SETON CHARITY PRIOR AUTHORIZATION LIST EFF: 10/01/2024 (updated 10/1/2024)		
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CPT, HCPCS or Revenue Code	**Description**	**Comments**
Inpatient (elective)	**All Elective/Scheduled Inpatient Admissions require prior authorization**	
Revenue Code		
0100	All inclusive room and board plus ancillary	
0101	All inclusive room and board	
0110	Room and Board Private (one bed)	
0111	Room and Board Private (one bed) - Medical/Surgical/GYN	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
0113	Room and Board Private (one bed) - Pediatric	
0117	Room and Board Private (one bed) - Oncology	
0119	Room and Board Private (one bed) - Other	
0121	Room and Board Semiprivate (two beds) - Medical/Surgical/GYN	
0123	Room and Board Semiprivate (two beds) - Pediatric	
0127	Room and Board Semiprivate (two beds) - Oncology	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
0130	Room & Board - Three and Four Beds General Classification	
0131	Room & Board - Three and Four Beds Medical/Surgical/Gyn	
0133	Room & Board - Three and Four Beds Pediatric	
0137	Room & Board - Three and Four Beds Oncology	
0139	Room & Board - Three and Four Beds Other	
0140	Room & Board - Deluxe Private General Classification	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
0141	Room & Board - Deluxe Private Medical/Surgical/Gyn	
0143	Room & Board - Deluxe Private Pediatric	
0147	Room & Board - Deluxe Private Oncology	
0149	Room & Board - Deluxe Private Other	
0150	Room & Board - Ward General Classification	
0151	Room & Board - Ward Medical/Surgical/Gyn	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
0153	Room & Board - Ward Pediatric	
0157	Room & Board - Ward Oncology	
0159	Room & Board - Ward Other	
0160	Room & Board - Other General Classification	
0164	Other Room & Board - Sterile Environment	
0167	Room & Board - Other Self Care	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
0169	Room & Board - Other Other	
CPT Codes		
00170	Anesthesia for intraoral treatments, including biopsy; not otherwise specified	Pre-certification of Anesthesia is only applicable when dental services are performed in a hospital/facility setting (POS 21 or 22)
00902	Exam Under Anesthesia	
01999	Unlisted anesthesia procedure(s)	Pre-certification of Anesthesia is only applicable when dental services are performed in a hospital/facility setting (POS 21 or 22)
11008	Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
11010	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues	
11011	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, and muscle	
11012	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone	
11040	Debridement; skin, partial thickness	
11041	Debridement; skin, full thickness	
11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
11047	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation;	
11960	Insertion of tissue expanders for other than breast	
11970	Replacement of tissue expander with permanent implant	
11971	Removal of tissue expander without insertion of implant	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
11982	Removal, non-biodegradable drug delivery implant	
14000	Adjacent tissue transfer or rearrangement, truck; defect 10 sq cm or less	
14001	Adjacent tissue transfer or rearrangement, trunk, defect 10.1 sq cm to 30.0 sq cm	
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	
14061	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm	
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof	
15004	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children	
15005	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 part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)	
15040	Harvest of skin for tissue cultured skin autograft, 100 sq cm or less	
15050	Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area (except on face), up to defect size 2 cm diameter	
15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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)	
15110	Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	
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)	
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	
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)	
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)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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)	
15130	Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	
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)	
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	
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)	
15150	Tissue cultured skin autograft, trunk, arms, legs; first 25 sq cm or less	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
15151	Tissue cultured skin autograft, trunk, arms, legs; additional 1 sq cm to 75 sq cm	
15152	Tissue cultured skin autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof	
15155	Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 25 sq cm or less	
15156	Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; additional 1 sq cm to 75 sq cm	
15157	Tissue cultured skin 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	
15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
15201	Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	
15220	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less	
15221	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	
15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less	
15241	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, or part thereof (List separately in addition to code for primary procedure)	
15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
15261	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof	
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface	
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof	
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof	
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof	
15570	Formation of direct or tubed pedicle, with or without transfer; trunk	
15731	Forehead flap with preservation of vascular pedicle	
15732	Muscle, myocutaneous, or fasciocutaneous flap; head and neck	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle	
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk	
15736	Muscle, myocutaneous, or fasciocutaneous flap; upper extremity	
15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity	
15740	Flap; island pedicle	
15756	Free muscle or myocutaneous flap with microvascular anastomosis	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure)	
15778	Implantation of absorbable mesh or other prosthesis for delayed closure of defect (s) (ie, external genitalia, perineum, abdominal wall) due to soft tissue infection or trauma	
17106	Destruction of cutaneous vascular proliferative lesions, less than 10 sq cm	
17107	Destruction of cutaneous vascular proliferative lesions, 10.0 to 50.0 sq cm	
17108	Destruction of cutaneous vascular proliferative lesions, over 50.0 sq cm	
17999	Unlisted procedure – skin, mucous membrane & subcutaneous tissue	EXCLUDED FROM COVERAGE : Any treatment for transsexualism, gender dysphoria, sexual re-assignment or sex change, including, but not be limited to, drugs, surgery, medical or psychiatric care

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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, 1 or more lesions	
19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	
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)	
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)	
19328	Removal of intact breast implant	
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)	
19342	Insertion or replacement of breast implant on separate day from mastectomy	
19350	Nipple/areola reconstruction	
19355	Correction of inverted nipples	
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)	
19361	Breast reconstruction with latissimus dorsi flap	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy	
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents	
19499	Unlisted procedure – breast	
20660	Application of cranial tongs, caliper, or stereotactic frame, including removal	
20670	Removal of implant; superficial (eg, buried wire, pin or rod)	
20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
20802	Replantation, arm (includes surgical neck of humerus through elbow joint), complete amputation	
