit | BR |
| P9039 | | Red blood cells, deglycerolized, each unit | BR |
| P9040 | | Red blood cells, leukocytes reduced, irradiated, each unit | BR |
| P9041 | | Infusion, albumin (human), 5%, 50 ml | $17.88 |
| P9043 | | Infusion, plasma protein fraction (human), 5%, 50 ml | $9.89 |
| P9044 | | Plasma, cryoprecipitate reduced, each unit | BR |
| P9045 | | Infusion, albumin (human), 5%, 250 ml | $62.31 |
| P9046 | | Infusion, albumin (human), 25%, 20 ml | $25.75 |
| P9047 | | Infusion, albumin (human), 25%, 50 ml | $53.23 |
| P9048 | | Infusion, plasma protein fraction (human), 5%, 250 ml | $19.80 |
| P9050 | | Granulocytes, pheresis, each unit | BR |
| P9051 | | Whole blood or red blood cells, leukocytes reduced, CMV-negative, each unit | BR |
| P9052 | | Platelets, HLA-matched leukocytes reduced, apheresis/pheresis, each unit | BR |
| P9053 | | Platelets, pheresis, leukocytes reduced, CMV-negative, irradiated, each unit | BR |
| P9054 | | Whole blood or red blood cells, leukocytes reduced, frozen, deglycerol, washed, each unit | BR |
| P9055 | | Platelets, leukocytes reduced, CMV-negative, apheresis/pheresis, each unit | BR |
| P9056 | | Whole blood, leukocytes reduced, irradiated, each unit | BR |
| P9057 | | Red blood cells, frozen/deglycerolized/washed, leukocytes reduced, irradiated, each unit | BR |
| P9058 | | Red blood cells, leukocytes reduced, CMV-negative, irradiated, each unit | BR |
| P9059 | | Fresh frozen plasma between 8–24 hours of collection, each unit | BR |
| P9060 | | Fresh frozen plasma, donor retested, each unit | BR |
| P9603 | | Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing home bound patient; prorated miles actually travelled | BR |
| P9604 | | Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing home bound patient; prorated trip charge | $3.90 |
| P9612 | | Catheterization for collection of specimen, single patient, all places of service | $25.71 |
| P9615 | | Catheterization for collection of specimen(s) (multiple patients) | BR |
| Q0035 | | Cardiokymography | $9.74 |
| Q0081 | | Infusion therapy, using other than chemotherapeutic drugs, per visit | $35.06 |
| Q0083 | | Chemotherapy administration by other than infusion technique only (e.g., subcutaneous, intramuscular, push), per visit | $64.66 |
| Q0084 | | Chemotherapy administration by infusion technique only, per visit | $110.23 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| Q0085 | | Chemotherapy administration by both infusion technique and other technique(s) (e.g., subcutaneous, intramuscular, push), per visit | BR |
| Q0091 | | Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory | BR |
| Q0092 | | Set-up portable x-ray equipment | $7.79 |
| Q0111 | | Wet mounts, including preparations of vaginal, cervical or skin specimens | $7.79 |
| Q0112 | | All potassium hydroxide (KOH) preparations | $8.96 |
| Q0113 | | Pinworm examination | BR |
| Q0114 | | Fern test | BR |
| Q0115 | | Post-coital direct, qualitative examinations of vaginal or cervical mucous | BR |
| Q0144 | | Azithromycin dihydrate, oral, capsules/powder, 1 gm | $15.21 |
| Q0163 | | Diphenhydramine HCl, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48-hour dosage regimen | $0.02 |
| Q0164 | | Prochlorperazine maleate, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen | $0.35 |
| Q0165 | | Prochlorperazine maleate, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen | $0.54 |
| Q0166 | | Granisetron HCl, 1 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24-hour dosage regimen | $31.88 |
| Q0167 | | Dronabinol, 2.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen | $2.34 |
| Q0168 | | Dronabinol, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen | $5.53 |
| Q0169 | | Promethazine HCl, 12.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen | $0.16 |
| Q0170 | | Promethazine HCl, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen | $0.09 |
| Q0171 | | Chlorpromazine HCl, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen | $0.18 |
| Q0172 | | Chlorpromazine HCl, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen | $0.29 |
| Q0173 | | Trimethobenzamide HCl, 250 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen | $0.23 |
| Q0174 | | Thiethylperazine maleate, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen | $0.42 |
| Q0175 | | Perphenzaine, 4 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen | $0.37 |
| Q0176 | | Perphenzaine, 8 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen | $0.46 |
| Q0177 | | Hydroxyzine pamoate, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen | $0.09 |
| Q0178 | | Hydroxyzine pamoate, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen | $0.12 |
| Q0179 | | Ondansetron HCl 8 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen | $38.46 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| Q0180 | | Dolasetron mesylate, 100 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24-hour dosage regimen | $48.70 |
| Q0181 | | Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen | BR |
| Q0480 | | Driver for use with pneumatic ventricular assist device, replacement only | $50,568.82 |
| Q0481 | | Microprocessor control unit for use with electric ventricular assist device, replacement only | $8,158.69 |
| Q0482 | | Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only | $2,555.45 |
| Q0483 | | Monitor/display module for use with electric ventricular assist device, replacement only | $10,527.33 |
| Q0484 | | Monitor/display module for use with electric or electric/pneumatic ventricular assist device, replacement only | $2,044.37 |
| Q0485 | | Monitor control cable for use with electric ventricular assist device, replacement only | $197.38 |
| Q0486 | | Monitor control cable for use with electric/pneumatic ventricular assist device, replacement only | $164.28 |
| Q0487 | | Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only | $191.66 |
| Q0488 | | Power pack base for use with electric ventricular assist device, replacement only | BR |
| Q0489 | | Power pack base for use with electric/pneumatic ventricular assist device, replacement only | $9,126.63 |
| Q0490 | | Emergency power source for use with electric ventricular assist device, replacement only | $394.77 |
| Q0491 | | Emergency power source for use with electric/pneumatic ventricular assist device, replacement only | $620.62 |
| Q0492 | | Emergency power supply cable for use with electric ventricular assist device, replacement only | $50.00 |
| Q0493 | | Emergency power supply cable for use with electric/pneumatic ventricular assist device, replacement only | $142.37 |
| Q0494 | | Emergency hand pump for use with electric/pneumatic ventricular assist device, replacement only | $120.47 |
| Q0495 | | Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only | $2,345.31 |
| Q0496 | | Battery for use with electric or electric/pneumatic ventricular assist device, replacement only | $841.77 |
| Q0497 | | Battery clips for use with electric or electric/pneumatic ventricular assist device, replacement only | $262.85 |
| Q0498 | | Holster for use with electric or electric/pneumatic ventricular assist device, replacement only | $288.40 |
| Q0499 | | Belt/vest for use with electric or electric/pneumatic ventricular assist device, replacement only | $93.70 |
| Q0500 | | Filters for use with electric or electric/pneumatic ventricular assist device, replacement only | $17.15 |
| Q0501 | | Shower cover for use with electric or electric/pneumatic ventricular assist device, replacement only | $286.74 |
| Q0502 | | Mobility cart for pneumatic ventricular assist device, replacement only | $365.05 |
| Q0503 | | Battery for pneumatic ventricular assist device, replacement only, each | $730.13 |
| Q0504 | | Power adapter for pneumatic ventricular assist device, replacement only, vehicle type | $385.27 |
| Q0505 | | Miscellaneous supply or accessory for use with ventricular assist device | BR |
| Q0510 | | Pharmacy supply fee for initial immunosuppressive drug(s), first month following transplant | BR |
| Q0511 | | Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s); for the first prescription In a 30-day period | BR |
| Q0512 | | Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s); for a subsequent prescription in a 30-day period | BR |
| Q0513 | | Pharmacy dispensing fee for inhalation drug(s); per 30 days | BR |
| Q0514 | | Pharmacy dispensing fee for inhalation drug(s); per 90 days | BR |
| Q0515 | | Injection, sermorelin acetate, 1 mcg | $1.59 |
| Q1003 | | New technology intraocular lens category 3 (reduced spherical aberration) | BR |
| Q1004 | | New technology intraocular lens category 4 as defined in Federal Register notice | BR |
| Q1005 | | New technology intraocular lens category 5 as defined in Federal Register notice | BR |
| Q2004 | | Irrigation solution for treatment of bladder calculi, for example renacidin, per 500 ml | $16.81 |
| Q2009 | | Injection, fosphenytoin, 50 mg | BR |
| Q2017 | | Injection, teniposide, 50 mg | $161.79 |
| Q3001 | | Radioelements for brachytherapy, any type, each | BR |
| Q3014 | | Telehealth originating site facility fee | BR |
| Q3025 | | Injection, interferon beta-1A, 11 mcg for intramuscular use | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| Q3026 | | Injection, interferon beta-1A, 11 mcg for subcutaneous use | BR |
| Q3031 | | Collagen skin test | BR |
| Q4001 | | Casting supplies, body cast adult, with or without head, plaster | $107.11 |
| Q4002 | | Cast supplies, body cast adult, with or without head, fiberglass | $227.86 |
| Q4003 | | Cast supplies, shoulder cast, adult (11 years +), plaster | $58.04 |
| Q4004 | | Cast supplies, shoulder cast, adult (11 years +), fiberglass | $123.47 |
| Q4005 | | Cast supplies, long arm cast, adult (11 years +), plaster | $31.94 |
| Q4006 | | Cast supplies, long arm cast, adult (11 years +), fiberglass | $67.97 |
| Q4007 | | Cast supplies, long arm cast, pediatric (0–10 years), plaster | $15.97 |
| Q4008 | | Cast supplies, long arm cast, pediatric (0–10 years), fiberglass | $33.89 |
| Q4009 | | Cast supplies, short arm cast, adult (11 years +), plaster | $24.54 |
| Q4010 | | Cast supplies, short arm cast, adult (11 years +), fiberglass | $52.58 |
| Q4011 | | Cast supplies, short arm cast, pediatric (0–10 years), plaster | $12.27 |
| Q4012 | | Cast supplies, short arm cast, pediatric (0–10 years), fiberglass | $26.29 |
| Q4013 | | Cast supplies, gauntlet cast (includes lower forearm and hand), adult (11 years +), plaster | $23.18 |
| Q4014 | | Cast supplies, gauntlet cast (includes lower forearm and hand), adult (11 years +), fiberglass | $49.47 |
| Q4015 | | Cast supplies, gauntlet cast (includes lower forearm and hand), pediatric (0–10 years), plaster | $11.69 |
| Q4016 | | Cast supplies, gauntlet cast (includes lower forearm and hand), pediatric (0–10 years), fiberglass | $24.73 |
| Q4017 | | Cast supplies, long arm splint, adult (11 years +), plaster | $20.25 |
| Q4018 | | Cast supplies, long arm splint, adult (11 years +), fiberglass | $43.23 |
| Q4019 | | Cast supplies, long arm splint, pediatric (0–10 years), plaster | $10.13 |
| Q4020 | | Cast supplies, long arm splint, pediatric (0–10 years), fiberglass | $21.62 |
| Q4021 | | Cast supplies, short arm splint, adult (11 years +), plaster | $20.25 |
| Q4022 | | Cast supplies, short arm splint, adult (11 years +), fiberglass | $43.23 |
| Q4023 | | Cast supplies, short arm splint, pediatric (0–10 years), plaster | $10.13 |
| Q4024 | | Cast supplies, short arm splint, pediatric (0–10 years), fiberglass | $21.62 |
| Q4025 | | Cast supplies, hip spica (one or both legs), adult (11 years +), plaster | $89.97 |
| Q4026 | | Cast supplies, hip spica (one or both legs), adult (11 years +), fiberglass | $191.44 |
| Q4027 | | Cast supplies, hip spica (one or both legs), pediatric (0–10 years), plaster | $44.99 |
| Q4028 | | Cast supplies, hip spica (one or both legs), pediatric (0–10 years), fiberglass | $95.82 |
| Q4029 | | Cast supplies, long leg cast, adult (11 years +), plaster | $44.40 |
| Q4030 | | Cast supplies, long leg cast, adult (11 years +), fiberglass | $94.26 |
| Q4031 | | Cast supplies, long leg cast, pediatric (0–10 years), plaster | $22.20 |
| Q4032 | | Cast supplies, long leg cast, pediatric (0–10 years), fiberglass | $47.13 |
| Q4033 | | Cast supplies, long leg cylinder cast, adult (11 years +), plaster | $37.78 |
| Q4034 | | Cast supplies, long leg cylinder cast, adult (11 years +), fiberglass | $80.24 |
| Q4035 | | Cast supplies, long leg cylinder cast, pediatric (0–10 years), plaster | $18.89 |
| Q4036 | | Cast supplies, long leg cylinder cast, pediatric (0–10 years), fiberglass | $40.12 |
| Q4037 | | Cast supplies, short leg cast, adult (11 years +), plaster | $50.83 |
| Q4038 | | Cast supplies, short leg cast, adult (11 years +), fiberglass | $108.09 |
| Q4039 | | Cast supplies, short leg cast, pediatric (0–10 years), plaster | $25.32 |
| Q4040 | | Cast supplies, short leg cast, pediatric (0–10 years), fiberglass | $54.14 |
| Q4041 | | Cast supplies, long leg splint, adult (11 years +), plaster | $29.02 |
| Q4042 | | Cast supplies, long leg splint, adult (11 years +), fiberglass | $61.74 |
| Q4043 | | Cast supplies, long leg splint, pediatric (0–10 years), plaster | $14.61 |
| Q4044 | | Cast supplies, long leg splint, pediatric (0–10 years), fiberglass | $30.97 |
| Q4045 | | Cast supplies, short leg splint, adult (11 years +), plaster | $18.89 |
| Q4046 | | Cast supplies, short leg splint, adult (11 years +), fiberglass | $40.12 |
| Q4047 | | Cast supplies, short leg splint, pediatric (0–10 years), plaster | $9.35 |
| Q4048 | | Cast supplies, short leg splint, pediatric (0–10 years), fiberglass | $20.06 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| **Q4049** | | Finger splint, static | $24.73 |
| **Q4050** | | Cast supplies, for unlisted types and materials of casts | BR |
| **Q4051** | | Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies) | BR |
| **Q4079** | | Injection, natalizumab, per 1 mg | BR |
| **Q4080** | | Iloprost, inhalation solution, administered through DME, up to 20 mcg | $27.44 |
| **Q4081** | | Injection, epoetin alfa, 100 units (for ESRD on dialysis) | BR |
| **Q4082** | | Drug or biological, not otherwise classified, Part B drug competitive acquisition program (CAP) | BR |
| **Q4083** | | Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection, per dose | $104.73 |
| **Q4084** | | Hyaluronan or derivative, Synvisc, for intra-articular injection, per dose | $161.92 |
| **Q4085** | | Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose | $100.59 |
| **Q4086** | | Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose | $172.94 |
| **Q5001** | | Hospice care provided in patient's home/residence | BR |
| **Q5002** | | Hospice care provided in assisted living facility | BR |
| **Q5003** | | Hospice care provided in nursing long-term care facility (LTC) or nonskilled nursing facility (NF) | BR |
| **Q5004** | | Hospice care provided in skilled nursing facility (SNF) | BR |
| **Q5005** | | Hospice care provided in inpatient hospital | BR |
| **Q5006** | | Hospice care provided in inpatient hospice facility | BR |
| **Q5007** | | Hospice care provided in long-term care facility | BR |
| **Q5008** | | Hospice care provided in inpatient psychiatric facility | BR |
| **Q5009** | | Hospice care provided in place not otherwise specified (NOS) | BR |
| **Q9945** | | Low osmolar contrast material, up to 149 mg/ml iodine concentration, per ml | BR |
| **Q9946** | | Low osmolar contrast material, 150–199 mg/ml iodine concentration, per ml | BR |
| **Q9947** | | Low osmolar contrast material, 200–249 mg/ml iodine concentration, per ml | BR |
| **Q9948** | | Low osmolar contrast material, 250–299 mg/ml iodine concentration, per ml | BR |
| **Q9949** | | Low osmolar contrast material, 300-349 mg/ml iodine concentration, per ml | BR |
| **Q9950** | | Low osmolar contrast material, 350–399 mg/ml iodine concentration, per ml | BR |
| **Q9951** | | Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml | BR |
| **Q9952** | | Injection, gadolinium-based magnetic resonance contrast agent, per ml | BR |
| **Q9953** | | Injection, iron-based magnetic resonance contrast agent, per ml | BR |
| **Q9954** | | Oral magnetic resonance contrast agent, per 100 ml | BR |
| **Q9955** | | Injection, perflexane lipid microspheres, per ml | BR |
| **Q9956** | | Injection, octafluoropropane microspheres, per ml | BR |
| **Q9957** | | Injection, perflutren lipid microspheres, per ml | $60.76 |
| **Q9958** | | High osmolar contrast material, up to 149 mg/ml iodine concentration, per ml | BR |
| **Q9959** | | High osmolar contrast material, 150–199 mg/ml iodine concentration, per ml | BR |
| **Q9960** | | High osmolar contrast material, 200–249 mg/ml iodine concentration, per ml | BR |
| **Q9961** | | High osmolar contrast material, 250–299 mg/ml iodine concentration, per ml | BR |
| **Q9962** | | High osmolar contrast material, 300–349 mg/ml iodine concentration, per ml | BR |
| **Q9963** | | High osmolar contrast material, 350–399 mg/ml iodine concentration, per ml | BR |
| **Q9964** | | High osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml | BR |
| **R0070** | | Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen | $39.73 |
| **R0075** | | Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen | $36.61 |
| **R0076** | | Transportation of portable EKG to facility or location, per patient | $35.83 |
| **S0012** | | Butorphanol tartrate, nasal spray, 25 mg | $58.22 |
| **S0014** | | Tacrine HCl, 10 mg | $0.82 |
| **S0017** | | Injection, aminocaproic acid, 5 grams | $1.44 |
| **S0020** | | Injection, bupivicaine HCl, 30 ml | BR |
| **S0021** | | Injection, ceftoperazone sodium, 1 gram | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| S0023 | | Injection, cimetidine HCl, 300 mg | $1.53 |
| S0028 | | Injection, famotidine, 20 mg | $2.02 |
| S0030 | | Injection, metronidazole, 500 mg | $5.06 |
| S0032 | | Injection, nafcillin sodium, 2 grams | $10.32 |
| S0034 | | Injection, ofloxacin, 400 mg | BR |
| S0039 | | Injection, sulfamethoxazole and trimethoprim, 10 ml | $7.16 |
| S0040 | | Injection, ticarcillin disodium and clavulanate potassium, 3.1 grams | $9.96 |
| S0073 | | Injection, aztreonam, 500 mg | $6.08 |
| S0074 | | Injection, cefotetan disodium, 500 mg | $4.81 |
| S0077 | | Injection, clindamycin phosphate, 300 mg | $2.91 |
| S0078 | | Injection, fosphenytoin sodium, 750 mg | BR |
| S0080 | | Injection, pentamidine isethionate, 300 mg | $58.51 |
| S0081 | | Injection, piperacillin sodium, 500 mg | BR |
| S0088 | | Imatinib injection, 100 mg | BR |
| S0090 | | Sildenafil citrate, 25 mg | $6.01 |
| S0091 | | Granisetron HCl, 1 mg (for circumstances falling under the Medicare statute, use Q0166) | $31.88 |
| S0092 | | Injection, hydromorphone HCl, 250 mg (loading dose for infusion pump) | $60.17 |
| S0093 | | Injection, morphine sulfate, 500 mg (loading dose for infusion pump) | $7.17 |
| S0104 | | Zidovudine, oral 100 mg | $1.54 |
| S0106 | | Bupropion HCl sustained release tablet, 150 mg, per bottle of 60 tablets | BR |
| S0108 | | Mercaptopurine, oral, 50 mg | $2.84 |
| S0109 | | Methadone, oral, 5 mg | $0.16 |
| S0117 | | Tretinoin, topical 5 grams | BR |
| S0122 | | Injection, menotropins, 75 IU | $51.80 |
| S0126 | | Injection, follitropin alfa, 75 IU | $68.40 |
| S0128 | | Injection, follitropin beta, 75 IU | $65.93 |
| S0132 | | Injection, ganirelix acetate, 250 mcg | BR |
| S0136 | | Clozapine, 25 mg | $0.85 |
| S0137 | | Didanosine (ddI), 25 mg | $0.36 |
| S0138 | | Finasteride, 5 mg | $5.78 |
| S0139 | | Minoxidil, 10 mg | $3.12 |
| S0140 | | Saquinavir, 200 mg | $1.60 |
| S0141 | | Zalcitabine (ddC), 0.375 mg | $1.46 |
| S0142 | | Colistimethate sodium, inhalation solution administrated through DME, concentrated form, per mg | $0.33 |
| S0143 | | Aztreonam, inhalation solution administered through DME, concentrated form, per gram | $20.32 |
| S0145 | | Injection, pegylated interferon alfa-2a, 180 mcg per ml | BR |
| S0146 | | Injection, pegylated interferon alfa-2b, 10 mcg per 0.5 ml | BR |
| S0147 | | Injection, alglucosidase alfa, 20 mg | BR |
| S0155 | | Sterile dilutant for epoprostenol, 50 ml | $7.29 |
| S0156 | | Exemestane, 25 mg | $4.85 |
| S0157 | | Becaplermin gel 0.01%, 0.5 gm | BR |
| S0160 | | Dextroamphetamine sulfate, 5 mg | $0.32 |
| S0161 | | Calcitrol, 0.25 mcg | BR |
| S0162 | | Injection, efalizumab, 125 mg | $164.69 |
| S0164 | | Injection, pantoprazole sodium, 40 mg | $2.50 |
| S0166 | | Injection, olanzapine, 2.5 mg | $2.87 |
| S0170 | | Anastrozole, oral, 1mg | $4.39 |
| S0171 | | Injection, bumetanide, 0.5 mg | $0.97 |
| S0172 | | Chlorambucil, oral, 2 mg | $1.12 |
| S0174 | | Dolasetron mesylate, oral 50 mg (for circumstances falling under the Medicare statute, use Q0180) | $43.58 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| **S0175** | | Flutamide, oral, 125 mg | $1.33 |
| **S0176** | | Hydroxyurea, oral, 500 mg | $0.86 |
| **S0177** | | Levamisole HCl, oral, 50 mg | $4.31 |
| **S0178** | | Lomustine, oral, 10 mg | $4.33 |
| **S0179** | | Megestrol acetate, oral, 20 mg | $0.45 |
| **S0180** | | Etonogestrel (contraceptive) implant system, including implant and supplies | BR |
| **S0181** | | Ondansetron HCl, oral, 4 mg (for circumstances falling under the Medicare statute, use Q0179) | $11.31 |
| **S0182** | | Procarbazine HCl, oral, 50 mg | $0.47 |
| **S0183** | | Prochlorperazine maleate, oral, 5 mg (for circumstances falling under the Medicare statute, use Q0164-Q0165) | $0.38 |
| **S0187** | | Tamoxifen citrate, oral, 10 mg | $1.50 |
| **S0189** | | Testosterone pellet, 75 mg | BR |
| **S0190** | | Mitepristone, oral, 200 mg | $57.49 |
| **S0191** | | Misoprostol, oral, 200 mcg | $0.68 |
| **S0194** | | Dialysis/stress vitamin supplement, oral, 100 capsules | BR |
| **S0195** | | Pneumococcal conjugate vaccine, polyvalent, intramuscular, for children from five years to nine years of age who have not previously received the vaccine | BR |
| **S0196** | | Injectable poly-l-lactic acid, restorative implant, 1 ml, face (deep dermis, subcutaneous layers) | BR |
| **S0197** | | Prenatal vitamins, 30-day supply | BR |
| **S0199** | | Medically induced abortion by oral ingestion of medication including all associated services and supplies (e.g., patient counseling, office visits, confirmation of pregnancy by HCG, ultrasound to confirm duration of pregnancy, ultrasound to confirm completion of abortion) except drugs | BR |
| **S0201** | | Partial hospitalization services, less than 24 hours, per diem | BR |
| **S0207** | | Paramedic intercept, nonhospital based ALS service (nonvoluntary), nontransport | BR |
| **S0208** | | Paramedic intercept, hospital-based ALS service (nonvoluntary), nontransport | BR |
| **S0209** | | Wheelchair van, mileage, per mile | BR |
| **S0215** | | Nonemergency transportation; mileage, per mile | BR |
| **S0220** | | Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient is present); approximately 30 minutes | BR |
| **S0221** | | Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient is present); approximately 60 minutes | BR |
| **S0250** | | Comprehensive geriatric assessment and treatment planning performed by assessment team | BR |
| **S0255** | | Hospice referral visit (advising patient and family of care options) performed by nurse, social worker, or other designated staff | BR |
| **S0257** | | Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service) | BR |
| **S0260** | | History and physical (outpatient or office) related to surgical procedure (list separately in addition to code for appropriate evaluation and management service) | BR |
| **S0265** | | Genetic counseling, under physician supervision, each 15 minutes | BR |
| **S0270** | | Physician management of patient home care, standard monthly case rate (per 30 days) | BR |
| **S0271** | | Physician management of patient home care, hospice monthly case rate (per 30 days) | BR |
| **S0272** | | Physician management of patient home care, episodic care monthly case rate (per 30 days) | BR |
| **S0273** | | Physician visit at member's home, outside of a capitation arrangement | BR |
| **S0274** | | Nurse practioner visit at member's home, outside of a capitation arrangement | BR |
| **S0302** | | Completed early periodic screening diagnosis and treatment (EPSDT) service (list in addition to code for appropriate evaluation and management service) | BR |
| **S0310** | | Hospitalist services (list separately in addition to code for appropriate evaluation and management service) | BR |
| **S0315** | | Disease management program; initial assessment and initiation of the program | BR |
| **S0316** | | Disease management program; follow-up/assessment | BR |
| **S0317** | | Disease management program; per diem | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| S0320 | | Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month | BR |
| S0340 | | Lifestyle modification program for management of coronary artery disease, including all supportive services; first quarter/stage | BR |
| S0341 | | Lifestyle modification program for management of coronary artery disease, including all supportive services; second or third quarter/stage | BR |
| S0342 | | Lifestyle modification program for management of coronary artery disease, including all supportive services; fourth quarter/stage | BR |
| S0345 | | Electrocardiographic monitoring utilizing a home computerized telemetry station with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, including recording, monitoring, receipt of transmissions, analysis, and physician review and interpretation; per 24-hour period | BR |
| S0346 | | Electrocardiographic monitoring utilizing a home computerized telemetry station with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, including recording, monitoring, receipt of transmissions, and analysis; per 24-hour period | BR |
| S0347 | | Electrocardiographic monitoring utilizing a home computerized telemetry station with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, including physician review and interpretation; per 24-hour period | BR |
| S0390 | | Routine foot care; removal and/or trimming of corns, calluses and/or nails and preventive maintenance in specific medical conditions (e.g., diabetes), per visit | BR |
| S0395 | | Impression casting of a foot performed by a practitioner other than the manufacturer of the orthotic | BR |
| S0400 | | Global fee for extracorporeal shock wave lithotripsy treatment of kidney stone(s) | BR |
| S0500 | | Disposable contact lens, per lens | BR |
| S0504 | | Single vision prescription lens (safety, athletic, or sunglass), per lens | BR |
| S0506 | | Bifocal vision prescription lens (safety, athletic, or sunglass), per lens | BR |
| S0508 | | Trifocal vision prescription lens (safety, athletic, or sunglass), per lens | BR |
| S0510 | | Nonprescription lens (safety, athletic, or sunglass), per lens | BR |
| S0512 | | Daily wear specialty contact lens, per lens | BR |
| S0514 | | Color contact lens, per lens | BR |
| S0515 | | Scleral lens, liquid bandage device, per lens | BR |
| S0516 | | Safety eyeglass frames | BR |
| S0518 | | Sunglasses frames | BR |
| S0580 | | Polycarbonate lens (list this code in addition to the basic code for the lens) | BR |
| S0581 | | Nonstandard lens (list this code in addition to the basic code for the lens) | BR |
| S0590 | | Integral lens service, miscellaneous services reported separately | BR |
| S0592 | | Comprehensive contact lens evaluation | BR |
| S0595 | | Dispensing new spectacle lenses for patient supplied frame | BR |
| S0601 | | Screening proctoscopy | BR |
| S0605 | | Digital rectal examination, annual | BR |
| S0610 | | Annual gynecological examination; new patient | BR |
| S0612 | | Annual gynecological examination; established patient | BR |
| S0613 | | Annual gynecological examination, clinical breast examination without pelvic examination | BR |
| S0618 | | Audiometry for hearing aid evaluation to determine the level and degree of hearing loss | BR |
| S0620 | | Routine ophthalmological examination including refraction; new patient | BR |
| S0621 | | Routine ophthalmological examination including refraction; established patient | BR |
| S0622 | | Physical exam for college, new or established patient (list separately in addition to appropriate evaluation and management code) | BR |
| S0625 | | Retinal telescreening by digital imaging of multiple different fundus areas to screen for vision threatening conditions, including imaging, interpretation and report | BR |
| S0630 | | Removal of sutures by a physician other than the physician who originally closed the wound | BR |
| S0800 | | Laser in situ keratomileusis (LASIK) | BR |
| S0810 | | Photorefractive keratectomy (PRK) | BR |
| S0812 | | Phototherapeutic keratectomy (PTK) | BR |
| S1001 | | Deluxe item, patient aware (list in addition to code for basic item) | BR |
| S1002 | | Customized item (list in addition to code for basic item) | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| **S1015** | | IV tubing extension set | BR |
| **S1016** | | Non-PVC (polyvinyl chloride) intravenous administration set, for use with drugs that are not stable in PVC e.g., Paclitaxel | BR |
| **S1030** | | Continuous noninvasive glucose monitoring device, purchase (for physician interpretation of data, use CPT code) | BR |
| **S1031** | | Continuous noninvasive glucose monitoring device, rental, including sensor, sensor replacement, and download to monitor (for physician interpretation of data, use CPT code) | BR |
| **S1040** | | Cranial remolding orthosis, pediatric, rigid, with soft interface material, custom fabricated, includes fitting and adjustment(s) | BR |
| **S2053** | | Transplantation of small intestine, and liver allografts | BR |
| **S2054** | | Transplantation of multivisceral organs | BR |
| **S2055** | | Harvesting of donor multivisceral organs, with preparation and maintenance of allografts; from cadaver donor | BR |
| **S2060** | | Lobar lung transplantation | BR |
| **S2061** | | Donor lobectomy (lung) for transplantation, living donor | BR |
| **S2065** | | Simultaneous pancreas kidney transplantation | BR |
| **S2068** | | Breast reconstruction with deep inferior epigastric perforator (DIEP) flap or superficial inferior epigastric artery (SIEA) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral | BR |
| **S2070** | | Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with endoscopic laser treatment of ureteral calculi (includes ureteral catheterization) | BR |
| **S2075** | | Laparoscopy, surgical; repair incisional or ventral hernia | BR |
| **S2076** | | Laparoscopy, surgical; repair umbilical hernia | BR |
| **S2077** | | Laparoscopy, surgical; implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to code for the incisional or ventral hernia repair) | BR |
| **S2079** | | Laparoscopic esophagomyotomy (Heller type) | BR |
| **S2080** | | Laser-assisted uvulopalatoplasty (LAUP) | BR |
| **S2083** | | Adjustment of gastric band diameter via subcutanous port by injection or aspiration of saline | BR |
| **S2095** | | Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium 90 microspheres | BR |
| **S2102** | | Islet cell tissue transplant from pancreas; allogeneic | BR |
| **S2103** | | Adrenal tissue transplant to brain | BR |
| **S2107** | | Adoptive immunotherapy, i.e., development of specific antitumor reactivity (e.g., tumor-infiltrating lymphocyte therapy) per course of treatment | BR |
| **S2112** | | Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells) | BR |
| **S2114** | | Arthroscopy, shoulder, surgical; tenodesis of biceps | BR |
| **S2115** | | Osteotomy, periacetabular, with internal fixation | BR |
| **S2117** | | Arthroereisis, subtalar | BR |
| **S2120** | | Low density lipoprotein (LDL) apheresis using heparin-induced extracorporeal LDL precipitation | BR |
| **S2135** | | Neurolysis, by injection, of metatarsal neuroma/interdigital neuritis, any interspace of the foot | BR |
| **S2140** | | Cord blood harvesting for transplantation, allogeneic | BR |
| **S2142** | | Cord blood-derived stem-cell transplantation, allogeneic | BR |
| **S2150** | | Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre- and post-transplant care in the global definition | BR |
| **S2152** | | Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor(s), procurement, transplantation, and related complications including: drugs; supplies; hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre- and post-transplant care in the global definition | BR |
| **S2202** | | Echosclerotherapy | BR |
| **S2205** | | Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using arterial graft(s), single coronary arterial graft | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| S2206 | | Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using arterial graft(s), two coronary arterial grafts | BR |
| S2207 | | Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using venous graft only, single coronary venous graft | BR |
| S2208 | | Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using single arterial and venous graft(s), single venous graft | BR |
| S2209 | | Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using two arterial grafts and single venous graft | BR |
| S2225 | | Myringotomy, laser-assisted | BR |
| S2230 | | Implantation of magnetic component of semi-implantable hearing device on ossicles in middle ear | BR |
| S2235 | | Implantation of auditory brain stem implant | BR |
| S2260 | | Induced abortion, 17 to 24 weeks | BR |
| S2265 | | Induced abortion, 25 to 28 weeks | BR |
| S2266 | | Induced abortion, 29 to 31 weeks | BR |
| S2267 | | Induced abortion, 32 weeks or greater | BR |
| S2300 | | Arthroscopy, shoulder, surgical; with thermally-induced capsulorrhaphy | BR |
| S2325 | | Hip core decompression | BR |
| S2340 | | Chemodenervation of abductor muscle(s) of vocal cord | BR |
| S2341 | | Chemodenervation of adductor muscle(s) of vocal cord | BR |
| S2342 | | Nasal endoscopy for postoperative debridement following functional endoscopic sinus surgery, nasal and/or sinus cavity(s), unilateral or bilateral | BR |
| S2344 | | Nasal/sinus endoscopy, surgical; with enlargement of sinus ostium opening using inflatable device (i.e., balloon sinuplasty) | BR |
| S2348 | | Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar | BR |
| S2350 | | Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, single interspace | BR |
| S2351 | | Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, each additional interspace (list separately in addition to code for primary procedure) | BR |
| S2360 | | Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; cervical | BR |
| S2361 | | Each additional cervical vertebral body (list separately in addition to code for primary procedure) | BR |
| S2400 | | Repair, congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion, procedure performed in utero | BR |
| S2401 | | Repair, urinary tract obstruction in the fetus, procedure performed in utero | BR |
| S2402 | | Repair, congenital cystic adenomatoid malformation in the fetus, procedure performed in utero | BR |
| S2403 | | Repair, extralobar pulmonary sequestration in the fetus, procedure performed in utero | BR |
| S2404 | | Repair, myelomeningocele in the fetus, procedure performed in utero | BR |
| S2405 | | Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero | BR |
| S2409 | | Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified | BR |
| S2411 | | Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome | BR |
| S2900 | | Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure) | BR |
| S3000 | | Diabetic indicator; retinal eye exam, dilated, bilateral | BR |
| S3005 | | Performance measurement, evaluation of patient self assessment, depression | BR |
| S3600 | | STAT laboratory request (situations other than S3601) | BR |
| S3601 | | Emergency STAT laboratory charge for patient who is homebound or residing in a nursing facility | BR |
| S3618 | | Blood chemistry for free beta human chorionic gonadotropin (hCG) | BR |
| S3620 | | Newborn metabolic screening panel, includes test kit, postage and the laboratory tests specified by the state for inclusion in this panel (e.g., galactose; hemoglobin, electrophoresis; hydroxyprogesterone, 17-d; phenylanine (PKU); and thyroxine, total) | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| S3625 | | Maternal serum triple marker screen including alpha-fetoprotein (APF), estriol, and human chorionic gonadotropin (hCG) | BR |
| S3626 | | Maternal serum quadruple marker screen including alpha-fetoprotein (AFP), estriol, human chorionic gonadotropin (hcG), and inhibin A | BR |
| S3630 | | Eosinophil count, blood, direct | BR |
| S3645 | | HIV-1 antibody testing of oral mucosal transudate | BR |
| S3650 | | Saliva test, hormone level; during menopause | BR |
| S3652 | | Saliva test, hormone level; to assess preterm labor risk | BR |