20805	Replantation, forearm (includes radius and ulna to radial carpal joint), complete amputation	
20808	Replantation, hand (includes hand through metacarpophalangeal joints), complete amputation	
20816	Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon), complete amputation	
20822	Replantation, digit, excluding thumb (includes distal tip to sublimis tendon insertion), complete amputation	
20824	Replantation, thumb (includes carpometacarpal joint to MP joint), complete amputation	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
20827	Replantation, thumb (includes distal tip to MP joint), complete amputation	
20838	Replantation, foot, complete amputation	
20902	Bone graft, any donor area; major or large	
20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)	
21025	Excision of bone (e.g., for osteomyelitis or bone abscess) mandible	
21032	Excision of maxillary Torus palatinus	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
21116	Injection procedure for temporomandibular joint arthrography	
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	
21181	Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial	
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm	
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	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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	
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
21198	Osteotomy, mandible, segmental	
21199	Osteotomy, mandible, segmental; with genioglossus advancement	
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	
21215	Graft, bone; mandible (includes obtaining graft)	
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)	
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)	
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)	
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)	
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach	
21261	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach	
21263	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach	
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach	
21275	Secondary revision of orbitocraniofacial reconstruction	
21280	Medial canthopexy (separate procedure)	
21282	Lateral canthopexy	
21299	Unlisted craniofacial and maxillofacial procedure	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
21325	Open treatment of nasal fracture; uncomplicated	
21330	Open treatment of nasal fracture; complicated, with internal and/or external skeletal fixation	
21335	Open treatment of nasal fracture; with concomitant open treatment of fractured septum	
21336	Open treatment of nasal septal fracture, with or without stabilization	
21338	Open treatment of nasoethmoid fracture; without external fixation	
21339	Open treatment of nasoethmoid fracture; with external fixation	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
21343	Open treatment of depressed frontal sinus fracture	
21344	Open treatment of complicated (eg, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches	
21346	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation	
21347	Open treatment of nasomaxillary complex fracture (LeFort II type); requiring multiple open approaches	
21348	Open treatment of nasomaxillary complex fracture (LeFort II type); bone grafting (includes obtaining graft)	
21356	Open treatment of depressed zygomatic arch fracture (eg, Gillies approach)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	
21365	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches	
21366	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)	
21385	Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation)	
21386	Open treatment of orbital floor blowout fracture; periorbital approach	
21387	Open treatment of orbital floor blowout fracture; combined approach	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
21390	Open treatment of orbital floor blowout fracture; periorbital approach, with alloplastic or other implant	
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)	
21406	Open treatment of fracture of orbit, except blowout; without implant	
21407	Open treatment of fracture of orbit, except blowout; with implant	
21408	Open treatment of fracture of orbit, except blowout; with bone grafting (includes obtaining graft)	
21422	Open treatment of palatal or maxillary fracture (LeFort I type)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
21423	Open treatment of palatal or maxillary fracture (LeFort I type); complicated (comminuted or involving cranial nerve foramina), multiple approaches	
21432	Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation	
21433	Open treatment of craniofacial separation (LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches	
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)	
21436	Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)	
21445	Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
21454	Open treatment of mandibular fracture with external fixation	
21461	Open treatment of mandibular fracture; without interdental fixation	
21462	Open treatment of mandibular fracture; with interdental fixation	
21465	Open treatment of mandibular condylar fracture	
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints	
21490	Open treatment of temporomandibular dislocation	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
21495	Open treatment of hyoid fracture	
21600	Excision of rib, partial	
21601	Excision of chest wall tumor including rib(s)	
21602	Excision of chest wall tumor involving rib(s), with plastic reconstruction; without mediastinal lymphadenectomy	
21603	Excision of chest wall tumor involving rib(s), with plastic reconstruction; with mediastinal lymphadenectomy	
21685	Hyoid myotomy and suspension	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
21805	Open treatment of rib fracture without fixation, each	
21810	Treatment of rib fracture requiring external fixation (flail chest)	
21811	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs	
21812	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4-6 ribs	
21813	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs	
21825	Open treatment of sternum fracture with or without skeletal fixation	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
21899	Unlisted Procedure, neck or thorax	
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment, lumbar	
22224	Osteotomy of spine, including diskectomy, anterior approach, single vertebral segment; lumbar	
22318	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; without grafting	
22319	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	
22325	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebrae or dislocated segment; lumbar	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
22326	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; cervical	
22327	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; thoracic	
22328	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; each additional fractured vertebra or dislocated segment (List separately in addition to code for primary procedure)	
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	
22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
22520	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic	
22521	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar	
22522	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	
22533	Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); lumbar	
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	
22558	Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); lumbar	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace	
22612	Arthrodesis, posterior or posterolateral technique, single interspace; thoracic (with lateral transverse technique, when performed)	
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or diskectomy to prepare interspace (other than for decompression), single interspace; lumbar	
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or diskectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)	
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar	Device donation required
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)	Device donation required

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)	Device donation required
22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)	Instrumentation donation required
22846	Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)	Instrumentation donation required
22847	Anterior instrumentation; 8 or more vertebral segments (List separately in addition to code for primary procedure)	Instrumentation donation required
22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)	Instrumentation donation required
22854	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	Instrumentation donation required

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
22855	Removal of anterior instrumentation	
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical	Device donation required
22860	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)	Device donation required
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	
22899	Unlisted procedure, spine (Vertebral Column)	Intracept Procedure - radiofrequency energy to ablate the BVN is not a covered benefit (pain mgmt)
23000	Removal of subdeltoid calcareous deposits, open	
23020	Capsular contracture release (eg, Sever type procedure)	
23035	Incision, bone cortex (eg, osteomyelitis or bone abscess), shoulder area	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
23040	Arthrotomy, glenohumeral joint, including exploration, drainage, or removal of foreign body	
23044	Arthrotomy, acromioclavicular, sternoclavicular joint, including exploration, drainage, orremovalof foreign body	
23071	Excision, tumor, soft tissue of shoulder area, subcutaneous;3 cm or greater	
23073	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular);5 cm or greater	
23075	Excision, soft tissue tumor, shoulder area; subcutaneous	
23076	Excision, soft tissue tumor, shoulder area;deep, subfascial, or intramuscular	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
23077	Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; less than 5 cm	
23078	Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; 5 cm or greater	
23100	Arthrotomy, glenohumeral joint, including biopsy	
23101	Arthrotomy, acromioclavicular joint or sternoclavicular joint, including biopsy and/or excision oftorn cartilage	
23105	Arthrotomy; glenohumeral joint, with synovectomy, with or without biopsy	
23106	Arthrotomy;sternoclavicular joint, with synovectomy, with or without biopsy	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
23107	Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose orforeignbody	
23120	Claviculectomy; partial	
23125	Claviculectomy;total	
23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release	
23140	Excision or curettage of bone cyst or benign tumor of clavicle or scapula;	
23145	Excision or curettage of bone cyst or benign tumor of clavicle or scapula;with autograft (includesobtaining graft)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
23146	Excision or curettage of bone cyst or benign tumor of clavicle or scapula;with allograft	
23150	Excision or curettage of bone cyst or benign tumor of proximal humerus;	
23155	Excision or curettage of bone cyst or benign tumor of proximal humerus;with autograft (includes obtaining graft)	
23156	Excision or curettage of bone cyst or benign tumor of proximal humerus;with allograft	
23170	Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle	
23172	Sequestrectomy (eg, for osteomyelitis or bone abscess), scapula	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
23174	Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck	
23180	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis),clavicle	
23182	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis),scapula	
23184	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis),proximalhumerus	
23190	Ostectomy of scapula, partial (eg, superior medial angle)	
23195	Resection, humeral head	

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23200	Radical resection for tumor; clavicle	
23210	Radical resection for tumor;scapula	
23220	Radical resection of bone tumor, proximal humerus;	
23330	Removal of foreign body, shoulder; subcutaneous	
23333	Removal of foreign body, shoulder; deep (subfascial or intramuscular)	
23334	Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
23335	Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid component	
23350	Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography	
23395	Muscle transfer, any type, shoulder or upper arm; single	
23397	Muscle transfer, any type, shoulder or upper arm;multiple	
23400	Scapulopexy (eg, Sprengels deformity or for paralysis)	
23405	Tenotomy, shoulder area; single tendon	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
23406	Tenotomy, shoulder area;multiple tendons through same incision	
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open;chronic	
23415	Coracoacromial ligament release, with or without acromioplasty	
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	
23430	Tenodesis of long tendon of biceps	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
23440	Resection or transplantation of long tendon of biceps	
23450	Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation	
23455	Capsulorrhaphy, anterior;with labral repair (eg, Bankart procedure)	
23460	Capsulorrhaphy, anterior, any type; with bone block	
23462	Capsulorrhaphy, anterior, any type;with coracoid process transfer	
23465	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability	
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	
23472	Arthroplasty, glenohumeral joint;total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	
23480	Osteotomy, clavicle, with or without internal fixation;	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
23485	Osteotomy, clavicle, with or without internal fixation;with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation)	
23490	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; clavicle	
23491	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate;proximal humerus	
23515	Open treatment of clavicular fracture, includes internal fixation, when performed	
23585	Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation, when performed	
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
23616	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; with proximal humeral prosthetic replacement	
23630	Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed	
23670	Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed	
23680	Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed	
23700	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)	
23800	Arthrodesis, glenohumeral joint;	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
23802	Arthrodesis, glenohumeral joint;with autogenous graft (includes obtaining graft)	
23900	Interthoracoscapular amputation (forequarter)	
23920	Disarticulation of shoulder	
23921	Disarticulation of shoulder; secondary closure or scar revision	
23929	Unlisted procedure, shoulder	
24220	Injection procedure for elbow arthrography	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
24300	Manipulation, elbow, under anesthesia	
24400	Osteotomy, humerus, with or without internal fixation	
24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)	
24420	Osteoplasty, humerus (eg, shortening or lengthening) (excluding 64876)	
24430	Repair of nonunion or malunion, humerus; without graft (eg, compression technique)	
24435	Repair of nonunion or malunion, humerus; with iliac or other autograft (includes obtaining graft)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
24470	Hemiepiphyseal arrest (eg, cubitus varus or valgus, distal humerus)	
24495	Decompression fasciotomy, forearm, with brachial artery exploration	
24498	Prophylactic treatment (nailing, pinning, plating or wiring), with or without methylmethacrylate, humeral shaft	
24515	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage	
24516	Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws	
24545	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
24546	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension	
24575	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	
24579	Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed	
24586	Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius)	
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	
24635	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
24665	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed	