| S3655 | | Antisperm antibodies test (immunobead) | BR |
| S3708 | | Gastrointestinal fat absorption study | BR |
| S3818 | | Complete gene sequence analysis; BRCA 1 gene | BR |
| S3819 | | Complete gene sequence analysis; BRCA 2 gene | BR |
| S3820 | | Complete BRCA1 and BRCA2 gene sequence analysis for susceptibility to breast and ovarian cancer | BR |
| S3822 | | Single mutation analysis (in individual with a known BRCA1 or BRCA2 mutation in the family) for susceptibility to breast and ovarian cancer | BR |
| S3823 | | Three-mutation BRCA1 and BRCA2 analysis for susceptibility to breast and ovarian cancer in Ashkenazi individuals | BR |
| S3828 | | Complete gene sequence analysis; MLH1 gene | BR |
| S3829 | | Complete gene sequence analysis; MLH2 gene | BR |
| S3830 | | Complete MLH1 and MLH2 gene sequence analysis for hereditary nonpolyposis colorectal cancer (HNPCC) genetic testing | BR |
| S3831 | | Single-mutation analysis (in individual with a known MLH1 and MLH2 mutation in the family) for hereditary nonpolyposis colorectal cancer (HNPCC) genetic testing | BR |
| S3833 | | Complete APC gene sequence analysis for susceptibility to familial adenomatous polyposis (FAP) and attenuated fap | BR |
| S3834 | | Single-mutation analysis (in individual with a known APC mutation in the family) for susceptibility to familial adenomatous polyposis (FAP) and attenuated FAP | BR |
| S3835 | | Complete gene sequence analysis for cystic fibrosis genetic testing | BR |
| S3837 | | Complete gene sequence analysis for hemochromatosis genetic testing | BR |
| S3840 | | DNA analysis for germline mutations of the RET proto-oncogene for susceptibility to multiple endocrine neoplasia type 2 | BR |
| S3841 | | Genetic testing for retinoblastoma | BR |
| S3842 | | Genetic testing for Von Hippel-Lindau disease | BR |
| S3843 | | DNA analysis of the F5 gene for susceptibility to factor V Leiden thrombophilia | BR |
| S3844 | | DNA analysis of the connexin 26 gene (GJB2) for susceptibility to congenital, profound deafness | BR |
| S3845 | | Genetic testing for alpha-thalassemia | BR |
| S3846 | | Genetic testing for hemoglobin E beta-thalassemia | BR |
| S3847 | | Genetic testing for Tay-Sachs disease | BR |
| S3848 | | Genetic testing for Gaucher disease | BR |
| S3849 | | Genetic testing for Niemann-Pick disease | BR |
| S3850 | | Genetic testing for sickle cell anemia | BR |
| S3851 | | Genetic testing for Canavan disease | BR |
| S3852 | | DNA analysis for APOE epilson 4 allele for susceptibility to Alzheimer's disease | BR |
| S3853 | | Genetic testing for myotonic muscular dystrophy | BR |
| S3854 | | Gene expression profiling panel for use in the management of breast cancer treatment | BR |
| S3855 | | Genetic testing for detection of mutations in the presenilin, 1 gene | BR |
| S3890 | | DNA analysis, fecal, for colorectal cancer screening | BR |
| S3900 | | Surface electromyography (EMG) | BR |
| S3902 | | Ballistocardiogram | BR |
| S3904 | | Masters two step | BR |
| S4005 | | Interim labor facility global (labor occurring but not resulting in delivery) | BR |
| S4011 | | In vitro fertilization; including but not limited to identification and incubation of mature oocytes, fertilization with sperm, incubation of embryo(s), and subsequent visualization for determination of development | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| S4013 | | Complete cycle, gamete intrafallopian transfer (GIFT), case rate | BR |
| S4014 | | Complete cycle, zygote intrafallopian transfer (ZIFT), case rate | BR |
| S4015 | | Complete in vitro fertilization cycle, not otherwise specified, case rate | BR |
| S4016 | | Frozen in vitro fertilization cycle, case rate | BR |
| S4017 | | Incomplete cycle, treatment cancelled prior to stimulation, case rate | BR |
| S4018 | | Frozen embryo transfer procedure cancelled before transfer, case rate | BR |
| S4020 | | In vitro fertilization procedure cancelled before aspiration, case rate | BR |
| S4021 | | In vitro fertilization procedure cancelled after aspiration, case rate | BR |
| S4022 | | Assisted oocyte fertilization, case rate | BR |
| S4023 | | Donor egg cycle, incomplete, case rate | BR |
| S4025 | | Donor services for in vitro fertilization (sperm or embryo), case rate | BR |
| S4026 | | Procurement of donor sperm from sperm bank | BR |
| S4027 | | Storage of previously frozen embryos | BR |
| S4028 | | Microsurgical epididymal sperm aspiration (MESA) | BR |
| S4030 | | Sperm procurement and cryopreservation services; initial visit | BR |
| S4031 | | Sperm procurement and cryopreservation services; subsequent visit | BR |
| S4035 | | Stimulated intrauterine insemination (IUI), case rate | BR |
| S4037 | | Cryopreserved embryo transfer, case rate | BR |
| S4040 | | Monitoring and storage of cryopreserved embryos, per 30 days | BR |
| S4042 | | Management of ovulation induction (interpretation of diagnostic tests and studies, non-face-to-face medical management of the patient), per cycle | BR |
| S4981 | | Insertion of levonorgestrel-releasing intrauterine system | BR |
| S4989 | | Contraceptive intrauterine device (e.g., Progestacert IUD), including implants and supplies | BR |
| S4990 | | Nicotine patches, legend | BR |
| S4991 | | Nicotine patches, nonlegend | BR |
| S4993 | | Contraceptive pills for birth control | BR |
| S4995 | | Smoking cessation gum | BR |
| S5000 | | Prescription drug, generic | BR |
| S5001 | | Prescription drug, brand name | BR |
| S5010 | | 5% dextrose and 45% normal saline, 1000 ml | BR |
| S5011 | | 5% dextrose in lactated ringer's, 1000 ml | BR |
| S5012 | | 5% dextrose with potassium chloride, 1000 ml | BR |
| S5013 | | 5% dextrose/45% normal saline with potassium chloride and magnesium sulfate, 1000 ml | BR |
| S5014 | | 5% dextrose/45% normal saline with potassium chloride and magnesium sulfate, 1500 ml | BR |
| S5035 | | Home infusion therapy, routine service of infusion device (e.g., pump maintenance) | BR |
| S5036 | | Home infusion therapy, repair of infusion device (e.g., pump repair) | BR |
| S5100 | | Day care services, adult; per 15 minutes | BR |
| S5101 | | Day care services, adult; per half day | BR |
| S5102 | | Day care services, adult; per diem | BR |
| S5105 | | Day care services, center-based; services not included in program fee, per diem | BR |
| S5108 | | Home care training to home care client, per 15 minutes | BR |
| S5109 | | Home care training to home care client, per session | BR |
| S5110 | | Home care training, family; per 15 minutes | BR |
| S5111 | | Home care training, family; per session | BR |
| S5115 | | Home care training, nonfamily; per 15 minutes | BR |
| S5116 | | Home care training, nonfamily; per session | BR |
| S5120 | | Chore services; per 15 minutes | BR |
| S5121 | | Chore services; per diem | BR |
| S5125 | | Attendant care services; per 15 minutes | BR |
| S5126 | | Attendant care services; per diem | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| **S5130** | | Homemaker service, NOS; per 15 minutes | BR |
| **S5131** | | Homemaker service, NOS; per diem | BR |
| **S5135** | | Companion care, adult (e.g., IADL/ADL); per 15 minutes | BR |
| **S5136** | | Companion care, adult (e.g. IADL/ADL); per diem | BR |
| **S5140** | | Foster care, adult; per diem | BR |
| **S5141** | | Foster care, adult; per month | BR |
| **S5145** | | Foster care, therapeutic, child; per diem | BR |
| **S5146** | | Foster care, therapeutic, child; per month | BR |
| **S5150** | | Unskilled respite care, not hospice; per 15 minutes | BR |
| **S5151** | | Unskilled respite care, not hospice; per diem | BR |
| **S5160** | | Emergency response system; installation and testing | BR |
| **S5161** | | Emergency response system; service fee, per month (excludes installation and testing) | BR |
| **S5162** | | Emergency response system; purchase only | BR |
| **S5165** | | Home modifications; per service | BR |
| **S5170** | | Home delivered meals, including preparation; per meal | BR |
| **S5175** | | Laundry service, external, professional; per order | BR |
| **S5180** | | Home health respiratory therapy, initial evaluation | BR |
| **S5181** | | Home health respiratory therapy, NOS, per diem | BR |
| **S5185** | | Medication reminder services, non-face-to-face; per month | BR |
| **S5190** | | Wellness assessment, performed by nonphysician | BR |
| **S5199** | | Personal care item, NOS, each | BR |
| **S5497** | | Home infusion therapy, catheter care/maintenance, not otherwise classified; includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S5498** | | Home infusion therapy, catheter care/maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem | BR |
| **S5501** | | Home infusion therapy, catheter care/maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S5502** | | Home infusion therapy, catheter care/maintenance, implanted access device, includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem (use this code for interim maintenance of vascular access not currently in use) | BR |
| **S5517** | | Home infusion therapy, all supplies necessary for restoration of catheter patency or declotting | BR |
| **S5518** | | Home infusion therapy, all supplies necessary for catheter repair | BR |
| **S5520** | | Home infusion therapy, all supplies (including catheter) necessary for a peripherally inserted central venous catheter (PICC) line insertion | BR |
| **S5521** | | Home infusion therapy, all supplies (including catheter) necessary for a midline catheter insertion | BR |
| **S5522** | | Home infusion therapy, insertion of peripherally inserted central venous catheter (PICC), nursing services only (no supplies or catheter included) | BR |
| **S5523** | | Home infusion therapy, insertion of midline venous catheter, nursing services only (no supplies or catheter included) | BR |
| **S5550** | | Insulin, rapid onset, 5 units | BR |
| **S5551** | | Insulin, most rapid onset (Lispro or Aspart); 5 units | BR |
| **S5552** | | Insulin, intermediate acting (NPH or LENTE); 5 units | BR |
| **S5553** | | Insulin, long acting; 5 units | BR |
| **S5560** | | Insulin delivery device, reusable pen; 1.5 ml size | BR |
| **S5561** | | Insulin delivery device, reusable pen; 3 ml size | BR |
| **S5565** | | Insulin cartridge for use in insulin delivery device other than pump; 150 units | BR |
| **S5566** | | Insulin cartridge for use in insulin delivery device other than pump; 300 units | BR |
| **S5570** | | Insulin delivery device, disposable pen (including insulin); 1.5 ml size | BR |
| **S5571** | | Insulin delivery device, disposable pen (including insulin); 3 ml size | BR |
| **S8030** | | Scleral application of tantalum ring(s) for localization of lesions for proton beam therapy | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| S8035 | | Magnetic source imaging | BR |
| S8037 | | Magnetic resonance cholangiopancreatography (MRCP) | BR |
| S8040 | | Topographic brain mapping | BR |
| S8042 | | Magnetic resonance imaging (MRI), low-field | BR |
| S8049 | | Intraoperative radiation therapy (single administration) | BR |
| S8055 | | Ultrasound guidance for multifetal pregnancy reduction(s), technical component (only to be used when the physician doing the reduction procedure does not perform the ultrasound. Guidance is included in the CPT code for multifetal pregnancy reduction — 59866) | BR |
| S8080 | | Scintimammography (radioimmunoscintigraphy of the breast), unilateral, including supply of radiopharmaceutical | BR |
| S8085 | | Fluorine-18 fluorodeoxyglucose (F-18 FDG) imaging using dual-head coincidence detection system (nondedicated PET scan) | BR |
| S8092 | | Electron beam computed tomography (also known as Ultrafast CT, Cine CT) | BR |
| S8096 | | Portable peak flow meter | BR |
| S8097 | | Asthma kit (including but not limited to portable peak expiratory flow meter, instructional video, brochure, and/or spacer) | BR |
| S8100 | | Holding chamber or spacer for use with an inhaler or nebulizer; without mask | BR |
| S8101 | | Holding chamber or spacer for use with an inhaler or nebulizer; with mask | BR |
| S8110 | | Peak expiratory flow rate (physician services) | BR |
| S8120 | | Oxygen contents, gaseous, 1 unit equals 1 cubic foot | BR |
| S8121 | | Oxygen contents, liquid, 1 unit equals 1 pound | BR |
| S8185 | | Flutter device | BR |
| S8186 | | Swivel adaptor | BR |
| S8189 | | Tracheostomy supply, not otherwise classified | BR |
| S8190 | | Electronic spirometer (or microspirometer) | BR |
| S8210 | | Mucus trap | BR |
| S8262 | | Mandibular orthopedic repositioning device, each | BR |
| S8265 | | Haberman feeder for cleft lip/palate | BR |
| S8270 | | Enuresis alarm, using auditory buzzer and/or vibration device | BR |
| S8301 | | Infection control supplies, not otherwise specified | BR |
| S8415 | | Supplies for home delivery of infant | BR |
| S8420 | | Gradient pressure aid (sleeve and glove combination), custom made | BR |
| S8421 | | Gradient pressure aid (sleeve and glove combination), ready made | BR |
| S8422 | | Gradient pressure aid (sleeve), custom made, medium weight | BR |
| S8423 | | Gradient pressure aid (sleeve), custom made, heavy weight | BR |
| S8424 | | Gradient pressure aid (sleeve), ready made | BR |
| S8425 | | Gradient pressure aid (glove), custom made, medium weight | BR |
| S8426 | | Gradient pressure aid (glove), custom made, heavy weight | BR |
| S8427 | | Gradient pressure aid (glove), ready made | BR |
| S8428 | | Gradient pressure aid (gauntlet), ready made | BR |
| S8429 | | Gradient pressure exterior wrap | BR |
| S8430 | | Padding for compression bandage, roll | BR |
| S8431 | | Compression bandage, roll | BR |
| S8450 | | Splint, prefabricated, digit (specify digit by use of modifier) | BR |
| S8451 | | Splint, prefabricated, wrist or ankle | BR |
| S8452 | | Splint, prefabricated, elbow | BR |
| S8460 | | Camisole, postmastectomy | BR |
| S8490 | | Insulin syringes (100 syringes, any size) | BR |
| S8940 | | Equestrian/hippotherapy, per session | BR |
| S8948 | | Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes | BR |
| S8950 | | Complex lymphedema therapy, each 15 minutes | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| **S8990** | | Physical or manipulative therapy performed for maintenance rather than restoration | BR |
| **S8999** | | Resuscitation bag (for use by patient on artificial respiration during power failure or other catastrophic event) | BR |
| **S9001** | | Home uterine monitor with or without associated nursing services | BR |
| **S9007** | | Ultrafiltration monitor | BR |
| **S9015** | | Automated EEG monitoring | BR |
| **S9024** | | Paranasal sinus ultrasound | BR |
| **S9025** | | Omnicardiogram/cardiointegram | BR |
| **S9034** | | Extracorporeal shockwave lithotripsy for gall stones | BR |
| **S9055** | | Procuren or other growth factor preparation to promote wound healing | BR |
| **S9056** | | Coma stimulation per diem | BR |
| **S9061** | | Home administration of aerosolized drug therapy (e.g., Pentamidine); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9075** | | Smoking cessation treatment | BR |
| **S9083** | | Global fee urgent care centers | BR |
| **S9088** | | Services provided in an urgent care center (list in addition to code for service) | BR |
| **S9090** | | Vertebral axial decompression, per session | BR |
| **S9092** | | Canolith repositioning, per visit | BR |
| **S9097** | | Home visit for wound care | BR |
| **S9098** | | Home visit, phototherapy services (e.g., Bili-lite), including equipment rental, nursing services, blood draw, supplies, and other services, per diem | BR |
| **S9109** | | Congestive heart failure telemonitoring, equipment rental, including telescale, computer system and software, telephone connections, and maintenance, per month | BR |
| **S9117** | | Back school, per visit | BR |
| **S9122** | | Home health aide or certified nurse assistant, providing care in the home; per hour | BR |
| **S9123** | | Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when CPT codes 99500–99602 can be used) | BR |
| **S9124** | | Nursing care, in the home; by licensed practical nurse, per hour | BR |
| **S9125** | | Respite care, in the home, per diem | BR |
| **S9126** | | Hospice care, in the home, per diem | BR |
| **S9127** | | Social work visit, in the home, per diem | BR |
| **S9128** | | Speech therapy, in the home, per diem | BR |
| **S9129** | | Occupational therapy, in the home, per diem | BR |
| **S9131** | | Physical therapy; in the home, per diem | BR |
| **S9140** | | Diabetic management program, follow-up visit to non-MD provider | BR |
| **S9141** | | Diabetic management program, follow-up visit to MD provider | BR |
| **S9145** | | Insulin pump initiation, instruction in initial use of pump (pump not included) | BR |
| **S9150** | | Evaluation by ocularist | BR |
| **S9208** | | Home management of preterm labor, including administrative services, professional pharmacy services, care coordination, and all necessary supplies or equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infusion per diem code) | BR |
| **S9209** | | Home management of preterm premature rupture of membranes (PPROM), including administrative services, professional pharmacy services, care coordination, and all necessary supplies or equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infusion per diem code) | BR |
| **S9211** | | Home management of gestational hypertension, includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately); per diem (do not use this code with any home infusion per diem code) | BR |
| **S9212** | | Home management of postpartum hypertension, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infusion per diem code) | BR |
| **S9213** | | Home management of preeclampsia, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing services coded separately); per diem (do not use this code with any home infusion per diem code) | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| S9214 | | Home management of gestational diabetes, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately); per diem (do not use this code with any home infusion per diem code) | BR |
| S9325 | | Home infusion therapy, pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem (do not use this code with S9326, S9327 or S9328) | BR |
| S9326 | | Home infusion therapy, continuous (24 hours or more) pain management infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| S9327 | | Home infusion therapy, intermittent (less than 24 hours) pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| S9328 | | Home infusion therapy, implanted pump pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| S9329 | | Home infusion therapy, chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with S9330 or S9331) | BR |
| S9330 | | Home infusion therapy, continuous (24 hours or more) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| S9331 | | Home infusion therapy, intermittent (less than 24 hours) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| S9335 | | Home therapy, hemodialysis; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing services coded separately), per diem | BR |
| S9336 | | Home infusion therapy, continuous anticoagulant infusion therapy (e.g., Heparin), administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| S9338 | | Home infusion therapy, immunotherapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| S9339 | | Home therapy; peritoneal dialysis, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| S9340 | | Home therapy; enteral nutrition; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem | BR |
| S9341 | | Home therapy; enteral nutrition via gravity; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem | BR |
| S9342 | | Home therapy; enteral nutrition via pump; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem | BR |
| S9343 | | Home therapy; enteral nutrition via bolus; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem | BR |
| S9345 | | Home infusion therapy, anti-hemophilic agent infusion therapy (e.g., factor VIII); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| S9346 | | Home infusion therapy, alpha-1-proteinase inhibitor (e.g., Prolastin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| S9347 | | Home infusion therapy, uninterrupted, long-term, controlled rate intravenous or subcutaneous infusion therapy (e.g., Epoprostenol); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| S9348 | | Home infusion therapy, sympathomimetic/inotropic agent infusion therapy (e.g., Dobutamine); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| S9349 | | Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| **S9351** | | Home infusion therapy, continuous or intermittent anti-emetic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and visits coded separately), per diem | BR |
| **S9353** | | Home infusion therapy, continuous insulin infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9355** | | Home infusion therapy, chelation therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9357** | | Home infusion therapy, enzyme replacement intravenous therapy; (e.g., Imiglucerase); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9359** | | Home infusion therapy, antitumor necrosis factor intravenous therapy; (e.g., Infliximab); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9361** | | Home infusion therapy, diuretic intravenous therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9363** | | Home infusion therapy, antispasmotic therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9364** | | Home infusion therapy, total parenteral nutrition (TPN); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem (do not use with home infusion codes S9365–S9368 using daily volume scales) | BR |
| **S9365** | | Home infusion therapy, total parenteral nutrition (TPN); 1 liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem | BR |
| **S9366** | | Home infusion therapy, total parenteral nutrition (TPN); more than 1 liter but no more than 2 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem | BR |
| **S9367** | | Home infusion therapy, total parenteral nutrition (TPN); more than 2 liters but no more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem | BR |
| **S9368** | | Home infusion therapy, total parenteral nutrition (TPN); more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem | BR |
| **S9370** | | Home therapy, intermittent antiemetic injection therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9372** | | Home therapy; intermittent anticoagulant injection therapy (e.g., Heparin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code for flushing of infusion devices with Heparin to maintain patency) | BR |
| **S9373** | | Home infusion therapy, hydration therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use with hydration therapy codes S9374–S9377 using daily volume scales) | BR |
| **S9374** | | Home infusion therapy, hydration therapy; one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9375** | | Home infusion therapy, hydration therapy; more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9376** | | Home infusion therapy, hydration therapy; more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9377** | | Home infusion therapy, hydration therapy; more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies (drugs and nursing visits coded separately), per diem | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| S9379 | | Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| S9381 | | Delivery or service to high risk areas requiring escort or extra protection, per visit | BR |
| S9401 | | Anticoagulation clinic, inclusive of all services except laboratory tests, per session | BR |
| S9430 | | Pharmacy compounding and dispensing services | See Page 405 |
| S9434 | | Modified solid food supplements for inborn errors of metabolism | BR |
| S9435 | | Medical foods for inborn errors of metabolism | BR |
| S9436 | | Childbirth preparation/Lamaze classes, nonphysician provider, per session | BR |
| S9437 | | Childbirth refresher classes, nonphysician provider, per session | BR |
| S9438 | | Cesarean birth classes, nonphysician provider, per session | BR |
| S9439 | | VBAC (vaginal birth after cesarean) classes, nonphysician provider, per session | BR |
| S9441 | | Asthma education, nonphysician provider, per session | BR |
| S9442 | | Birthing classes, nonphysician provider, per session | BR |
| S9443 | | Lactation classes, nonphysician provider, per session | BR |
| S9444 | | Parenting classes, nonphysician provider, per session | BR |
| S9445 | | Patient education, not otherwise classified, nonphysician provider, individual, per session | BR |
| S9446 | | Patient education, not otherwise classified, nonphysician provider, group, per session | BR |
| S9447 | | Infant safety (including CPR) classes, nonphysician provider, per session | BR |
| S9449 | | Weight management classes, nonphysician provider, per session | BR |
| S9451 | | Exercise classes, nonphysician provider, per session | BR |
| S9452 | | Nutrition classes, nonphysician provider, per session | BR |
| S9453 | | Smoking cessation classes, nonphysician provider, per session | BR |
| S9454 | | Stress management classes, nonphysician provider, per session | BR |
| S9455 | | Diabetic management program, group session | BR |
| S9460 | | Diabetic management program, nurse visit | BR |
| S9465 | | Diabetic management program, dietitian visit | BR |
| S9470 | | Nutritional counseling, dietitian visit | BR |
| S9472 | | Cardiac rehabilitation program, nonphysician provider, per diem | BR |
| S9473 | | Pulmonary rehabilitation program, nonphysician provider, per diem | BR |
| S9474 | | Enterostomal therapy by a registered nurse certified in enterostomal therapy, per diem | BR |
| S9475 | | Ambulatory setting substance abuse treatment or detoxification services, per diem | BR |
| S9476 | | Vestibular rehabilitation program, nonphysician provider, per diem | BR |
| S9480 | | Intensive outpatient psychiatric services, per diem | BR |
| S9482 | | Family stabilization services, per 15 minutes | BR |
| S9484 | | Crisis intervention mental health services, per hour | BR |
| S9485 | | Crisis intervention mental health services, per diem | BR |
| S9490 | | Home infusion therapy, corticosteroid infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| S9494 | | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately, per diem) (do not use this code with home infusion codes for hourly dosing schedules S9497–S9504) | BR |
| S9497 | | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every three hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| S9500 | | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| S9501 | | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| **S9502** | | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every eight hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9503** | | Home infusion therapy, antibiotic, antiviral, or antifungal; once every six hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9504** | | Home infusion therapy, antibiotic, antiviral, or antifungal; once every four hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9529** | | Routine venipuncture for collection of specimen(s), single home bound, nursing home, or skilled nursing facility patient | BR |
| **S9537** | | Home therapy; hematopoietic hormone injection therapy (e.g., erythropoietin, G-CSF, GM-CSF); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9538** | | Home transfusion of blood product(s); administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (blood products, drugs, and nursing visits coded separately), per diem | BR |
| **S9542** | | Home injectable therapy, not otherwise classified, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9558** | | Home injectable therapy; growth hormone, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9559** | | Home injectable therapy, interferon, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9560** | | Home injectable therapy; hormonal therapy (e.g.; leuprolide, goserelin), including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9562** | | Home injectable therapy, palivizumab, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9590** | | Home therapy, irrigation therapy (e.g., sterile irrigation of an organ or anatomical cavity); including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | BR |
| **S9810** | | Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour (do not use this code with any per diem code) | BR |
| **S9900** | | Services by authorized Christian Science practitioner for the process of healing, per diem; not to be used for rest or study; excludes in-patient services | BR |
| **S9970** | | Health club membership, annual | BR |
| **S9975** | | Transplant related lodging, meals and transportation, per diem | BR |
| **S9976** | | Lodging, per diem, not otherwise specified | BR |
| **S9977** | | Meals, per diem not otherwise specified | BR |
| **S9981** | | Medical records copying fee, administrative | BR |
| **S9982** | | Medical records copying fee, per page | BR |
| **S9986** | | Not medically necessary service (patient is aware that service not medically necessary) | BR |
| **S9988** | | Services provided as part of a Phase 1 clinical trial | BR |
| **S9989** | | Services provided outside of the United States of America (list in addition to code(s) for services(s)) | BR |
| **S9990** | | Services provided as part of a Phase II clinical trial | BR |
| **S9991** | | Services provided as part of a Phase III clinical trial | BR |
| **S9992** | | Transportation costs to and from trial location and local transportation costs (e.g., fares for taxicab or bus) for clinical trial participant and one caregiver/companion | BR |
| **S9994** | | Lodging costs (e.g., hotel charges) for clinical trial participant and one caregiver/companion | BR |
| **S9996** | | Meals for clinical trial participant and one caregiver/companion | BR |
| **S9999** | | Sales tax | BR |
| **V2020** | | Frames, purchases | $56.06 |
| **V2025** | | Deluxe frame | BR |
| **V2100** | | Sphere, single vision, plano to plus or minus 4.00, per lens | $35.02 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| V2101 | | Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens | $36.91 |
| V2102 | | Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens | $51.93 |
| V2103 | | Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens | $30.42 |
| V2104 | | Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens | $33.68 |
| V2105 | | Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens | $36.67 |
| V2106 | | Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens | $40.70 |
| V2107 | | Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, 0.12 to 2.00d cylinder, per lens | $38.70 |
| V2108 | | Spherocylinder, single vision, plus or minus 4.25d to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens | $40.07 |
| V2109 | | Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens | $44.33 |
| V2110 | | Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere, over 6.00d cylinder, per lens | $43.75 |
| V2111 | | Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens | $45.60 |
| V2112 | | Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25d to 4.00d cylinder, per lens | $49.78 |
| V2113 | | Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens | $56.11 |
| V2114 | | Spherocylinder, single vision sphere over plus or minus 12.00d, per lens | $60.78 |
| V2115 | | Lenticular (myodisc), per lens, single vision | $66.15 |
| V2118 | | Aniseikonic lens, single vision | $65.57 |
| V2121 | | Lenticular lens, per lens, single | $67.70 |
| V2199 | | Not otherwise classified, single vision lens | BR |
| V2200 | | Sphere, bifocal, plano to plus or minus 4.00d, per lens | $45.84 |
| V2201 | | Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens | $49.96 |
| V2202 | | Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens | $58.79 |
| V2203 | | Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens | $46.25 |
| V2204 | | Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens | $48.35 |
| V2205 | | Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens | $52.28 |
| V2206 | | Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens | $56.16 |
| V2207 | | Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens | $51.09 |
| V2208 | | Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens | $53.62 |
| V2209 | | Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens | $57.73 |
| V2210 | | Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens | $63.68 |
| V2211 | | Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens | $66.04 |
| V2212 | | Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens | $68.19 |
| V2213 | | Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens | $68.88 |
| V2214 | | Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens | $74.87 |
| V2215 | | Lenticular (myodisc), per lens, bifocal | $76.01 |
| V2218 | | Aniseikonic, per lens, bifocal | $90.45 |
| V2219 | | Bifocal seg width over 28mm | $39.82 |
| V2220 | | Bifocal add over 3.25d | $32.29 |
| V2221 | | Lenticular lens, per lens, bifocal | $78.99 |
| V2299 | | Specialty bifocal (by report) | BR |
| V2300 | | Sphere, trifocal, plano to plus or minus 4.00d, per lens | $58.36 |
| V2301 | | Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00d per lens | $68.78 |
| V2302 | | Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00, per lens | $73.32 |
| V2303 | | Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens | $57.42 |
| V2304 | | Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 2.25 to 4.00d cylinder, per lens | $60.09 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| V2305 | | Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00 cylinder, per lens | $69.62 |
| V2306 | | Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens | $71.68 |
| V2307 | | Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens | $67.87 |
| V2308 | | Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens | $71.13 |
| V2309 | | Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens | $77.49 |
| V2310 | | Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens | $76.57 |
| V2311 | | Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens | $79.67 |
| V2312 | | Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens | $80.12 |
| V2313 | | Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens | $89.49 |
| V2314 | | Spherocylinder, trifocal, sphere over plus or minus 12.00d, per lens | $96.10 |
| V2315 | | Lenticular (myodisc), per lens, trifocal | $106.69 |
| V2318 | | Aniseikonic lens, trifocal | $131.17 |
| V2319 | | Trifocal seg width over 28 mm | $44.40 |
| V2320 | | Trifocal add over 3.25d | $46.85 |
| V2321 | | Lenticular lens, per lens, trifocal | $105.17 |
| V2399 | | Specialty trifocal (by report) | BR |
| V2410 | | Variable asphericity lens, single vision, full field, glass or plastic, per lens | $80.18 |
| V2430 | | Variable asphericity lens, bifocal, full field, glass or plastic, per lens | $96.63 |
| V2499 | | Variable sphericity lens, other type | BR |
| V2500 | | Contact lens, PMMA, spherical, per lens | $72.68 |
| V2501 | | Contact lens, PMMA, toric or prism ballast, per lens | $110.71 |
| V2502 | | Contact lens, PMMA, bifocal, per lens | $136.38 |
| V2503 | | Contact lens, PMMA, color vision deficiency, per lens | $125.60 |
| V2510 | | Contact lens, gas permeable, spherical, per lens | $99.21 |
| V2511 | | Contact lens, gas permeable, toric, prism ballast, per lens | $142.55 |
| V2512 | | Contact lens, gas permeable, bifocal, per lens | $168.45 |
| V2513 | | Contact lens, gas permeable, extended wear, per lens | $141.43 |
| V2520 | | Contact lens, hydrophilic, spherical, per lens | $93.26 |
| V2521 | | Contact lens, hydrophilic, toric, or prism ballast, per lens | $162.36 |
| V2522 | | Contact lens, hydrophilic, bifocal, per lens | $158.01 |
| V2523 | | Contact lens, hydrophilic, extended wear, per lens | $134.65 |
| V2530 | | Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see CPT Level I code 92325) | $199.43 |
| V2531 | | Contact lens, scleral, gas permeable, per lens (for contact lens modification, see CPT Level I code 92325) | $437.83 |
| V2599 | | Contact lens, other type | BR |
| V2600 | | Hand held low vision aids and other nonspectacle mounted aids | BR |
| V2610 | | Single lens spectacle mounted low vision aids | BR |
| V2615 | | Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system | BR |
| V2623 | | Prosthetic eye, plastic, custom | $802.67 |
| V2624 | | Polishing/resurfacing of ocular prosthesis | $54.43 |
| V2625 | | Enlargement of ocular prosthesis | $330.95 |
| V2626 | | Reduction of ocular prosthesis | $178.40 |
| V2627 | | Scleral cover shell | $1,152.20 |
| V2628 | | Fabrication and fitting of ocular conformer | $272.06 |
| V2629 | | Prosthetic eye, other type | BR |
| V2630 | | Anterior chamber intraocular lens | BR |
| V2631 | | Iris supported intraocular lens | BR |