24666	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed; with radial head prosthetic replacement	
24685	Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed	
24900	Amputation, arm through humerus; with primary closure	
24920	Amputation, arm through humerus; open, circular (guillotine)	
24925	Amputation, arm through humerus; secondary closure or scar revision	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
24930	Amputation, arm through humerus; re-amputation	
24931	Amputation, arm through humerus; with implant	
24935	Stump elongation, upper extremity	
24999	Unlisted procedure, humerus or elbow	
25020	Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; without debridement of nonviable muscle and/or nerve	
25023	Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; with debridement of nonviable muscle and/or nerve	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
25246	Injection procedure for wrist arthrography	
25259	Manipulation, wrist, under anesthesia	
25270	Repair, tendon or muscle, extensor, forearm and/or wrist; primary, single, each tendon or muscle	
25272	Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, single, each tendon or muscle	
25274	Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, with free graft (includes obtaining graft), each tendon or muscle	
25275	Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
25320	Capsulorrhaphy or reconstruction, wrist, open (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability	
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	
25400	Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique)	
25405	Repair of nonunion or malunion, radius OR ulna; with autograft (includes obtaining graft)	
25415	Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)	
25420	Repair of nonunion or malunion, radius AND ulna; with autograft (includes obtaining graft)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
25431	Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone	
25440	Repair of nonunion, scaphoid carpal (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)	
25515	Open treatment of radial shaft fracture, includes internal fixation, when performed	
25525	Open treatment of radial shaft fracture, includes internal fixation, when performed, and closed treatment of distal radioulnar joint dislocation (Galeazzi fracture/ dislocation), includes percutaneous skeletal fixation, when performed	
25526	Open treatment of radial shaft fracture, includes internal fixation, when performed, and open treatment of distal radioulnar joint dislocation (Galeazzi fracture/ dislocation), includes internal fixation, when performed, includes repair of triangular fibrocartilage complex	
25545	Open treatment of ulnar shaft fracture, includes internal fixation, when performed	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
25574	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius OR ulna	
25575	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna	
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments	
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments	
25628	Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
25645	Open treatment of carpal bone fracture (other than carpal scaphoid [navicular]), each bone	
25652	Open treatment of ulnar styloid fracture	
25675	Closed treatment of distal radioulnar dislocation with manipulation	
25685	Open treatment of trans-scaphoperilunar type of fracture dislocation	
25900	Amputation, forearm, through radius and ulna	
25905	Amputation, forearm, through radius and ulna; open, circular (guillotine)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
25907	Amputation, forearm, through radius and ulna; secondary closure or scar revision	
25909	Amputation, forearm, through radius and ulna; re-amputation	
25920	Disarticulation through wrist	
25922	Disarticulation through wrist; secondary closure or scar revision	
25924	Disarticulation through wrist; re-amputation	
25927	Transmetacarpal amputation	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
25929	Transmetacarpal amputation; secondary closure or scar revision	
25931	Transmetacarpal amputation; re-amputation	
25999	Unlisted procedure, forearm and wrist	
26341	Manipulation, palmar fascial cord (i.e. Dupuytren's cord, post enzyme injection	
26410	Repair, extensor tendon, hand, primary or secondary; without free graft, each tendon	
26412	Repair, extensor tendon, hand, primary or secondary; with free graft (includes obtaining graft), each tendon	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
26418	Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon	
26420	Repair, extensor tendon, finger, primary or secondary; with free graft (includes obtaining graft) each tendon	
26426	Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); using local tissue(s), including lateral band(s), each finger	
26428	Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); with free graft (includes obtaining graft), each finger	
26433	Repair of extensor tendon, distal insertion, primary or secondary; without graft (eg, mallet finger)	
26434	Repair of extensor tendon, distal insertion, primary or secondary; with free graft (includes obtaining graft)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	
26665	Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed	
26685	Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint	
26686	Open treatment of carpometacarpal dislocation, other than thumb; complex, multiple, or delayed reduction	
26715	Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed	
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
26746	Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each	
26765	Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each	
26785	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single	
26910	Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseous transfer	
26951	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	
26952	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with local advancement flaps (V-Y, hood)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
26989	Unlisted procedure, hands or fingers	
26992	Incision, bone cortex, pelvis and/or hip joint (eg, osteomyelitis or bone abscess)	
27000	Tenotomy, adductor of hip, percutaneous (separate procedure)	
27001	Tenotomy, adductor of hip, open	
27003	Tenotomy, adductor, subcutaneous, open, with obturator neurectomy	
27005	Tenotomy, hip flexor(s), open (separate procedure)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27006	Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)	
27025	Fasciotomy, hip or thigh, any type	
27027	Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral	
27030	Arthrotomy, hip, with drainage (eg, infection)	
27033	Arthrotomy, hip, including exploration or removal of loose or foreign body	
27035	Denervation, hip joint, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral, or obturatornerves	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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)	
27040	Biopsy, soft tissue of pelvis and hip area; superficial	
27041	Biopsy, soft tissue of pelvis and hip area;deep, subfascial or intramuscular	
27043	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous;3 cm or greater	
27045	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or greater	
27047	Excision, tumor, pelvis and hip area; subcutaneous tissue	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27048	Excision, tumor, pelvis and hip area;deep, subfascial, intramuscular	
27049	Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; less than 5 cm	
27050	Arthrotomy, with biopsy; sacroiliac joint	
27052	Arthrotomy, with biopsy;hip joint	
27054	Arthrotomy with synovectomy, hip joint	
27057	Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonvia ble muscle, unilateral	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27059	Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater	
27060	Excision; ischial bursa	
27062	Excision;trochanteric bursa or calcification	
27065	Excision of bone cyst or benign tumor; superficial (wing of ilium, symphysis pubis, or greater trochanteroffemur) with or without autograft	
27066	Excision of bone cyst or benign tumor;deep, with or without autograft	