| Code | Mod | Description | Amount |
|---|---|---|---|
| V2632 | | Posterior chamber intraocular lens | BR |
| V2700 | | Balance lens, per lens | $39.17 |
| V2702 | | Deluxe lens feature | BR |
| V2710 | | Slab off prism, glass or plastic, per lens | $57.33 |
| V2715 | | Prism, per lens | $10.39 |
| V2718 | | Press-on lens, fresnell prism, per lens | $25.53 |
| V2730 | | Special base curve, glass or plastic, per lens | $18.85 |
| V2744 | | Tint, photochromatic, per lens | $14.67 |
| V2745 | | Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens | $9.19 |
| V2750 | | Antireflective coating, per lens | $17.07 |
| V2755 | | U-V lens, per lens | $14.85 |
| V2756 | | Eye glass case | BR |
| V2760 | | Scratch resistant coating, per lens | $14.33 |
| V2761 | | Mirror coating, any type, solid, gradient or equal, any lens material, per lens | $14.50 |
| V2762 | | Polarization, any lens material, per lens | $47.89 |
| V2770 | | Occluder lens, per lens | $17.45 |
| V2780 | | Oversize lens, per lens | $11.21 |
| V2781 | | Progressive lens, per lens | BR |
| V2782 | | Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens | $51.71 |
| V2783 | | Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens | $58.31 |
| V2784 | | Lens, polycarbonate or equal, any index, per lens | $37.92 |
| V2785 | | Processing, preserving and transporting corneal tissue | BR |
| V2786 | | Specialty occupational multifocal lens, per lens | BR |
| V2788 | | Presbyopia correcting function of intraocular lens | BR |
| V2790 | | Amniotic membrane for surgical reconstruction, per procedure | BR |
| V2797 | | Vision supply, accessory and/or service component of another HCPCS vision code | BR |
| V2799 | | Vision service, miscellaneous | BR |
| V5008 | | Hearing screening | $50.18 |
| V5010 | | Assessment for hearing aid | $65.79 |
| V5011 | | Fitting/orientation/checking of hearing aid | $102.58 |
| V5014 | | Repair/modification of a hearing aid | $123.77 |
| V5020 | | Conformity evaluation | $57.70 |
| V5030 | | Hearing aid, monaural, body worn, air conduction | $910.96 |
| V5040 | | Hearing aid, monaural, body worn, bone conduction | $692.42 |
| V5050 | | Hearing aid, monaural, in the ear | $800.57 |
| V5060 | | Hearing aid, monaural, behind the ear | $669.00 |
| V5070 | | Glasses, air conduction | $371.85 |
| V5080 | | Glasses, bone conduction | $934.37 |
| V5090 | | Dispensing fee, unspecified hearing aid | $332.27 |
| V5095 | | Semi-implantable middle ear hearing prosthesis | BR |
| V5100 | | Hearing aid, bilateral, body worn | $1,498.84 |
| V5110 | | Dispensing fee, bilateral | $337.85 |
| V5120 | | Binaural, body | $1,310.13 |
| V5130 | | Binaural, in the ear | $1,393.75 |
| V5140 | | Binaural, behind the ear | $1,449.50 |
| V5150 | | Binaural, glasses | $1,547.62 |
| V5160 | | Dispensing fee, binaural | $404.47 |
| V5170 | | Hearing aid, CROS, in the ear | $1,076.53 |

| Code | Mod | Description | Amount |
|---|---|---|---|
| V5180 | | Hearing aid, CROS, behind the ear | $910.96 |
| V5190 | | Hearing aid, CROS, glasses | $1,064.83 |
| V5200 | | Dispensing fee, CROS | $335.06 |
| V5210 | | Hearing aid, BICROS, in the ear | $1,169.64 |
| V5220 | | Hearing aid, BICROS, behind the ear | $1,123.92 |
| V5230 | | Hearing aid, BICROS, glasses | $1,161.83 |
| V5240 | | Dispensing fee, BICROS | $346.77 |
| V5241 | | Dispensing fee, monaural hearing aid, any type | BR |
| V5242 | | Hearing aid, analog, monaural, CIC (completely in the ear canal) | BR |
| V5243 | | Hearing aid, analog, monaural, ITC (in the canal) | BR |
| V5244 | | Hearing aid, digitally programmable analog, monaural, CIC | BR |
| V5245 | | Hearing aid, digitally programmable, analog, monaural, ITC | BR |
| V5246 | | Hearing aid, digitally programmable analog, monaural, ITE (in the ear) | BR |
| V5247 | | Hearing aid, digitally programmable analog, monaural, BTE (behind the ear) | BR |
| V5248 | | Hearing aid, analog, binaural, CIC | BR |
| V5249 | | Hearing aid, analog, binaural, ITC | BR |
| V5250 | | Hearing aid, digitally programmable analog, binaural, CIC | BR |
| V5251 | | Hearing aid, digitally programmable analog, binaural, ITC | BR |
| V5252 | | Hearing aid, digitally programmable, binaural, ITE | BR |
| V5253 | | Hearing aid, digitally programmable, binaural, BTE | BR |
| V5254 | | Hearing aid, digital, monaural, CIC | BR |
| V5255 | | Hearing aid, digital, monaural, ITC | BR |
| V5256 | | Hearing aid, digital, monaural, ITE | BR |
| V5257 | | Hearing aid, digital, monaural, BTE | BR |
| V5258 | | Hearing aid, digital, binaural, CIC | BR |
| V5259 | | Hearing aid, digital, binaural, ITC | BR |
| V5260 | | Hearing aid, digital, binaural, ITE | BR |
| V5261 | | Hearing aid, digital, binaural, BTE | BR |
| V5262 | | Hearing aid, disposable, any type, monaural | BR |
| V5263 | | Hearing aid, disposable, any type, binaural | BR |
| V5264 | | Ear mold/insert, not disposable, any type | BR |
| V5265 | | Ear mold/insert, disposable, any type | BR |
| V5266 | | Battery for use in hearing device | BR |
| V5267 | | Hearing aid supplies/accessories | BR |
| V5268 | | Assistive listening device, telephone amplifier, any type | BR |
| V5269 | | Assistive listening device, alerting, any type | BR |
| V5270 | | Assistive listening device, television amplifier, any type | BR |
| V5271 | | Assistive listening device, television caption decoder | BR |
| V5272 | | Assistive listening device, TDD | BR |
| V5273 | | Assistive listening device, for use with cochlear implant | BR |
| V5274 | | Assistive listening device, not otherwise specified | BR |
| V5275 | | Ear impression, each | BR |
| V5298 | | Hearing aid, not otherwise classified | BR |
| V5299 | | Hearing service, miscellaneous | BR |
| V5336 | | Repair/modification of augmentative communicative system or device (excludes adaptive hearing aid) | BR |
| V5362 | | Speech screening | BR |
| V5363 | | Language screening | BR |
| V5364 | | Dysphagia screening | BR |