27067	Excision of bone cyst or benign tumor;with autograft requiring separate incision	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27070	Partial excision (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial (eg, wing ofilium, symphysis pubis, or greater trochanter of femur)	
27071	Partial excision (craterization, saucerization) (eg, osteomyelitis or bone abscess); deep (subfascial or intramuscular)	
27075	Radical resection of tumor or infection; wing of ilium, one pubic or ischial ramus or symphysis pubis	
27076	Radical resection of tumor or infection;ilium, including acetabulum, both pubic rami, or ischium and acetabulum	
27077	Radical resection of tumor or infection;innominate bone, total	
27078	Radical resection of tumor or infection;ischial tuberosity and greater trochanter of femur	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27080	Coccygectomy, primary	
27086	Removal of foreign body, pelvis or hip; subcutaneous tissue	
27087	Removal of foreign body, pelvis or hip;deep (subfascial or intramuscular)	
27090	Removal of hip prosthesis; (separate procedure)	
27091	Removal of hip prosthesis;complicated, including total hip prosthesis, methylmethacrylate with or withoutinsertion of spacer	
27093	Injection procedure for hip arthrography; without anesthesia	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27095	Injection procedure for hip arthrography; with anesthesia	
27096	Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid	
27097	Release or recession, hamstring, proximal	
27098	Transfer, adductor to ischium	
27100	Transfer external oblique muscle to greater trochanter including fascial or tendon extension (graft)	
27105	Transfer paraspinal muscle to hip (includes fascial or tendon extension graft)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27110	Transfer iliopsoas; to greater trochanter of femur	
27111	Transfer iliopsoas;to femoral neck	
27120	Acetabuloplasty; (eg, Whitman, Colonna, Haygroves, or cup type)	
27122	Acetabuloplasty;resection, femoral head (eg, Girdlestone procedure)	
27125	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)	
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	
27137	Revision of total hip arthroplasty;acetabular component only, with or without autograft or allograft	
27138	Revision of total hip arthroplasty;femoral component only, with or without allograft	
27140	Osteotomy and transfer of greater trochanter of femur (separate procedure)	
27146	Osteotomy, iliac, acetabular or innominate bone;	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27147	Osteotomy, iliac, acetabular or innominate bone;with open reduction of hip	
27151	Osteotomy, iliac, acetabular or innominate bone;with femoral osteotomy	
27156	Osteotomy, iliac, acetabular or innominate bone;with femoral osteotomy and with open reduction of hip	
27158	Osteotomy, pelvis, bilateral (eg, congenital malformation)	
27161	Osteotomy, femoral neck (separate procedure)	
27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27170	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)	
27175	Treatment of slipped femoral epiphysis; by traction, without reduction	
27176	Treatment of slipped femoral epiphysis;by single or multiple pinning, in situ	
27177	Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft (includes obtaining graft)	
27178	Open treatment of slipped femoral epiphysis;closed manipulation with single or multiple pinning	
27179	Open treatment of slipped femoral epiphysis;osteoplasty of femoral neck (Heyman type procedure)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27181	Open treatment of slipped femoral epiphysis;osteotomy and internal fixation	
27185	Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur	
27187	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femoralneckand proximal femur	
27194	Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation, requiring more than local anesthesia,	
27197	Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation	
27198	Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; with manipulation, requiring more than local anesthesia (ie, general anesthesia, moderate sedation, spinal/epidural)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27202	Open treatment of coccygeal fracture	
27215	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral, for pelvic bone fracture patterns that do not disrupt the pelvic ring, includes internal fixation, when performed	
27217	Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes pubic symphysis and/or ipsilateral superior/inferior rami)	
27218	Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes ipsilateral ilium, sacroiliac joint and/or sacrum)	
27226	Open treatment of posterior or anterior acetabular wall fracture, with internal fixation	
27227	Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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	
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	
27244	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage	
27245	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage	
27248	Open treatment of greater trochanteric fracture, includes internal fixation, when performed	
27253	Open treatment of hip dislocation, traumatic, without internal fixation	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27254	Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation	
27269	Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed	
27275	Manipulation, hip joint, requiring general anesthesia	
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	
27280	Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed	
27282	Arthrodesis, symphysis pubis (including obtaining graft)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27284	Arthrodesis, hip joint (including obtaining graft);	
27286	Arthrodesis, hip joint (including obtaining graft);with subtrochanteric osteotomy	
27290	Interpelviabdominal amputation (hindquarter amputation)	
27295	Disarticulation of hip	
27299	Unlisted procedure, pelvis or hip joint	
27303	Incision, deep, with opening of bone cortex, femur or knee (eg, osteomyelitis or bone abscess)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27305	Fasciotomy, iliotibial (tenotomy), open	
27306	Tenotomy, percutaneous, adductor or hamstring; single tendon (separate procedure)	
27307	Tenotomy, percutaneous, adductor or hamstring;multiple tendons	
27310	Arthrotomy, knee, with exploration, drainage, or removal of foreign body (eg, infection)	
27323	Biopsy, soft tissue of thigh or knee area; superficial	
27324	Biopsy, soft tissue of thigh or knee area;deep (subfascial or intramuscular)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27325	Neurectomy, hamstring muscle	
27326	Neurectomy, popliteal (gastrocnemius)	
27327	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm	
27328	Excision, tumor, thigh or knee area;deep, subfascial, or intramuscular; less than 5 cm	
27329	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; less than 5 cm	
27330	Arthrotomy, knee; with synovial biopsy only	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27331	Arthrotomy, knee;including joint exploration, biopsy, or removal of loose or foreign bodies	
27332	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral	
27333	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee;medial AND lateral	
27334	Arthrotomy, with synovectomy, knee; anterior OR posterior	
27335	Arthrotomy, with synovectomy, knee;anterior AND posterior including popliteal area	
27337	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27339	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or greater	
27340	Excision, prepatellar bursa	
27345	Excision of synovial cyst of popliteal space (eg, Baker's cyst)	
27347	Excision of lesion of meniscus or capsule (eg, cyst, ganglion), knee	
27350	Patellectomy or hemipatellectomy	
27355	Excision or curettage of bone cyst or benign tumor of femur;	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27356	Excision or curettage of bone cyst or benign tumor of femur;with allograft	
27357	Excision or curettage of bone cyst or benign tumor of femur;with autograft (includes obtaining graft)	
27358	Excision or curettage of bone cyst or benign tumor of femur;with internal fixation (List in addition to code for primary procedure)	
27360	Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess)	
27364	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; 5 cm or greater	
27365	Radical resection of tumor, bone, femur or knee	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27370	Injection of contrast for knee arthrography	
27372	Removal of foreign body, deep, thigh region or knee area	
27380	Suture of infrapatellar tendon; primary	
27381	Suture of infrapatellar tendon;secondary reconstruction, including fascial or tendon graft	
27385	Suture of quadriceps or hamstring muscle rupture; primary	
27386	Suture of quadriceps or hamstring muscle rupture;secondary reconstruction, including fascial or tendon graft	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27390	Tenotomy, open, hamstring, knee to hip; single tendon	
27391	Tenotomy, open, hamstring, knee to hip;multiple tendons, one leg	
27392	Tenotomy, open, hamstring, knee to hip;multiple tendons, bilateral	
27393	Lengthening of hamstring tendon; single tendon	
27394	Lengthening of hamstring tendon;multiple tendons, one leg	
27395	Lengthening of hamstring tendon;multiple tendons, bilateral	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27396	Transplant, hamstring tendon to patella; single tendon	
27397	Transplant, hamstring tendon to patella;multiple tendons	
27400	Transfer, tendon or muscle, hamstrings to femur (eg, Egger's type procedure)	
27403	Arthrotomy with meniscus repair, knee	
27405	Repair, primary, torn ligament and/or capsule, knee; collateral	
27407	Repair, primary, torn ligament and/or capsule, knee;cruciate	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27409	Repair, primary, torn ligament and/or capsule, knee;collateral and cruciate ligaments	
27412	Autologous chondrocyte implantation, knee	
27415	Osteochondral allograft, knee, open	
27416	Osteochondral autograft(s) , knee, open (eg, mosaicplasty) (includes harvesting of autograft(s))	
27418	Anterior tibial tubercleplasty (eg, Maquet type procedure)	
27420	Reconstruction of dislocating patella; (eg, Hauser type procedure)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27422	Reconstruction of dislocating patella;with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)	
27424	Reconstruction of dislocating patella;with patellectomy	
27425	Lateral retinacular release, open	
27427	Ligamentous reconstruction (augmentation), knee; extra-articular	Augmentation donation required
27428	Ligamentous reconstruction (augmentation), knee;intra-articular (open)	Augmentation donation required
27429	Ligamentous reconstruction (augmentation), knee;intra-articular (open) and extra-articular	Augmentation donation required

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27430	Quadricepsplasty (eg, Bennett or Thompson type)	Device donation required
27435	Capsulotomy, posterior capsular release, knee	
27437	Arthroplasty, patella; without prosthesis	
27438	Arthroplasty, patella; with prosthesis	Device donation required
27440	Arthroplasty, knee, tibial plateau	Device donation required
27441	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy	Device donation required

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27442	Arthroplasty, femoral condyles or tibial plateau(s), knee	Device donation required
27443	Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy	Device donation required
27445	Arthroplasty, knee, hinge prosthesis (e.g., Walldius type)	Device donation required
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	Device donation required
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	Device donation required
27448	Osteotomy, femur, shaft or supracondylar; without fixation	

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27450	Osteotomy, femur, shaft or supracondylar;with fixation	
27454	Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft (eg, Sofield type procedure)	
27455	Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus (bowleg) or genu valgus (knock-knee)); before epiphyseal closure	
27457	Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus (bowleg) or genu valgus (knock-knee));after epiphyseal closure	
27465	Osteoplasty, femur; shortening (excluding 64876)	
27466	Osteoplasty, femur;lengthening	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27468	Osteoplasty, femur;combined, lengthening and shortening with femoral segment transfer	
27470	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)	
27472	Repair, nonunion or malunion, femur, distal to head and neck;with iliac or other autogenous bone graft (includes obtaining graft)	
27475	Arrest, epiphyseal, any method (eg, epiphysiodesis); distal femur	
27477	Arrest, epiphyseal, any method (eg, epiphysiodesis);tibia and fibula, proximal	
27479	Arrest, epiphyseal, any method (eg, epiphysiodesis);combined distal femur, proximal tibia and fibula	

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27485	Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (eg, genu varus or valgus)	
27486	Revision of total knee arthroplasty, with or without allograft; one component	Device donation required
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	Device donation required
27488	Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee	
27495	Prophylactic treatment (nailing, pinning, plating, or wiring) with or without methylmethacrylate, femur	
27496	Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor);	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27497	Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor);with debridement of nonviable muscle and/or nerve	
27498	Decompression fasciotomy, thigh and/or knee, multiple compartments;	
27499	Decompression fasciotomy, thigh and/or knee, multiple compartments;with debridement of nonviable muscle and/or nerve	
27506	Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws	
27507	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage	
27511	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed	
27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed	
27519	Open treatment of distal femoral epiphyseal separation, includes internal fixation, when performed	
27524	Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair	
27535	Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed	
27536	Open treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal fixation	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27540	Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed	
27556	Open treatment of knee dislocation, includes internal fixation, when performed; without primary ligamentous repair or augmentation/reconstruction	
27557	Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair	
27558	Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair, with augmentation/reconstruction	
27570	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)	
27580	Arthrodesis, knee, any technique	

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

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27599	Unlisted procedure, femur or knee	
27648	Injection procedure for ankle arthrography	
27702	Arthroplasty, ankle; with implant (total ankle)	Device donation required
27703	Arthroplasty, ankle; revision, total ankle	Device donation required
27720	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)	
27722	Repair of nonunion or malunion, tibia; with sliding graft	

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27724	Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)	
27725	Repair of nonunion or malunion, tibia; by synostosis, with fibula, any method	
27726	Repair of fibula nonunion and/or malunion with internal fixation	
27758	Open treatment of tibial shaft fracture (with or without fibular fracture), with plate/screws, with or without cerclage	
27759	Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage	
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	
27784	Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed	
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	
27814	Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed	
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	
27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	
27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only	
27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula	
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	
27832	Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula	
27846	Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; without repair or internal fixation	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