# Inpatient Hospital Payment Schedule and Rules

## Inpatient Reimbursement Methodology

Inpatient hospital maximum reimbursement allowable (MRA) totals are provided by DRG in this Fee Schedule. As of the date of publication, the DRG maximum reimbursement allowable is based upon the 2007 CMS relative weights multiplied by a base rate of $8,436.00. Any DRGs outside of this Fee Schedule will be reimbursed at seventy-five percent (75%) of charge. DRG MRAs represent payment in full, unless the outlier payment is applicable or a contract between a payer/provider is negotiated.

### Implants, Durable Medical Equipment (DME), and Supplies

Generally, durable medical equipment and supplies provided or administered in a hospital setting are not separately reimbursed since they are included in the payment reimbursement.

Implantables are included in the applicable DRG reimbursement for inpatient treatment, and, therefore, the provider of inpatient services is not required to furnish the payer with an invoice for implantables. For implantables used in the outpatient setting, reimbursement shall be made separately from the facility fee and all other charges; and the provider shall furnish a suitable invoice evidencing the cost of the implantable to the payer within sixty (60) days from the date of service the implantable is used. Upon receipt of this invoice, the payer shall pay the amount due within thirty (30) days thereafter.

Only the actual invoiced cost of the item(s), plus ten percent (10%) will be reimbursed. Tax, handling, and freight charges are included in the facilities invoiced cost and shall not be reimbursed separately.

## Payment for Outliers

Most DRG payments will be at the base rate times the DRG weight. However, to provide additional reimbursement where the Mississippi Workers' Compensation Commission deems the DRG payment inadequate to cover the costs incurred by the facility, the Commission has established an outlier payment for high-cost cases.

The outlier payment will be made according to the following calculation:

Example for DRG 127:

**Step 1:** Are Total Billed Charges ≤ DRG Payment?

If **Yes:** Total Billed Charges = Total Payment

If **No:** Continue to Step 2

**Step 2:** Are Total Billed Charges > (2.5 x DRG Payment)?

If **No:** Outlier Payment Add-on = $0.00 and Total Payment = DRG Payment

If **Yes:** Outlier Payment Add-on = (Total Billed Charges – (2.5 x (DRG Payment) x 0.75

**Continue to Step 3**

**Step 3:** Total Payment = (DRG Payment) + (Outlier Payment Add-on)

| | Total Billed Charges | DRG Payment | Outlier Threshold Trigger | Outlier Payment Add-on | Total Payment |
|---|---|---|---|---|---|
| Example A | $30,000 | $8,849.36 | Yes | $5,907.45 | $14,756.81 |
| Example B | $5,000 | $8,849.36 | No | $0.00 | $8,849.36 |
| Example C | $15,000 | $8,849.36 | No | $0.00 | $8,849.36 |
| Example D | $50,000 | $8,849.36 | Yes | $20,907.45 | $29,756.81 |

**Example A Detail**

**Step 1:** Are Total Billed Charges DRG Payment?

Total Billed Charges = $30,000

DRG Payment = $8,849.36

**No: Continue to Step 2**

**Step 2:** Are Total Billed Charges > (2.5 DRG Payment)?

Total Billed Charges = $30,000

2.5 x DRG Payment = $22,123.40

Is $30,000 > $22,123.40?

**Yes**

Outlier Payment Add-on = Total Billed Charges – (2.5 x DRG Payment) x 0.75

Total Billed Charges = $30,000

2.5 x DRG Payment = $22,123.40

$30,000 – $22,123.40 x 0.75 = $5,907.45

**Continue to Step 3**

**Step 3:** Total Payment = (DRG Payment) + (Outlier Payment Add-on)

DRG Payment = $8,849.36

Outlier Payment Add-on = $5,907.45

$8,849.36 + $5,907.45 = **$14,756.81**

**Outliers for DRG 462, Rehabilitation.**

The percent of outlier payment for DRG 462 only will be ninety-five percent (95%) rather than the seventy-five percent (75%) listed above. Therefore, in Step 2 above, the calculation for DRG 462 would be:

Outlier Payment Add-on = Total Billed Charges – (2.5 x DRG Payment) x 0.95

## V. Disputed Medical Charges

Disputes over charges, fees, services or other issues related to treatment under the terms of the Workers' Compensation Law shall be resolved in accordance with the Dispute Resolution Rules set forth elsewhere in this Fee Schedule.

| DRG | Description | 2007 Amount |
|---|---|---|
| 1 | CRANIOTOMY AGE GREATER THAN 17 WITH CC | $29,231.58 |
| 2 | CRANIOTOMY AGE GREATER THAN 17 WITHOUT CC | $16,471.29 |
| 3 | CRANIOTOMY AGE 0-17 | $16,967.33 |
| 6 | CARPAL TUNNEL RELEASE | $6,672.88 |
| 7 | PERIPH&CRANIAL NERVE&OTH NERV SYSTEM PROC W/CC | $22,447.35 |
| 8 | PERIPH&CRANIAL NERVE&OTH NERV SYSTEM PROC W/O CC | $13,457.95 |
| 9 | SPINAL DISORDERS AND INJURIES | $11,512.61 |
| 10 | NERVOUS SYSTEM NEOPLASMS WITH CC | $10,592.24 |
| 11 | NERVOUS SYSTEM NEOPLASMS WITHOUT CC | $7,248.21 |
| 12 | DEGENERATIVE NERVOUS SYSTEM DISORDERS | $7,864.04 |
| 13 | MULTIPLE SCLEROSIS AND CEREBELLAR ATAXIA | $7,205.19 |
| 14 | INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION | $10,222.74 |
| 15 | NONSPECIFIC CVA & PRECERBRL OCCL W/O INFARCT | $7,965.27 |
| 16 | NONSPECIFIC CEREBROVASCULAR DISORDERS WITH CC | $11,455.24 |
| 17 | NONSPECIFIC CEREBROVASCULAR DISORDERS WITHOUT CC | $6,024.15 |
| 18 | CRANIAL AND PERIPHERAL NERVE DISORDERS WITH CC | $8,468.06 |
| 19 | CRANIAL&PERIPHERAL NERVE DISORDERS WITHOUT CC | $6,068.86 |
| 21 | VIRAL MENINGITIS | $11,920.07 |
| 22 | HYPERTENSIVE ENCEPHALOPATHY | $9,829.63 |
| 23 | NONTRAUMATIC STUPOR AND COMA | $6,761.45 |
| 26 | SEIZURE AND HEADACHE AGE 0-17 | $8,500.11 |
| 27 | TRAUMATIC STUPOR AND COMA COMA > ONE HOUR | $11,387.76 |
| 28 | TRAUMAT STUPOR&COMA COMA < 1 HOUR AGE > 17 W/CC | $11,267.97 |
| 29 | TRAUMAT STUPOR&COMA COMA < 1 HR AGE > 17 W/O CC | $6,243.48 |
| 30 | TRAUMATIC STUPOR&COMA COMA < ONE HOUR AGE 0-17 | $2,869.93 |
| 31 | CONCUSSION AGE GREATER THAN 17 WITH CC | $8,263.91 |
| 32 | CONCUSSION AGE GREATER THAN 17 WITHOUT CC | $5,405.79 |
| 33 | CONCUSSION AGE 0-17 | $1,801.93 |
| 34 | OTHER DISORDERS OF NERVOUS SYSTEM WITH CC | $8,583.63 |
| 35 | OTHER DISORDERS OF NERVOUS SYSTEM WITHOUT CC | $5,556.79 |
| 36 | RETINAL PROCEDURES | $6,796.04 |
| 37 | ORBITAL PROCEDURES | $10,177.19 |
| 38 | PRIMARY IRIS PROCEDURES | $5,226.10 |
| 39 | LENS PROCEDURES WITH/WITHOUT VITRECTOMY | $5,450.50 |
| 40 | EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE > 17 | $8,696.67 |
| 41 | EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17 | $2,920.54 |
| 42 | INTRAOCULAR PROCEDURES EXCEPT RETINA IRIS&LENS | $6,510.06 |
| 43 | HYPHEMA | $5,223.57 |
| 44 | ACUTE MAJOR EYE INFECTIONS | $6,062.11 |
| 45 | NEUROLOGICAL EYE DISORDERS | $6,271.32 |
| 46 | OTHER DISORDERS OF THE EYE AGE > 17 WITH CC | $6,677.09 |
| 47 | OTHER DISORDERS OF THE EYE AGE > 17 WITHOUT CC | $4,656.67 |
| 48 | OTHER DISORDERS OF THE EYE AGE 0-17 | $2,572.98 |
| 49 | MAJOR HEAD AND NECK PROCEDURES | $14,074.62 |
| 50 | SIALOADENECTOMY | $7,423.68 |
| 51 | SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY | $7,413.56 |
| 52 | CLEFT LIP AND PALATE REPAIR | $5,481.71 |
| 53 | SINUS AND MASTOID PROCEDURES AGE GREATER THAN 17 | $11,422.34 |
| 54 | SINUS AND MASTOID PROCEDURES AGE 0-17 | $4,170.76 |
| 55 | MISCELLANEOUS EAR NOSE MOUTH&THROAT PROCEDURES | $8,142.43 |
| 56 | RHINOPLASTY | $7,538.41 |
| 57 | T&A PROC NO TONSILLECT&/ADENOIDECT ONLY AGE > 17 | $8,414.91 |
| 58 | T&A PROC NO TONSILLECT&/ADENOIDECT ONLY AGE 0-17 | $2,367.99 |

| DRG | Description | 2007 Amount |
|---|---|---|
| 59 | TONSILLECTOMY &OR ADENOIDECTOMY ONLY AGE > 17 | $5,746.60 |
| 60 | TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE 0-17 | $1,802.77 |
| 61 | MYRINGOTOMY WITH TUBE INSERTION AGE > 17 | $13,486.63 |
| 62 | MYRINGOTOMY WITH TUBE INSERTION AGE 0-17 | $2,553.58 |
| 63 | OTHER EAR NOSE MOUTH&THROAT OPERATING ROOM PROC | $11,775.81 |
| 64 | EAR NOSE MOUTH AND THROAT MALIGNANCY | $10,543.31 |
| 65 | DYSEQUILIBRIUM | $5,195.73 |
| 66 | EPISTAXIS | $5,297.81 |
| 67 | EPIGLOTTITIS | $6,952.95 |
| 68 | OTITIS MEDIA AND URI AGE GREATER THAN 17 WITH CC | $5,571.98 |
| 69 | OTITIS MEDIA AND URI AGE > 17 WITHOUT CC | $4,142.08 |
| 70 | OTITIS MEDIA AND URI AGE 0-17 | $3,019.24 |
| 71 | LARYNGOTRACHEITIS | $6,544.65 |
| 72 | NASAL TRAUMA AND DEFORMITY | $6,566.58 |
| 73 | OTHER EAR NOSE MOUTH&THROAT DIAGNOSES AGE > 17 | $7,170.60 |
| 74 | OTHER EAR NOSE MOUTH&THROAT DIAGNOSES AGE 0-17 | $2,902.83 |
| 75 | MAJOR CHEST PROCEDURES | $25,603.26 |
| 76 | OTH RESPIRATORY SYSTEM OPERATING ROOM PROC W/CC | $23,946.43 |
| 77 | OTH RESPIRATORY SYSTEM OP ROOM PROC WITHOUT CC | $10,027.03 |
| 78 | PULMONARY EMBOLISM | $10,424.37 |
| 79 | RESPIRATORY INFS&INFLAMMATIONS AGE > 17 W/CC | $13,723.68 |
| 80 | RESPIRATORY INF&INFLAM AGE > 17 WITHOUT CC | $7,544.31 |
| 81 | RESPIRATORY INFECTIONS&INFLAMMATIONS AGE 0-17 | $13,142.44 |
| 82 | RESPIRATORY NEOPLASMS | $11,912.48 |
| 83 | MAJOR CHEST TRAUMA WITH CC | $8,695.83 |
| 84 | MAJOR CHEST TRAUMA WITHOUT CC | $5,085.22 |
| 85 | PLEURAL EFFUSION WITH CC | $10,510.41 |
| 86 | PLEURAL EFFUSION WITHOUT CC | $6,016.56 |
| 87 | PULMONARY EDEMA AND RESPIRATORY FAILURE | $11,673.74 |
| 88 | CHRONIC OBSTRUCTIVE PULMONARY DISEASE | $7,489.48 |
| 89 | SIMPLE PNEUMONIA AND PLEURISY AGE > 17 WITH CC | $8,753.19 |
| 90 | SIMPLE PNEUMONIA&PLEURISY AGE > 17 WITHOUT CC | $5,186.45 |
| 91 | SIMPLE PNEUMONIA AND PLEURISY AGE 0-17 | $4,722.47 |
| 92 | INTERSTITIAL LUNG DISEASE WITH CC | $10,105.48 |
| 93 | INTERSTITIAL LUNG DISEASE WITHOUT CC | $6,273.85 |
| 94 | PNEUMOTHORAX WITH CC | $9,679.47 |
| 95 | PNEUMOTHORAX WITHOUT CC | $4,952.78 |
| 96 | BRONCHITIS AND ASTHMA AGE > 17 WITH CC | $6,200.46 |
| 97 | BRONCHITIS AND ASTHMA AGE > 17 WITHOUT CC | $4,579.90 |
| 98 | BRONCHITIS AND ASTHMA AGE 0-17 | $4,951.93 |
| 99 | RESPIRATORY SIGNS AND SYMPTOMS WITH CC | $6,035.96 |
| 100 | RESPIRATORY SIGNS AND SYMPTOMS WITHOUT CC | $4,564.72 |
| 101 | OTHER RESPIRATORY SYSTEM DIAGNOSES WITH CC | $7,266.77 |
| 102 | OTHER RESPIRATORY SYSTEM DIAGNOSES WITHOUT CC | $4,742.72 |
| 103 | HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYS | $159,147.67 |
| 104 | CARD VALVE&OTH MAJOR CARDIOTHOR PROC W/CARD CATH | $69,936.97 |
| 105 | CARD VALV&OTH MAJ CARDIOTHOR PROC W/O CARD CATH | $51,094.32 |
| 106 | COR BYPS W/PERQ TRANSLUMINAL COR ANGIOPLASTY | $56,844.30 |
| 108 | OTHER CARDIOTHORACIC PROCEDURES | $48,544.12 |
| 110 | MAJOR CARDIOVASCULAR PROCEDURES WITH CC | $32,110.79 |
| 111 | MAJOR CARDIOVASCULAR PROCEDURES WITHOUT CC | $20,987.92 |
| 113 | AMP CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB&TOE | $27,540.17 |
| 114 | UPPER LIMB&TOE AMP CIRCULATORY SYSTEM DISORDERS | $14,785.78 |
| 117 | CARDIAC PACEMAKER REV EXCEPT DEVICE REPLACEMENT | $11,568.29 |

| DRG | Description | 2007 Amount |
|---|---|---|
| 118 | CARDIAC PACEMAKER DEVICE REPLACEMENT | $14,077.15 |
| 119 | VEIN LIGATION AND STRIPPING | $12,277.75 |
| 120 | OTHER CIRCULATORY SYSTEM OPERATING ROOM PROC | $20,392.34 |
| 121 | CIRC D/O W/ACUTE MI&MAJOR COMPS DISCHARGED ALIVE | $13,637.64 |
| 122 | CIRC D/O W/ACUTE MI W/O MAJ COMPS DISCHRGD ALIVE | $8,116.28 |
| 123 | CIRCULATORY DISORDERS WITH ACUTE MI EXPIRED | $12,571.33 |
| 124 | CIRC D/O EXCEPT ACUTE MI W/CARD CATH&COMPLEX DX | $11,893.92 |
| 125 | CIRC D/O NO ACUTE MI W/CARD CATH W/O COMPLEX DX | $8,883.11 |
| 126 | ACUTE AND SUBACUTE ENDOCARDITIS | $22,484.47 |
| 127 | HEART FAILURE AND SHOCK | $8,849.36 |
| 128 | DEEP VEIN THROMBOPHLEBITIS | $6,326.16 |
| 129 | CARDIAC ARREST UNEXPLAINED | $8,535.54 |
| 130 | PERIPHERAL VASCULAR DISORDERS WITH CC | $8,193.04 |
| 131 | PERIPHERAL VASCULAR DISORDERS WITHOUT CC | $4,854.92 |
| 132 | ATHEROSCLEROSIS WITH CC | $5,329.86 |
| 133 | ATHEROSCLEROSIS WITHOUT CC | $4,634.74 |
| 134 | HYPERTENSION | $5,221.04 |
| 135 | CARD CONGENITAL&VALVULAR DISORDERS AGE > 17 W/CC | $7,934.06 |
| 136 | CARD CONGEN&VALVULAR D/O AGE > 17 WITHOUT CC | $5,550.89 |
| 137 | CARDIAC CONGENITAL&VALVULAR DISORDERS AGE 0-17 | $7,080.33 |
| 138 | CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS W/CC | $7,056.71 |
| 139 | CARD ARRHYTHMIA&CONDUCTION DISORDERS WITHOUT CC | $4,468.55 |
| 140 | ANGINA PECTORIS | $4,252.59 |
| 141 | SYNCOPE AND COLLAPSE WITH CC | $6,439.20 |
| 142 | SYNCOPE AND COLLAPSE WITHOUT CC | $5,071.72 |
| 143 | CHEST PAIN | $4,755.37 |
| 144 | OTHER CIRCULATORY SYSTEM DIAGNOSES WITH CC | $11,288.21 |
| 145 | OTHER CIRCULATORY SYSTEM DIAGNOSES WITHOUT CC | $4,921.56 |
| 146 | RECTAL RESECTION WITH CC | $23,140.79 |
| 147 | RECTAL RESECTION WITHOUT CC | $12,758.61 |
| 149 | MAJOR SMALL&LARGE BOWEL PROCEDURES WITHOUT CC | $12,111.57 |
| 150 | PERITONEAL ADHESIOLYSIS WITH CC | $23,511.98 |
| 151 | PERITONEAL ADHESIOLYSIS WITHOUT CC | $10,851.23 |
| 152 | MINOR SMALL AND LARGE BOWEL PROCEDURES WITH CC | $15,909.45 |
| 153 | MINOR SMALL&LARGE BOWEL PROCEDURES WITHOUT CC | $9,265.26 |
| 155 | STOMACH ESOPH&DUODEN PROC AGE > 17 WITHOUT CC | $10,922.93 |
| 156 | STOMACH ESOPHAGEAL&DUODENAL PROCEDURES AGE 0-17 | $7,292.08 |
| 157 | ANAL AND STOMAL PROCEDURES WITH CC | $11,329.55 |
| 158 | ANAL AND STOMAL PROCEDURES WITHOUT CC | $5,548.36 |
| 159 | HERNIA PROC NO INGUINAL&FEMORAL AGE > 17 W/CC | $12,076.98 |
| 160 | HERNIA PROC NO ING&FEMORAL AGE > 17 WITHOUT CC | $7,318.23 |
| 161 | INGUINAL&FEMORAL HERNIA PROCEDURES AGE > 17 W/CC | $10,463.17 |
| 162 | INGUINAL&FEMORAL HERNIA PROC AGE > 17 WITHOUT CC | $5,834.34 |
| 163 | HERNIA PROCEDURES AGE 0-17 | $5,744.07 |
| 164 | APPY W/COMPLICATED PRINCIPAL DIAGNOSIS W/CC | $18,115.47 |
| 165 | APPY W/COMP PRINCIPAL DIAGNOSIS WITHOUT CC | $9,990.75 |
| 166 | APPY WITHOUT COMP PRINCIPAL DIAGNOSIS W/CC | $11,839.93 |
| 167 | APPY WITHOUT COMP PRINCIPAL DX WITHOUT CC | $7,593.24 |
| 168 | MOUTH PROCEDURES WITH CC | $10,820.86 |
| 169 | MOUTH PROCEDURES WITHOUT CC | $6,478.00 |
| 170 | OTHER DIGESTIVE SYSTEM OPERATING ROOM PROC W/CC | $25,241.36 |
| 171 | OTH DIGESTIVE SYSTEM OP ROOM PROC WITHOUT CC | $10,327.35 |
| 172 | DIGESTIVE MALIGNANCY WITH CC | $12,057.57 |
| 173 | DIGESTIVE MALIGNANCY WITHOUT CC | $6,449.32 |

| DRG | Description | 2007 Amount |
|---|---|---|
| 174 | GASTROINTESTINAL HEMORRHAGE WITH CC | $8,685.71 |
| 175 | GASTROINTESTINAL HEMORRHAGE WITHOUT CC | $4,899.63 |
| 176 | COMPLICATED PEPTIC ULCER | $9,511.59 |
| 177 | UNCOMPLICATED PEPTIC ULCER WITH CC | $7,873.32 |
| 178 | UNCOMPLICATED PEPTIC ULCER WITHOUT CC | $5,820.84 |
| 179 | INFLAMMATORY BOWEL DISEASE | $9,114.25 |
| 180 | GASTROINTESTINAL OBSTRUCTION WITH CC | $8,376.95 |
| 181 | GASTROINTESTINAL OBSTRUCTION WITHOUT CC | $4,879.38 |
| 182 | ESOPHAGIT GASTRONTERIT&MISC DIGESTV D/O >17 W/CC | $6,624.79 |
| 183 | ESOPHAGIT GASTRONTRIT&MISC DIGESTV D/O >17 NO CC | $4,927.47 |
| 184 | ESOPHAGIT GASTROENTRIT&MISC DIGESTV D/O AGE 0-17 | $5,223.57 |
| 185 | DENTAL&ORAL DISEASE NO EXTRACTS&RESTS AGE > 17 | $7,496.23 |
| 186 | DENTAL&ORAL DISEASE NO EXTRACS&RESTS AGE 0-17 | $2,778.82 |
| 187 | DENTAL EXTRACTIONS AND RESTORATIONS | $7,103.96 |
| 188 | OTHER DIGESTIVE SYSTEM DIAGNOSES AGE > 17 W/CC | $9,221.39 |
| 189 | OTHER DIGESTIVE SYSTEM DIAGNOSES AGE > 17 W/O CC | $4,990.74 |
| 190 | OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17 | $5,357.70 |
| 191 | PANCREAS LIVER AND SHUNT PROCEDURES WITH CC | $33,224.34 |
| 192 | PANCREAS LIVER AND SHUNT PROCEDURES WITHOUT CC | $14,121.86 |
| 193 | BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W/CC | $28,539.83 |
| 194 | BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W/O CC | $13,395.52 |
| 195 | CHOLECYSTECTOMY W/COMMON DUCT EXPLORATION W/CC | $25,730.64 |
| 196 | CHOLECT W/COMMON DUCT EXPLORATION WITHOUT CC | $13,001.56 |
| 197 | CHOLECT NO LAPAROSCOPE W/O COMMON DUCT EXPL W/CC | $21,526.98 |
| 198 | CHOLECT NO LAPAROSCOPE W/O CMN DUCT EXPL W/O CC | $9,938.45 |
| 199 | HEPATOBILIARY DIAGNOSTIC PROCEDURE MALIGNANCY | $18,854.46 |
| 200 | HEPATOBILIARY DIAGNOSTIC PROC NON-MALIGNANCY | $23,959.93 |
| 201 | OTHER HEPATOBILIARY/PANCREAS OPERATING ROOM PROC | $31,976.66 |
| 202 | CIRRHOSIS AND ALCOHOLIC HEPATITIS | $11,300.87 |
| 203 | MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS | $11,533.70 |
| 204 | DISORDERS OF PANCREAS EXCEPT MALIGNANCY | $9,270.32 |
| 205 | D/O LIVER NO MALIG CIRRHOSIS&ALCOHOLIC HEP W/CC | $10,134.17 |
| 206 | D/O LIVR NO MALIG CIRRHOSIS&ALCOHOLIC HEP W/O CC | $6,147.31 |
| 207 | DISORDERS OF THE BILIARY TRACT WITH CC | $9,987.38 |
| 208 | DISORDERS OF THE BILIARY TRACT WITHOUT CC | $5,812.40 |
| 210 | HIP&FEMUR PROC EXCEPT MAJOR JOINT AGE > 17 W/CC | $16,046.96 |
| 211 | HIP&FEM PROC EXCEPT MAJ JOINT AGE > 17 W/O CC | $10,915.34 |
| 212 | HIP&FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17 | $7,730.75 |
| 213 | AMP MUSCULOSKELETAL SYSTEM&CONNECTIVE TISSUE D/O | $17,862.39 |
| 216 | BX MUSCULOSKELETAL SYSTEM&CONNECTIVE TISSUE | $15,812.44 |
| 217 | WND DEBRID&SKN GFT NO HND MSK&CNCTV TISS D/O | $25,728.96 |
| 218 | LOW EXT&HUM PROC NO HIP FOOT&FEM AGE > 17 W/CC | $14,385.91 |
| 219 | LOW EXT&HUM PROC NO HIP FOOT&FEM AGE > 17 W/O CC | $9,307.44 |
| 220 | LOWER EXTREM&HUM PROC NO HIP FOOT&FEM AGE 0-17 | $5,051.48 |
| 223 | MAJOR SHLDR/ELB PROC/OTH UPPER EXTREM PROC W/CC | $9,892.05 |
| 224 | SHLDR ELB/FOREARM PROC NO MAJ JOINT PROC W/O CC | $7,233.03 |
| 225 | FOOT PROCEDURES | $10,776.99 |
| 226 | SOFT TISSUE PROCEDURES WITH CC | $13,784.42 |
| 227 | SOFT TISSUE PROCEDURES WITHOUT CC | $7,270.14 |
| 228 | MAJOR THUMB/JOINT PROC/OTH HAND/WRIST PROC W/CC | $9,725.02 |
| 229 | HAND/WRIST PROC NO MAJOR JOINT PROC WITHOUT CC | $6,080.67 |
| 230 | LOCAL EXCISION&REMOVAL INTRL FIX DEVICES HIP&FEM | $11,291.59 |
| 232 | ARTHROSCOPY | $8,209.92 |
| 233 | OTH MUSCULOSKEL SYS&CNCTV TISS OR PROC W/CC | $16,056.24 |

| DRG | Description | 2007 Amount |
|---|---|---|
| 234 | OTH MUSCULOSKEL SYS&CNCTV TISS OR PROC W/O CC | $10,599.83 |
| 235 | FRACTURES OF FEMUR | $6,939.45 |
| 236 | FRACTURES OF HIP AND PELVIS | $6,485.60 |
| 237 | SPRAINS STRAINS&DISLOCATIONS OF HIP PELVIS&THIGH | $5,544.98 |
| 238 | OSTEOMYELITIS | $11,894.76 |
| 239 | PATH FX&MUSCULOSKEL&CONNECTIVE TISSUE MALIG | $9,450.85 |
| 240 | CONNECTIVE TISSUE DISORDERS WITH CC | $11,647.59 |
| 241 | CONNECTIVE TISSUE DISORDERS WITHOUT CC | $5,598.97 |
| 242 | SEPTIC ARTHRITIS | $9,317.56 |
| 243 | MEDICAL BACK PROBLEMS | $6,723.49 |
| 244 | BONE DISEASES AND SPECIFIC ARTHROPATHIES WITH CC | $6,237.58 |
| 245 | BONE DISEASES&SPECIFIC ARTHROPATHIES WITHOUT CC | $4,169.91 |
| 246 | NONSPECIFIC ARTHROPATHIES | $5,323.96 |
| 247 | SIGNS&SX MUSCULOSKEL SYSTEM&CONNECTIVE TISSUE | $5,005.92 |
| 248 | TENDONITIS MYOSITIS AND BURSITIS | $7,487.79 |
| 249 | AFTERCARE MUSCULOSKEL SYSTEM&CONNECTIVE TISSUE | $6,332.06 |
| 250 | FX SPRAIN STRN&DISLOC FORARM HND/FOOT >17 W/CC | $6,099.23 |
| 251 | FX SPRAIN STRN&DISLOC FORARM HND/FOOT >17 W/O CC | $4,320.92 |
| 252 | FX SPRAIN STRN&DISLOC FOREARM HAND/FOOT 0-17 | $2,193.36 |
| 253 | FX SPRAIN STRN&DISLOC UP ARM&LW LEG NO FT >17 CC | $6,900.65 |
| 254 | FX SPRAIN&DISLOC UP ARM&LW LEG NO FT >17 W/O CC | $4,199.44 |
| 255 | FX SPRAIN STRN&DISLOC UP ARM&LW LEG NO FT 0-17 | $2,554.42 |
| 256 | OTH MUSCULOSKEL SYSTEM&CNCTV TISSUE DIAGNOSES | $7,351.13 |
| 257 | TOTAL MASTECTOMY FOR MALIGNANCY WITH CC | $7,696.16 |
| 258 | TOTAL MASTECTOMY FOR MALIGNANCY WITHOUT CC | $6,014.87 |
| 259 | SUBTOTAL MASTECTOMY FOR MALIGNANCY WITH CC | $8,486.62 |
| 260 | SUBTOTAL MASTECTOMY FOR MALIGNANCY WITHOUT CC | $5,752.51 |
| 261 | BREAST PROC NON-MALIGNANCY NO BX&LOCAL EXCISION | $8,043.73 |
| 262 | BREAST BIOPSY AND LOCAL EXCISION NON-MALIGNANCY | $8,116.28 |
| 263 | SKIN GRAFT &/ DEBRID SKIN ULCER/CELLULITIS W/CC | $17,909.63 |
| 264 | SKIN GFT &/ DEBRID SKIN ULCER/CELLULITIS W/O CC | $9,262.73 |
| 265 | SKN GFT &/ DEBRID NO SKN ULCER/CELLULITIS W/CC | $14,299.86 |
| 266 | SKN GFT &/ DEBRID NO SKN ULCR/CELLULITIS W/O CC | $7,707.13 |
| 267 | PERIANAL AND PILONIDAL PROCEDURES | $7,966.96 |
| 268 | SKIN SUBCUTANEOUS TISSUE&BREAST PLASTIC PROC | $10,307.95 |
| 269 | OTHER SKIN SUBCUTANEOUS TISSUE&BREAST PROC W/CC | $15,117.31 |
| 270 | OTH SKIN SUBQ TISSUE&BREAST PROC WITHOUT CC | $6,925.11 |
| 271 | SKIN ULCERS | $9,079.67 |
| 272 | MAJOR SKIN DISORDERS WITH CC | $8,736.32 |
| 273 | MAJOR SKIN DISORDERS WITHOUT CC | $4,937.59 |
| 274 | MALIGNANT BREAST DISORDERS WITH CC | $9,545.33 |
| 275 | MALIGNANT BREAST DISORDERS WITHOUT CC | $5,022.79 |
| 276 | NONMALIGNANT BREAST DISORDERS | $6,267.95 |
| 277 | CELLULITIS AGE GREATER THAN 17 WITH CC | $7,556.97 |
| 278 | CELLULITIS AGE GREATER THAN 17 WITHOUT CC | $4,765.50 |
| 279 | CELLULITIS AGE 0-17 | $6,683.00 |
| 280 | TRAUMA SKIN SUBQ TISSUE&BREAST AGE > 17 W/CC | $6,509.22 |
| 281 | TRAUMA SKIN SUBQ TISSUE&BREAST AGE > 17 W/O CC | $4,392.63 |
| 282 | TRAUMA SKIN SUBCUTANEOUS TISSUE&BREAST AGE 0-17 | $2,221.20 |
| 283 | MINOR SKIN DISORDERS WITH CC | $6,415.58 |
| 284 | MINOR SKIN DISORDERS WITHOUT CC | $3,867.06 |
| 285 | AMP LOWER LIMB ENDOCRN NUTRITIONAL&METABOLIC D/O | $18,368.55 |
| 286 | ADRENAL AND PITUITARY PROCEDURES | $16,111.07 |
| 287 | SKIN GFT&WOUND DEBRID ENDOCRN NUTRIT&METAB D/O | $16,456.11 |

| DRG | Description | 2007 Amount |
|---|---|---|
| 288 | OPERATING ROOM PROCEDURES FOR OBESITY | $16,138.07 |
| 289 | PARATHYROID PROCEDURES | $7,799.08 |
| 290 | THYROID PROCEDURES | $7,428.74 |
| 291 | THYROGLOSSAL PROCEDURES | $4,934.22 |
| 292 | OTH ENDOCRN NUTRIT&METAB OP ROOM PROC W/CC | $22,764.55 |
| 293 | OTH ENDOCRN NUTRIT&METAB OP ROOM PROC WITHOUT CC | $11,736.16 |
| 294 | DIABETES AGE GREATER THAN 35 | $6,638.29 |
| 295 | DIABETES AGE 0-35 | $6,457.76 |
| 296 | NUTRITIONAL&MISC METAB D/O AGE > 17 W/CC | $7,030.56 |
| 297 | NUTRITIONAL&MISC METAB D/O AGE > 17 WITHOUT CC | $4,293.92 |
| 298 | NUTRITIONAL&MISCELLANEOUS METABOLIC D/O AGE 0-17 | $4,853.23 |
| 299 | INBORN ERRORS OF METABOLISM | $8,849.36 |
| 300 | ENDOCRINE DISORDERS WITH CC | $9,442.41 |
| 301 | ENDOCRINE DISORDERS WITHOUT CC | $5,237.91 |
| 302 | KIDNEY TRANSPLANT | $26,279.83 |
| 303 | KIDNEY URETER&MAJOR BLADDER PROCEDURES NEOPLASM | $16,683.03 |
| 304 | KIDNEY URETER&MAJOR BLADD PROC NON-NEOPLSM W/CC | $19,801.82 |
| 305 | KIDNEY URETER&MAJ BLADD PROC NON-NEOPLSM W/O CC | $9,718.27 |
| 306 | PROSTATECTOMY WITH CC | $11,295.80 |
| 307 | PROSTATECTOMY WITHOUT CC | $5,408.32 |
| 308 | MINOR BLADDER PROCEDURES WITH CC | $12,311.50 |
| 309 | MINOR BLADDER PROCEDURES WITHOUT CC | $7,610.96 |
| 310 | TRANSURETHRAL PROCEDURES WITH CC | $10,233.71 |
| 311 | TRANSURETHRAL PROCEDURES WITHOUT CC | $5,527.27 |
| 312 | URETHRAL PROCEDURES AGE GREATER THAN 17 WITH CC | $9,926.64 |
| 313 | URETHRAL PROCEDURES AGE > 17 WITHOUT CC | $6,297.47 |
| 314 | URETHRAL PROCEDURES AGE 0-17 | $4,282.11 |
| 315 | OTHER KIDNEY&URINARY TRACT OPERATING ROOM PROC | $17,861.54 |
| 316 | RENAL FAILURE | $10,631.05 |
| 317 | ADMISSION FOR RENAL DIALYSIS | $6,805.32 |
| 318 | KIDNEY AND URINARY TRACT NEOPLASMS WITH CC | $10,440.39 |
| 319 | KIDNEY AND URINARY TRACT NEOPLASMS WITHOUT CC | $5,132.46 |
| 320 | KIDNEY AND UTIS AGE GREATER THAN 17 WITH CC | $7,397.53 |
| 321 | KIDNEY AND UTIS AGE GREATER THAN 17 WITHOUT CC | $4,886.97 |
| 322 | KIDNEY AND URINARY TRACT INFECTIONS AGE 0-17 | $5,196.58 |
| 323 | URINARY STONES WITH CC &/ ESW LITHOTRIPSY | $6,967.29 |
| 324 | URINARY STONES WITHOUT CC | $4,259.34 |
| 325 | KIDNEY&URINARY TRACT SIGNS&SX AGE > 17 W/CC | $5,824.21 |
| 326 | KIDNEY&URIN TRACT SIGNS&SX AGE > 17 WITHOUT CC | $3,833.32 |
| 327 | KIDNEY&URINARY TRACT SIGNS&SYMPTOMS AGE 0-17 | $1,779.15 |
| 328 | URETHRAL STRICTURE AGE GREATER THAN 17 WITH CC | $6,153.22 |
| 329 | URETHRAL STRICTURE AGE > 17 WITHOUT CC | $4,385.03 |
| 330 | URETHRAL STRICTURE AGE 0-17 | $2,756.88 |
| 331 | OTH KIDNEY&URINARY TRACT DIAGNOSES AGE > 17 W/CC | $9,245.86 |
| 332 | OTH KIDNEY&URIN TRACT DIAGNOSES AGE > 17 W/O CC | $5,276.72 |
| 333 | OTHER KIDNEY&URINARY TRACT DIAGNOSES AGE 0-17 | $8,579.41 |
| 334 | MAJOR MALE PELVIC PROCEDURES WITH CC | $11,980.81 |
| 335 | MAJOR MALE PELVIC PROCEDURES WITHOUT CC | $9,426.39 |
| 336 | TRANSURETHRAL PROSTATECTOMY WITH CC | $7,234.71 |
| 337 | TRANSURETHRAL PROSTATECTOMY WITHOUT CC | $4,957.84 |
| 338 | TESTES PROCEDURES FOR MALIGNANCY | $11,639.15 |
| 339 | TESTES PROCEDURES NON-MALIGNANCY AGE > 17 | $10,589.71 |
| 340 | TESTES PROCEDURES FOR NON-MALIGNANCY AGE 0-17 | $2,449.81 |
| 341 | PENIS PROCEDURES | $11,320.27 |