27848	Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; with repair or internal or external fixation	
27860	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)	
27880	Amputation, leg, through tibia and fibula	
27881	Amputation, leg, through tibia and fibula; with immediate fitting technique including application of first cast	
27882	Amputation, leg, through tibia and fibula; open, circular (guillotine)	
27884	Amputation, leg, through tibia and fibula; secondary closure or scar revision	

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CPT, HCPCS or Revenue Code	Description	Comments
27886	Amputation, leg, through tibia and fibula; re-amputation	
27888	Amputation, ankle, through malleoli of tibia and fibula (eg, Syme, Pirogoff type procedures), with plastic closure and resection of nerves	
27889	Ankle disarticulation	
27899	Unlisted procedure, leg or ankle	
28293	Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant	
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	
28445	Open treatment of talus fracture, includes internal fixation, when performed	
28446	Open osteochondral autograft, talus (includes obtaining graft(s))	
28450	Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each	
28455	Treatment of tarsal bone fracture (except talus and calcaneus); with manipulation, each	
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
28485	Open treatment of metatarsal fracture, includes internal fixation	
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each	
28531	Open treatment of sesamoid fracture, with or without internal fixation	
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	
28675	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed	
28800	Amputation, foot; midtarsal (eg, Chopart type procedure)	
28805	Amputation, foot; transmetatarsal	
28810	Amputation, metatarsal, with toe, single	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
28820	Amputation, toe; metatarsophalangeal joint	
28825	Amputation, toe; interphalangeal joint	
28899	Unlisted procedure, foot or toes	
29799	Unlisted procedure, casting or strapping	
29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)	
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion	
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body	
29820	Arthroscopy, shoulder, surgical; synovectomy, partial	
29821	Arthroscopy, shoulder, surgical; synovectomy, complete	
29822	Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])	
29823	Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)	
29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation	
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release	
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	
29828	Arthroscopy, shoulder, surgical;biceps tenodesis	
29847	Arthroscopy, wrist, surgical; internal fixation for fracture or instability	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament	
29850	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)	
29851	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 art hroscopy)	
29855	Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed (includes arthroscopy)	
29856	Arthroscopically aided treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal or external fixation (includes arthroscopy)	
29860	Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
29861	Arthroscopy, hip, surgical; with removal of loose body or foreign body	
29862	Arthroscopy, hip, surgical;with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum	
29863	Arthroscopy, hip, surgical;with synovectomy	
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft)	
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	
29868	Arthoscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)	
29871	Arthroscopy, knee, surgical; for infection, lavage and drainage	
29873	Arthroscopy, knee, surgical;with lateral release	
29874	Arthroscopy, knee, surgical;for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)	
29875	Arthroscopy, knee, surgical;synovectomy, limited (eg, plica or shelf resection) (separate procedure)	
29876	Arthroscopy, knee, surgical;synovectomy, major, two or more compartments (eg, medial or lateral)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
29877	Arthroscopy, knee, surgical;debridement/shaving of articular cartilage (chondroplasty)	
29879	Arthroscopy, knee, surgical;abrasion arthroplasty (includes chondroplasty where necessary) or multipledrillingor microfracture	
29880	Arthroscopy, knee, surgical;with meniscectomy (medial AND lateral, including any meniscal shaving)	
29881	Arthroscopy, knee, surgical;with meniscectomy (medial OR lateral, including any meniscal shaving)	
29882	Arthroscopy, knee, surgical;with meniscus repair (medial OR lateral)	
29883	Arthroscopy, knee, surgical;with meniscus repair (medial AND lateral)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
29884	Arthroscopy, knee, surgical;with lysis of adhesions, with or without manipulation (separate procedure)	
29885	Arthroscopy, knee, surgical;drilling for osteochondritis dissecans with bone grafting, with or withoutinternalfixation (including debridement of base of lesion)	
29886	Arthroscopy, knee, surgical;drilling for intact osteochondritis dissecans lesion	
29887	Arthroscopy, knee, surgical;drilling for intact osteochondritis dissecans lesion with internal fixation	
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
29892	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)	
29914	Arthroscopy, hip, surgical;with femoroplasty (ie, treatment of cam lesion)	
29915	Arthroscopy, hip, surgical;with acetabuloplasty (ie, treatment of pincer lesion)	
29916	Arthroscopy, hip, surgical;with labral repair	
29999	Unlisted procedure, arthroscopy	
30150	Rhinectomy; partial	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
30420	Rhinoplasty, primary; including major septal repair	
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip an palate, including columellar lengthening; tip, septum, osteotomies	
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)	
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
30999	Unlisted procedure, nose	
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa	
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)	
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)	
31299	Unlisted procedure, accessory sinuses	
31584	Laryngoplasty; with open reduction and fixation of (eg, plating) fracture, includes tracheostomy, if performed	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
31599	Unlisted procedure, larynx	
31899	Unlisted procedure, trachea, bronchi	
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	
32553	Placement of interstitial device for radiation therapy guidance, percutaneous, intra-thoracic, single or multiple	
32664	Thoracoscopy, surgical; with thoracic sympathectomy	
32672	Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
32999	Unlisted procedure, lungs and pleura	
33016	Pericardiocentesis, including imaging guidance, when performed	
33017	Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; 6 years and older without congenital cardiac anomaly	
33018	Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; birth through 5 years of age or any age with congenital cardiac anomaly	
33019	Pericardial drainage with insertion of indwelling catheter, percutaneous, including CT guidance	
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	Device donation required
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	Device donation required
33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (List separately in addition to code for primary procedure)	Device donation required
33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system	
33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
33230	Insertion of pacing cardioverter-defibrillator pulse generator only; with existing dual leads	Device donation required
33231	Insertion of pacing cardioverter-defibrillator pulse generator only; with existing multiple leads	Device donation required
33240	Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator	Device donation required
33249	Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber	Device donation required
33254	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
33257	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to code for primary procedure)	