| DRG | Description | 2007 Amount |
|---|---|---|
| 342 | CIRCUMCISION AGE GREATER THAN 17 | $6,835.69 |
| 343 | CIRCUMCISION AGE 0-17 | $1,332.04 |
| 344 | OTHER MALE REPRODUCTIVE SYSTEM OR PROC MALIG | $10,227.81 |
| 345 | OTHER MALE REPRODUCTIVE SYSTEM OR PROC NO MALIG | $10,955.83 |
| 346 | MALIGNANCY OF MALE REPRODUCTIVE SYSTEM WITH CC | $9,040.02 |
| 347 | MALIGNANCY MALE REPRODUCTIVE SYSTEM WITHOUT CC | $4,542.79 |
| 348 | BENIGN PROSTATIC HYPERTROPHY WITH CC | $6,267.10 |
| 349 | BENIGN PROSTATIC HYPERTROPHY WITHOUT CC | $3,893.21 |
| 350 | INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM | $6,536.21 |
| 351 | MALE STERILIZATION | $2,043.20 |
| 352 | OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES | $6,596.11 |
| 353 | PELV EVISCERATION RADL HYST&RADL VULVECTOMY | $15,346.77 |
| 354 | UTERN&ADNEXA PROC NON-OVARIAN/ADNEXAL MALIG W/CC | $12,625.32 |
| 355 | UTERN&ADNEXA PROC NON-OVARIAN/ADNEXAL MAL W/O CC | $7,654.83 |
| 356 | FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROC | $6,386.90 |
| 357 | UTERINE&ADNEXA PROC OVARIAN/ADNEXAL MALIGNANCY | $18,770.10 |
| 358 | UTERINE AND ADNEXA PROCEDURES NONMALIGNANCY W/CC | $9,632.22 |
| 359 | UTERINE&ADNEXA PROC NONMALIGNANCY WITHOUT CC | $6,793.51 |
| 360 | VAGINA CERVIX AND VULVA PROCEDURES | $7,432.96 |
| 361 | LAPAROSCOPY AND INCISIONAL TUBAL INTERRUPTION | $8,964.09 |
| 362 | ENDOSCOPIC TUBAL INTERRUPTION | $2,611.79 |
| 363 | D&C CONIZATION & RADIO IMPLANT MALIGNANCY | $9,303.22 |
| 364 | DILATION&CURETTAGE CONIZATION EXCEPT MALIGNANCY | $7,538.41 |
| 365 | OTHER FEMALE REPRODUCTIVE SYSTEM OR PROC | $17,300.55 |
| 366 | MALIGNANCY OF FEMALE REPRODUCTIVE SYSTEM WITH CC | $10,516.32 |
| 367 | MALIGNANCY FEMALE REPRODUCTIVE SYSTEM WITHOUT CC | $4,947.71 |
| 368 | INFECTIONS FEMALE REPRODUCTIVE SYSTEM | $9,867.59 |
| 369 | MENSTRUAL&OTH FEMALE REPRODUCTIVE SYSTEM D/O | $5,566.07 |
| 370 | CESAREAN SECTION WITH CC | $7,594.09 |
| 371 | CESAREAN SECTION WITHOUT CC | $5,538.23 |
| 372 | VAGINAL DELIVERY WITH COMPLICATING DIAGNOSES | $4,774.78 |
| 373 | VAGINAL DELIVERY WITHOUT COMPLICATING DIAGNOSES | $3,299.32 |
| 374 | VAGINAL DELIV W/STERILIZATION &/ DILATION&CURET | $5,487.62 |
| 375 | VAGINAL DELIV W/OR PROC EXCEPT STERILIZ &/ D&C | $9,492.19 |
| 376 | POSTPARTUM&POSTABORTION DIAGNOSES W/O OR PROC | $5,188.14 |
| 377 | POSTPARTUM&POSTABORTION DIAGNOSES W/OR PROC | $10,508.73 |
| 378 | ECTOPIC PREGNANCY | $6,042.71 |
| 379 | THREATENED ABORTION | $3,490.82 |
| 380 | ABORTION WITHOUT DILATION AND CURETTAGE | $3,737.15 |
| 381 | ABORTION W/D&C ASPIRATION CURETTAGE/HYSTEROTOMY | $5,964.25 |
| 382 | FALSE LABOR | $1,532.82 |
| 383 | OTH ANTEPARTUM DIAGNOSES W/MEDICAL COMPLICATIONS | $4,304.89 |
| 384 | OTH ANTEPARTUM DIAGNOSES W/O MEDICAL COMPS | $3,197.24 |
| 385 | NEONATES DIED/TRNSF ANOTHER ACUTE CARE FACILITY | $11,900.67 |
| 386 | EXTREME IMMATURITY/RESP DISTRESS SYND OF NEONATE | $39,243.43 |
| 387 | PREMATURITY WITH MAJOR PROBLEMS | $26,802.02 |
| 388 | PREMATURITY WITHOUT MAJOR PROBLEMS | $16,171.81 |
| 389 | FULL-TERM NEONATE WITH MAJOR PROBLEMS | $27,531.73 |
| 390 | NEONATES WITH OTHER SIGNIFICANT PROBLEMS | $9,744.42 |
| 391 | NORMAL NEWBORN | $1,319.39 |
| 392 | SPLENECTOMY AGE GREATER THAN 17 | $25,478.41 |
| 393 | SPLENECTOMY AGE 0-17 | $11,657.71 |
| 394 | OTHER OR PROCEDURES BLOOD&BLOOD FORMING ORGANS | $16,280.64 |
| 395 | RED BLOOD CELL DISORDERS AGE GREATER THAN 17 | $6,742.05 |

| DRG | Description | 2007 Amount |
|---|---|---|
| 396 | RED BLOOD CELL DISORDERS AGE 0-17 | $5,613.31 |
| 397 | COAGULATION DISORDERS | $11,192.04 |
| 398 | RETICULOENDOTHELIAL AND IMMUNITY DISORDERS W/CC | $9,506.53 |
| 399 | RETICULOENDOTHELIAL&IMMUNITY D/O WITHOUT CC | $5,668.99 |
| 401 | LYMPHOMA&NONACUTE LEUKEM W/OTH OR PROC W/CC | $25,014.43 |
| 402 | LYMPHOMA&NONACUTE LEUKEM W/OTH OR PROC W/O CC | $9,795.88 |
| 403 | LYMPHOMA AND NONACUTE LEUKEMIA WITH CC | $15,712.05 |
| 404 | LYMPHOMA AND NONACUTE LEUKEMIA WITHOUT CC | $7,781.37 |
| 405 | ACUTE LEUKEMIA WITHOUT MAJOR OR PROC AGE 0-17 | $16,527.81 |
| 406 | MYELOPROLIFERATIVE D/O /PD NEO MAJ OR PROC W/CC | $22,946.76 |
| 407 | MYELOPROLIFERATIVE D/O /PD NEO MAJ OR PROC NO CC | $9,739.36 |
| 408 | MYELOPROLIFERATIVE D/O /PD NEOPLASMS OTH OR PROC | $18,264.78 |
| 409 | RADIOTHERAPY | $10,922.93 |
| 410 | CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DX | $9,201.99 |
| 411 | HISTORY OF MALIGNANCY WITHOUT ENDOSCOPY | $3,105.29 |
| 412 | HISTORY OF MALIGNANCY WITH ENDOSCOPY | $7,220.37 |
| 413 | OTH MYELOPROLIFERATIVE D/O /PD NEOPLASM DX W/CC | $11,259.53 |
| 414 | OTH MYELOPROLIFERATVE D/O /PD NEOPLASM DX W/O CC | $6,477.16 |
| 417 | SEPTICEMIA AGE 0-17 | $15,894.27 |
| 418 | POSTOPERATIVE AND POST-TRAUMATIC INFECTIONS | $9,273.69 |
| 419 | FEVER OF UNKNOWN ORIGIN AGE > 17 WITH CC | $7,266.77 |
| 420 | FEVER OF UNKNOWN ORIGIN AGE > 17 WITHOUT CC | $5,025.33 |
| 421 | VIRAL ILLNESS AGE GREATER THAN 17 | $6,535.37 |
| 422 | VIRAL ILLNESS&FEVER OF UNKNOWN ORIGIN AGE 0-17 | $5,210.07 |
| 423 | OTHER INFECTIOUS AND PARSITIC DISEASES DIAGNOSES | $15,504.52 |
| 424 | OP ROOM PROC W/PRINCIPAL DX MENTAL ILLNESS | $18,970.03 |
| 425 | ACUTE ADJ REACTIONS & PSYCHOSOCIAL DYSFUNCTION | $5,313.84 |
| 426 | DEPRESSIVE NEUROSES | $4,320.92 |
| 427 | NEUROSES EXCEPT DEPRESSIVE | $4,707.29 |
| 428 | DISORDERS OF PERSONALITY AND IMPULSE CONTROL | $6,577.55 |
| 429 | ORGANIC DISTURBANCES AND MENTAL RETARDATION | $7,076.12 |
| 430 | PSYCHOSES | $6,125.38 |
| 431 | CHILDHOOD MENTAL DISORDERS | $5,676.58 |
| 432 | OTHER MENTAL DISORDER DIAGNOSES | $5,577.04 |
| 433 | ALCOHOL/DRUG ABUSE/DEPENDENCE LEFT AMA | $2,770.38 |
| 439 | SKIN GRAFTS FOR INJURIES | $16,088.30 |
| 440 | WOUND DEBRIDEMENTS FOR INJURIES | $16,273.89 |
| 441 | HAND PROCEDURES FOR INJURIES | $8,368.51 |
| 442 | OTHER OPERATING ROOM PROCEDURES INJURIES WITH CC | $21,539.64 |
| 443 | OTHER OPERATING ROOM PROC INJURIES WITHOUT CC | $8,856.11 |
| 444 | TRAUMATIC INJURY AGE GREATER THAN 17 WITH CC | $6,575.86 |
| 445 | TRAUMATIC INJURY AGE GREATER THAN 17 WITHOUT CC | $4,471.92 |
| 446 | TRAUMATIC INJURY AGE 0-17 | $2,562.01 |
| 447 | ALLERGIC REACTIONS AGE GREATER THAN 17 | $4,840.58 |
| 448 | ALLERGIC REACTIONS AGE 0-17 | $843.60 |
| 449 | POISONING & TOXIC EFFECTS OF DRUGS AGE > 17 W/CC | $7,366.32 |
| 450 | POISONING & TOXIC EFFECTS RX AGE > 17 WITHOUT CC | $3,728.71 |
| 451 | POISONING AND TOXIC EFFECTS OF DRUGS AGE 0-17 | $2,275.19 |
| 452 | COMPLICATIONS OF TREATMENT WITH CC | $9,014.71 |
| 453 | COMPLICATIONS OF TREATMENT WITHOUT CC | $4,468.55 |
| 454 | OTH INJURY POISONING&TOXIC EFFECT DIAGNOSIS W/CC | $7,268.46 |
| 455 | OTH INJURY POISONING&TOXIC EFFECT DX WITHOUT CC | $4,103.27 |
| 461 | OR PROC W/DIAGNOSES OTH CONTACT W/HEALTH SRVC | $13,250.43 |
| 462 | REHABILITATION | $7,980.46 |

| DRG | Description | 2007 Amount |
|---|---|---|
| 463 | SIGNS AND SYMPTOMS WITH CC | $6,038.49 |
| 464 | SIGNS AND SYMPTOMS WITHOUT CC | $4,446.62 |
| 465 | AFTERCARE W/HISTORY MALIGNANCY AS SEC DIAGNOSIS | $5,022.79 |
| 466 | AFTERCARE WITHOUT HISTORY MALIGNANCY AS SEC DX | $6,440.04 |
| 467 | OTHER FACTORS INFLUENCING HEALTH STATUS | $4,014.69 |
| 468 | EXT OPERATING ROOM PROC UNRELATED PRINCIPAL DX | $33,680.73 |
| 469 | PRINCIPAL DIAGNOSIS INVALID AS DISCHRG DIAGNOSIS | $0.00 |
| 470 | UNGROUPABLE | $0.00 |
| 471 | BILATERAL/MULTIPLE MAJOR JOINT PROC LOWER EXTREM | $25,665.69 |
| 473 | ACUTE LEUKEMIA WITHOUT MAJ OP ROOM PROC AGE > 17 | $28,364.36 |
| 476 | PROSTATIC OP ROOM PROC UNRELATED PRINCIPAL DX | $18,267.31 |
| 477 | NON-EXT OP ROOM PROC UNRELATED PRINCIPAL DX | $17,639.68 |
| 479 | OTHER VASCULAR PROCEDURES WITHOUT CC | $12,148.68 |
| 480 | LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT | $79,379.39 |
| 481 | BONE MARROW TRANSPLANT | $53,930.50 |
| 482 | TRACHEOSTOMY FOR FACE MOUTH AND NECK DIAGNOSES | $28,252.16 |
| 484 | CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA | $42,995.76 |
| 485 | LIMB REATTACHMENT HIP & FEM PROC MX SIG TRAUMA | $29,566.49 |
| 486 | OTH OPERATING ROOM PROC MX SIGNIFICANT TRAUMA | $40,784.69 |
| 487 | OTHER MULTIPLE SIGNIFICANT TRAUMA | $15,969.35 |
| 488 | HIV WITH EXTENSIVE OPERATING ROOM PROCEDURE | $43,274.99 |
| 489 | HIV WITH MAJOR RELATED CONDITION | $15,118.16 |
| 490 | HIV WITH/WITHOUT OTHER RELATED CONDITION | $8,780.19 |
| 491 | MAJOR JOINT&LIMB REATTACHMENT PROC UPPER EXTREM | $14,512.45 |
| 492 | CHEMOTHERAPY W/ACUTE LEUKEMIA AS SEC DIAGNOSIS | $29,434.89 |
| 493 | LAP CHOLE WITHOUT COMMON DUCT EXPLORATION W/CC | $15,421.01 |
| 494 | LAP CHOLE WITHOUT COMMON DUCT EXPL WITHOUT CC | $8,705.95 |
| 495 | LUNG TRANSPLANT | $71,015.94 |
| 496 | COMBINED ANTERIOR/POSTERIOR SPINAL FUSION | $53,806.50 |
| 497 | SPINAL FUSION EXCEPT CERVICAL WITH CC | $32,218.77 |
| 498 | SPINAL FUSION EXCEPT CERVICAL WITHOUT CC | $25,220.27 |
| 499 | BACK&NECK PROCEDURES EXCEPT SPINAL FUSION W/CC | $11,715.07 |
| 500 | BACK&NECK PROC EXCEPT SPINAL FUSION WITHOUT CC | $7,780.52 |
| 501 | KNEE PROC W/PRINCIPAL DIAGNOSIS INFECTION W/CC | $22,293.82 |
| 502 | KNEE PROC W/PRINCIPAL DX INFECTION WITHOUT CC | $12,041.55 |
| 503 | KNEE PROC WITHOUT PRINCIPAL DIAGNOSIS INFECTION | $10,502.82 |
| 504 | EXT 3RD DEG BURN OR FULL THICK BRN W/SKIN GRAFT | $94,925.25 |
| 505 | EXT 3RD DEG BURN OR FULL THICK BRN W/OSKIN GRAFT | $22,211.99 |
| 506 | FULL THICK BRN W/SKN GFT/INHAL INJR W/CC/TRAUMA | $31,935.32 |
| 507 | FULL THICK BRN SKN GFT/INHAL INJR W/O CC/TRAUMA | $16,305.10 |
| 508 | FULL THICK BRN NO SKN GFT/INHAL INJR W/CC/TRAUMA | $11,942.85 |
| 509 | FULL THICK BRN W/SKN GFT/INHAL INJR NO CC/TRAUMA | $7,041.53 |
| 510 | NON-EXTENSIVE BURNS W/CC OR SIGNIFICANT TRAUMA | $10,525.60 |
| 511 | NON-EXT BURNS WITHOUT CC/SIGNIFICANT TRAUMA | $5,752.51 |
| 512 | SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT | $52,799.24 |
| 513 | PANCREAS TRANSPLANT | $33,550.82 |
| 515 | CARD DEFIBRILLATOR IMPLANT WITHOUT CARD CATH | $44,114.37 |
| 518 | PERQ CV PROC W/O AMI W/O COR ART STENT IMPLANT | $13,824.92 |
| 519 | CERVICAL FUSION WITH CC | $21,460.34 |
| 520 | CERVICAL FUSION WITHOUT CC | $14,821.21 |
| 521 | ALCOHOL/DRUG ABUSE OR DEPENDENCE WITH CC | $6,190.34 |
| 522 | ALCOHOL/DRUG ABS/DEPEND W/REHAB TX WITHOUT CC | $5,055.69 |
| 523 | ALCOHOL/DRUG ABS/DEPEND W/O REHAB TX W/O CC | $3,539.75 |
| 524 | TRANSIENT ISCHEMIA | $6,219.86 |

| DRG | Description | 2007 Amount |
|---|---|---|
| 525 | OTHER HEART ASSIST SYSTEM IMPLANT | $18,785.28 |
| 528 | INTRACRANIAL VASCULAR PROC W/PDX HEMORRHAGE | $59,580.09 |
| 529 | VENTRICULAR SHUNT PROCEDURES W/CC | $18,337.33 |
| 530 | VENTRICULAR SHUNT PROCEDURES W/O CC | $10,280.11 |
| 531 | SPINAL PROCEDURES W/CC | $26,294.17 |
| 532 | SPINAL PROCEDURES W/O CC | $12,297.16 |
| 533 | EXTRACRANIAL PROCEDURES W/CC | $13,044.59 |
| 534 | EXTRACRANIAL PROCEDURES W/O CC | $8,373.57 |
| 535 | CARD DEFIB IMPLANT W/CARD CATH W/AMI/HF/SHOCK | $62,207.91 |
| 536 | CARD DEFIB IMPLANT W/CARD CATH W/O AMI/HF/SHOCK | $55,713.87 |
| 537 | LOCAL EXC&REMV INT FIX DEVC NO HIP&FEMUR W/CC | $15,488.50 |
| 538 | LOCAL EXC&REMV INT FIX DEVC NO HIP&FEMUR W/O CC | $8,673.90 |
| 539 | LYMPHOMA & LEUKEMIA W/MAJOR OR PROCEDURE W/CC | $26,916.75 |
| 540 | LYMPHOMA & LEUKEMIA W/MJR OR PROC WO CC | $9,919.89 |
| 541 | TRACH MV 96/>HR/PRIN DX NO FCE MTH&NCK W/MJR OR | $162,436.02 |
| 542 | TRACH MV 96/>HR/PRIN DX NO FCE MTH&NCK WO/MJR OR | $98,228.78 |
| 543 | CRANOTMY W/IMPLT CHEMO AGT/ACUTE CVS DX | $36,744.69 |
| 544 | MAJOR JNT REPLACEMENT/REATTACHMENT LOWER EXTREM | $16,769.08 |
| 545 | REVISION OF HIP OR KNEE REPLACEMENT | $21,374.29 |
| 546 | SPINAL FUSION EXC CERV W/CURVATURE SPINE/MALIG | $45,395.80 |
| 547 | CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX | $51,788.60 |
| 548 | CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX | $39,176.78 |
| 549 | CORONARY BYPASS W/O CARDIAC CATH W MAJOR CV DX | $42,387.53 |
| 550 | CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX | $30,288.61 |
| 551 | PERM PACEMKR IMPL W/MAJ CV DX /AICD LEAD/GNRTR | $25,615.07 |
| 552 | OTH PERM CARD PACEMAKER IMPLANT W/O MAJOR CV DX | $17,597.50 |
| 553 | OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX | $25,412.61 |
| 554 | OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX | $17,524.10 |
| 555 | PERCUTANEOUS CARDIOVASCULAR PROC W MAJOR CV DX | $19,458.48 |
| 556 | PERQ CV PROC NON-RX-ELUT STNT W/O MAJ CV DX | $14,971.37 |
| 557 | PERQ CARDIOVASC PROC RX-ELUT STNT W/MAJ CV DX | $23,296.86 |
| 558 | PERQ CARDIOVASC PROC RX-ELUT STNT W/O MAJ CV DX | $17,558.69 |
| 559 | ACUTE ISCHEMIC STROKE W/ THRMBOLYT AGT | $19,001.25 |
| 560 | BACTERIAL&TUBERCULOSIS INFECT OF NERVOUS SYST | $24,520.08 |
| 561 | NONBCT INFECT OF NERVOUS SYSTEM EX VRL MENINGTIS | $18,716.95 |
| 562 | SEIZURE AGE > 17 W CC | $8,930.35 |
| 563 | SEIZURE AGE > 17 W/O CC | $5,432.78 |
| 564 | HEADACHES AGE >17 | $5,846.99 |
| 565 | RESP SYSTEM DX W VENTILATOR SUPPORT 96+ HOURS | $44,229.95 |
| 566 | RESP SYSTEM DX W VENTILATOR SUPPORT < 96 HRS | $19,702.28 |
| 567 | STOMACH ESPH&DUOD PROC AGE >17 W CC W MAJ GI DX | $44,044.36 |
| 568 | STOMACH ESPH&DUOD PROC AGE >17 W CC W/O MJ GI DX | $28,400.64 |
| 569 | MAJ SML & LG BOWEL PROC W CC W MAJ GI DX | $36,635.02 |
| 570 | MAJ SML&LG BOWEL PROC W CC W/O MAJ GI DX | $22,774.67 |
| 571 | MAJOR ESOPHAGEAL DISORDERS | $9,371.55 |
| 572 | MAJ GI DISORDERS AND PERITONEAL INFECTIONS | $11,285.68 |
| 573 | MAJOR BLADDER PROCEDURES | $28,251.32 |
| 574 | MAJ HEMAT/IMMUNO DX EXC SICKLE CELL&COAGUL | $10,716.25 |
| 575 | SEPTICEMIA W MV96+ HOURS AGE >17 | $50,374.73 |
| 576 | SEPTICEMIA W/O MV96+ HOURS AGE >17 | $13,494.23 |
| 577 | CAROTID ARTERY STENT PROCEDURE | $15,065.85 |
| 578 | INFECTIOUS & PARASITIC DISEASES W OR PROCEDURE | $41,041.14 |
| 579 | POSTOP OR POST-TRAUMA INFECT W OR PROC (12/2006) | $23,964.99 |

# Forms

## I. Guidelines

A. Reproduced on the following pages are the forms that should or may be used by providers when billing workers' compensation related services. Instructions are given below.

B. Bills for services rendered should be sent directly to the party responsible for reimbursement. Do not send bills directly to the Medical Cost Containment Division as this will delay payment.

C. The following forms should be used for provider reimbursement:

- CMS-1500 (08/05) (Projected to be effective June 1, 2007 pending correction of printed format) Electronic equivalent 837p
- UB-04 (effective May 23, 2007) Electronic equivalent 837i
- J400 2006-Dental Form

D. The information to include on each form where appropriate is:

1. Claimant's full name and address as shown on the employer's record
2. Social security number should be entered in the field for insured's ID number; this cuts down on errors and helps correlate the billing to the appropriate file
3. Correct date of injury. Some claimants have multiple open files and can only be assigned by date
4. Proper name and address of the employer, not just an individual's name
5. Name of the insurance payer as registered with the state
6. Date the claimant's disability should begin per the attending physician
7. Attending physician's diagnoses and claimant's complaints
8. Disabilities the claimant has that are not related to this injury
9. Description of treatment plan, including any prescriptions
10. Indication if the injury/illness appears to be work related
11. Indication as to whether the claimant can be released to light or full duty work; full duty is considered to be the work at the time of the accident
12. Length of time the claimant should be off work as a result of the injury or illness
13. Date of the visit, the service(s) or procedure(s) performed, and charges
14. Physician's complete name and address
15. Physician and provider group national provider identifier (NPI) for billing group and treating physician
16. Physician's or group's federal tax identification number (tax identification number [TIN] or social security number)
17. Injury/illness as described by the claimant

E. The following pages have samples of the CMS-1500 (08/05), UB-04, 2006 American Dental Association Dental Claim Form J400, Request for Resolution of Dispute, and Utilization Review Request Form.

## II. Utilization Review Request Form

The form entitled Mississippi Workers' Compensation Utilization Review is a communication tool for use between the provider and the utilization review company. The form can be faxed between the provider and payer as applicable.

The utilization review process is mandatory under the *Mississippi Workers'Compensation Medical Fee Schedule*; however, the use of the Utilization Review Request Form is optional. The use of the form is encouraged if it proves helpful in the timely processing of requests for utilization review of medical services.

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## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | NPI | |
| 2 | | | | | | | | | NPI | |
| 3 | | | | | | | | | NPI | |
| 4 | | | | | | | | | NPI | |
| 5 | | | | | | | | | NPI | |
| 6 | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

# UB–04

| 1 | 2 | 3a PAT. CNTL # | 4 TYPE OF BILL |
|---|---|---|---|
| | | b. MED. REC. # | |
| | | 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 |

| 8 PATIENT NAME | a | 9 PATIENT ADDRESS | a |
|---|---|---|---|
| b | | b | c d e |

| 10 BIRTHDATE | 11 SEX | 12 ADMISSION DATE | 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

| | 31 OCCURRENCE CODE | 31 OCCURRENCE DATE | 32 OCCURRENCE CODE | 32 OCCURRENCE DATE | 33 OCCURRENCE CODE | 33 OCCURRENCE DATE | 34 OCCURRENCE CODE | 34 OCCURRENCE DATE | 35 OCCURRENCE SPAN CODE | 35 OCCURRENCE SPAN FROM | 35 OCCURRENCE SPAN THROUGH | 36 OCCURRENCE SPAN CODE | 36 OCCURRENCE SPAN FROM | 36 OCCURRENCE SPAN THROUGH | 37 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a | | | | | | | | | | | | | | | | a |
| b | | | | | | | | | | | | | | | | b |

| 38 | | 39 VALUE CODES CODE | 39 VALUE CODES AMOUNT | 40 VALUE CODES CODE | 40 VALUE CODES AMOUNT | 41 VALUE CODES CODE | 41 VALUE CODES AMOUNT |
|---|---|---|---|---|---|---|---|
| | a | | | | | | |
| | b | | | | | | |
| | c | | | | | | |
| | d | | | | | | |

| | 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | 1 |
| 2 | | | | | | | | | 2 |
| 3 | | | | | | | | | 3 |
| 4 | | | | | | | | | 4 |
| 5 | | | | | | | | | 5 |
| 6 | | | | | | | | | 6 |
| 7 | | | | | | | | | 7 |
| 8 | | | | | | | | | 8 |
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| 12 | | | | | | | | | 12 |
| 13 | | | | | | | | | 13 |
| 14 | | | | | | | | | 14 |
| 15 | | | | | | | | | 15 |
| 16 | | | | | | | | | 16 |
| 17 | | | | | | | | | 17 |
| 18 | | | | | | | | | 18 |
| 19 | | | | | | | | | 19 |
| 20 | | | | | | | | | 20 |
| 21 | | | | | | | | | 21 |
| 22 | | | | | | | | | 22 |
| 23 | | *PAGE ____ OF ____* | *CREATION DATE* | | *TOTALS* | | | | 23 |

| | 50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | | |
|---|---|---|---|---|---|---|---|---|---|
| A | | | | | | | 57 | | A |
| B | | | | | | | OTHER | | B |
| C | | | | | | | PRV ID | | C |

| | 58 INSURED'S NAME | 59 P REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO. | |
|---|---|---|---|---|---|---|
| A | | | | | | A |
| B | | | | | | B |
| C | | | | | | C |

| | 63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME | |
|---|---|---|---|---|
| A | | | | A |
| B | | | | B |
| C | | | | C |

| 66 DX | 67 | A | B | C | D | E | F | G | H | 68 |
|---|---|---|---|---|---|---|---|---|---|---|
| | I | J | K | L | M | N | O | P | Q | |

| 69 ADMIT DX | 70 PATIENT REASON DX | a | b | c | 71 PPS CODE | 72 ECI | a | b | c | 73 |
|---|---|---|---|---|---|---|---|---|---|---|

| 74 PRINCIPAL PROCEDURE CODE | DATE | a. OTHER PROCEDURE CODE | DATE | b. OTHER PROCEDURE CODE | DATE | 75 |
|---|---|---|---|---|---|---|
| | | | | | | |
| c. OTHER PROCEDURE CODE | DATE | d. OTHER PROCEDURE CODE | DATE | e. OTHER PROCEDURE CODE | DATE | |
| | | | | | | |

| 80 REMARKS | 81CC | | | |
|---|---|---|---|---|
| | a | | | |
| | b | | | |
| | c | | | |
| | d | | | |

| 76 ATTENDING | NPI | QUAL | |
|---|---|---|---|
| LAST | | FIRST | |
| 77 OPERATING | NPI | QUAL | |
| LAST | | FIRST | |
| 78 OTHER | NPI | QUAL | |
| LAST | | FIRST | |
| 79 OTHER | NPI | QUAL | |
| LAST | | FIRST | |

UB-04 CMS-1450 APPROVED OMB NO. NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

## ADA Dental Claim Form

**HEADER INFORMATION**

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

**PRIMARY PAYER INFORMATION**

3. Name, Address, City, State, Zip Code

**OTHER COVERAGE**

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code

**PRIMARY SUBSCRIBER INFORMATION**

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

**PATIENT INFORMATION**

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

**RECORD OF SERVICES PROVIDED**

| | 24. Procedure Date (MM/DD/CCYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 30. Description | 31. Fee |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |

**MISSING TEETH INFORMATION**

34. (Place an 'X' on each missing tooth)

| Permanent | | | | | | | | | | | | | | | | Primary | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | A | B | C | D | E | F | G | H | I | J |
| 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | T | S | R | Q | P | O | N | M | L | K |

32. Other Fee(s)

33. Total Fee

35. Remarks

**AUTHORIZATIONS**

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) –

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) Date

54. Provider ID | 55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) –

58. Treating Provider Specialty



100-2414 3/03 UHC

# Mississippi Workers' Compensation Commission

## Utilization Review Request Form

| Name of Claimant | Social Security Number | Date of Injury |
|---|---|---|
| Address of Claimant | City | State Zip Code |
| Sex ❑ Male ❑ Female | Claimant's Date of Birth | |
| Name of Hospital/Facility | | |
| Address | City | State Zip Code |
| Proposed Date of Admission/Procedure | Diagnosis and/or ICD•9 CM | Expected Length of Stay |
| Major Procedure | | |
| Medical Justification | | |
| Provider Number | Requesting Physician | Caller's Name & Number |
| Address | City | State Zip Code |
| Is Surgery anticipated, if yes procedure ❑ Yes ❑ No | Is general anesthesia required? ❑ Yes ❑ No | |
| _____ Date | _____ days PAS 75% | _____ Certification Number |
| (1) Adm. Pre Cert | (2) Out Pt. | (3) Recert (4) Appeal (5) Changes |

| Recerts | | Changes |
|---|---|---|
| 1. | No. Recert _____ | Date of Service _____ |
| | Total Days Approved _____ | Change |
| | File D/C Active _____ | |
| | Date _____ | |
| 2. | No. Recert _____ | |
| | Total Days Approved _____ | |
| | File D/C Active _____ | |
| | Date _____ | |
| 3. | No. Recert _____ | |
| | Total Days Approved _____ | |
| | File D/C Active _____ | |
| | Date _____ | |
| 4. | No. Recert _____ | |
| | Total Days Approved _____ | |
| | File D/C Active _____ | |
| | Date _____ | |
| 5. | No. Recert _____ | |
| | Total Days Approved _____ | |
| | File D/C Active _____ | |
| | Date _____ | |

**PROCEDURAL RULE 18. SUBPOENAS WITNESS FEES AND SANCTIONS**.

**(a) For Attendance of Witnesses: Forms; Issuance**. Every subpoena shall be issued by the Commission Secretary or as provided in section 71-3-61 of the Act, under the seal of the Commission, shall state the name of the Commission and the title of the action, and shall command each person to whom it is directed to attend and give testimony at a time and place therein specified. The Commission Secretary shall issue a subpoena, or a subpoena for the production of documentary evidence, signed and sealed, but otherwise in blank, to a party requesting it, who shall fill it in before service.

**(b) For Production of Documentary Evidence**.

(1) A subpoena may also command the person to whom it is directed to produce the books, papers, documents, or tangible things designated therein and in such cases the party to whom the subpoena is directed is entitled to be reimbursed by the requesting party for the reasonable costs of producing the things subpoenaed; but the Commission or Administrative Judge, upon motion made promptly and in any event at or before the time specified in the subpoena for compliance therewith, may (a) quash or modify the subpoena if it is unreasonable and oppressive or (b) condition the denial of the motion upon the advance by the person in whose behalf the subpoena is issued of the reasonable cost of producing the books, papers, documents, or tangible things.

(2) A subpoena issued pursuant to subparagraph (b)(1) of this rule may compel the production of books, papers, documents, or tangible things by the person in possession, custody, or control thereof without the necessity that such person by deposed.

(3) Unless for good cause shown the Commission or Administrative Judge enlarges or shortens the time, a subpoena issued pursuant to subparagraph (b)(1 ) of this rule shall allow not less than ten (10) days for the person upon whom it is served to produce the books, papers, documents, or tangible things therein specified. A copy of all such subpoenas shall be served forthwith upon counsel for all opposite parties.

**(c) Service**. A subpoena may be served by the sheriff, by his deputy, or by any person who is not a party and is not less than 18 years of age, and his return endorsed thereon shall be prima facie proof of service, or the witness may acknowledge service in writing on the subpoena. Service of the subpoena shall be executed upon the witness personally.

**(d) Subpoena for Taking Depositions; Place of Examination**.

(1) Proof of service of a notice to take deposition as provided in Rules 30(b) and 31(a) of the Mississippi Rules of Civil Procedure constitutes a sufficient authorization for the issuance by the Commission Secretary of subpoenas for the persons named or described therein. The subpoena may command the person to whom it is directed to produce and permit inspection and copying of designated books, papers, documents, or tangible things which constitute or contain matters within

the scope of the examination permitted by Rule 26(b) of the Mississippi Rules of Civil Procedure, but in that event the subpoena will be subject to the provisions of Rule 26(b) and subdivision (b)(1) of this rule.

(2) The person to whom the subpoena is directed may within ten (10) days after the service thereof or on or before the time specified in the subpoena for compliance if such time is less than ten (10) days after service serve upon the attorney designated in the subpoena written objection to inspection or copying of any or all of the designated materials. If objection is made, the party serving the subpoena shall not be entitled to inspect and copy the material except pursuant to an order of the Commission or Administrative Judge and the party serving the subpoena may, if objection has been made, move upon notice to the deponent for an order at any time before or during the taking of the deposition.

(3) A resident of the State of Mississippi may be required to attend an examination only in the county wherein he resides or is employed or transacts his business in person, or at such other convenient place as is fixed by an order of the Commission or Administrative Judge. A non-resident of this state subpoenaed within this state may be required to attend only in the county wherein he is served, or at a place within this state not more than forty (40) miles from the place of service, or at such other convenient place as is fixed by an order of the Commission or Administrative Judge.

**(e) Subpoena for a Hearing or Trial**. At the request of any party subpoenas for attendance at a hearing or trial shall be issued by the Secretary of the Commission, if available, otherwise by a Commissioner or an Administrative Judge. A subpoena requiring the attendance of a witness at a hearing or trial may be served at any place within the state.

**(f) Contempt**. Failure by any person without adequate excuse to obey a subpoena served upon him may be certified to the proper Circuit Court for contempt proceedings by the Commission.

**(g) Sanctions**. On motion of a party or of the person upon whom a subpoena for the production of books, papers, documents, or tangible things is served and upon a showing that the subpoena power is being exercised in bad faith or in such manner as unreasonably to annoy, embarrass, or oppress the party or the person upon whom the subpoena is served, the Commission may order that the subpoena be quashed and may enter such further orders as justice may require to curb abuses of the power granted under this rule. To this end, the Commission or Administrative Judge may award to the successful movant attorney's fees and expenses for challenging the subpoena and may order that they be paid directly by the attorney who caused the issuance of such subpoena.

**(h) Witness Fees**. Witnesses subpoenaed to appear in proceedings before the Commission shall receive a witness fee of Twenty Five Dollars ($25.00) per day plus mileage at the rate authorized by General Rule 14. The Commission or Administrative Judge may allow the payment from the Administrative Expense Fund of said fees and mileage to witnesses, other than expert medical witnesses, subpoenaed at the request of claimants. A payment not to exceed Three Hundred Fifty Dollars ($350.00) for a deposition or for testifying at an evidentiary hearing, may be allowed to each medical expert so testifying on behalf of a claimant, said payment likewise to be paid from

said fund. The aforesaid payment of Three Hundred Fifty Dollars ($350.00) for expert medical testimony by deposition from said fund shall only apply to depositions taken by claimant and filed with the Commission in a controverted claim. Except on prior written approval of the Commission or an Administrative Judge, payment for expert medical witnesses on behalf of the claimant, whether by deposition or at an evidentiary hearing, shall be limited to two (2).

The Commission may at its discretion suspend or eliminate payment for expert medical witness fees as provided herein without notice.

Inasmuch as the Administrative Expense Fund is funded by assessments against the carriers writing compensation insurance in the state and self-insurers, as provided by section 71-3-99 of the Act, and inasmuch as the application, computation, requisition, and disbursement of payments of fees and mileage for witnesses or carriers and self-insurers result in additional expense which ultimately must be borne by them, said carriers and self-insurers are, therefore, required to pay said fees and mileage directly to each witness subpoenaed at their request. It is not intended that carriers and self-insurers shall pay fees and mileage, if payment of same is ordered to be paid by claimant pursuant to section 71-3-59 of the Act.

This Rule shall be in force and effect on and after August 1, 2007

**GENERAL RULE 12. MEDICAL FEES: MEDICAL DISPUTE RESOLUTION**.

The fees of physicians, hospitals, and other attendant parties must be reasonable and measured according to the employee's need and must be within the guidelines established by the Commission in its Medical fee schedule(s) pursuant to Mississippi Code Annotated section 71-3-15 (3) (1972), as amended.

The procedure for resolving disputes over the fees charged for services, or for other issues which arise from utilization, billing or payment of medical services, is set forth in detail in the Medical Fee Schedule, and is incoporated herein by reference. Please consult the most current edition of the Medical Fee Schedule for the detailed rules regardling fee and other dispute resolution.

This Rule shall be in force and effect on and after August 1, 2007.