33258	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in addition to code for primary procedure)	
33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system	Device donation required
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system	Device donation required
33265	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass	
33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed	Device donation required
33271	Insertion of subcutaneous implantable defibrillator electrode	Device donation required
33273	Repositioning of previously implanted subcutaneous implantable defibrillator electrode	Device donation required
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	Limit 8 cases/year. Authorize procedure in provider's office only
33286	Removal, subcutaneous cardiac rhythm monitor	
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
33366	Transcatheter transapical replacemt aortic valve	Device donation required
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed	Device donation required
33510	Coronary artery bypass, vein only; single coronary venous graft	
33511	Coronary artery bypass, vein only; 2 coronary venous grafts	
33512	Coronary artery bypass, vein only; 3 coronary venous grafts	
33513	Coronary artery bypass, vein only; 4 coronary venous grafts	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
33514	Coronary artery bypass, vein only; 5 coronary venous grafts	
33516	Coronary artery bypass, vein only; 6 or more coronary venous grafts	
33517	Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft	
33518	Coronary artery bypass, using venous graft(s) and arterial graft(s); 2 venous grafts	
33548	Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, DOR procedures)	
33858	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic dissection	

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CPT, HCPCS or Revenue Code	Description	Comments
33859	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic disease other than dissection (eg, aneurysm)	
33863	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction	
33866	Aortic hemiarch graft including isolation and control of the arch vessels, beveled open distal aortic anastomosis extending under one or more of the arch vessels, and total circulatory arrest or isolated cerebral perfusion (List separately in addition to code for primary procedure)	
33871	Transverse aortic arch graft, with cardiopulmonary bypass, with profound hypothermia, total circulatory arrest and isolated cerebral perfusion with reimplantation of arch vessel(s) (eg, island pedicle or individual arch vessel reimplantation)	
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 thora	
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	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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	
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)	
33886	Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta	
33894	Endovascular stent repair of coarctation of the ascending, transverse, or descending thoracic or abdominal aorta, involving stent placement; across major side branches	
33895	Endovascular stent repair of coarctation of the ascending, transverse, or descending thoracic or abdominal aorta, involving stent placement; not crossing major side branches	
33897	Percutaneous transluminal angioplasty of native or recurrent coarctation of the aorta	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
33900	Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, unilateral	
33901	Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, bilateral	
33902	Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, unilateral	
33903	Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, bilateral	
33904	Percutaneous pulmonary artery revascularization by stent placement, each additional vessel or separate lesion, normal or abnormal connections (List separately in addition to code for primary procedure)	
33999	Unlisted procedure, cardiac surgery	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
34716	Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral	
34717	Endovascular repair of iliac artery at the time of aorto-iliac artery endograft placement by deployment of an iliac branched endograft including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone	
34718	Endovascular repair of iliac artery, not associated with placement of an aorto-iliac artery endograft at the same session, by deployment of an iliac branched endograft, including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies)	
34841	Endovasc viscer aorta repair fenest 1 endograft	
34842	Endovasc viscer aorta repair fenest 2 endograft	
34843	Endovasc viscer aorta repair fenest 3 endograft	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
34844	Endovasc viscer aorta repr fenest 4+ endograft	
34845	Viscer and infrarenal abdom aorta 1 prosthesis	
34846	Viscer and infrarenal abdom aorta 2 prosthesis	
34847	Viscer and infrarenal abdom aorta 3 prosthesis	
34848	Viscer and infrarenal abdom aorta 4+ prosthesis	
35702	Exploration not followed by surgical repair, artery; upper extremity (eg, axillary, brachial, radial, ulnar)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
35703	Exploration not followed by surgical repair, artery; lower extremity (eg, common femoral, deep femoral, superficial femoral, popliteal, tibial, peroneal)	
35884	Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with autogenous vein patch graft	
36260	Insertion of implantable intra-arterial infusion pump (eg, for chemotherapy of liver)	
36299	Unlisted procedure, vascular injection	
36470	Injection of sclerosing solution; single vein	
36471	Injection of sclerosing solution; multiple veins, same leg	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	
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)	
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	
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)	
36514	Therapeutic apheresis; for plasma pheresis	
36516	Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
36522	Photopheresis, extracorporeal	
37184	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s)	
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	
37188	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel,	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery (s), unilateral; with transluminal angioplasty	
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery (s), unilateral; with atherectomy, includes angioplasty within the same vesse	
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery (s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel	
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery (s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel	
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel	
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel	
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel	
37241	Vascular embolization or occlusion venous rs&i	
37243	Vascular embolize/occlude organ tumor infarct	
37244	Vascular embolization or occlusion hemorrhage	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	
37501	Unlisted vascular endoscopy procedure	
37700	Ligation and division long saphenous vein at saphenofemoral junction, or distal interruptions	
37718	Ligation, division, and stripping, short saphenous vein	
37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	
37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	
37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	
37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	
37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	
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	
37760	Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
37761	Ligate leg veins open	
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	
37766	Stab phlebectomy of varicose veins, one extremity; more than 20 incisions	
37780	Ligation and division of short saphenous vein at saphenopopliteal junction	
37785	Ligation, division, and/or excision of varicose vein cluster(s), one leg	
37799	Unlisted procedure, vascular surgery	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
38129	Unlisted laparoscopy procedure, spleen	
38589	Unlisted laparoscopy procedure, lymphatic system	
38780	Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure)	
38999	Unlisted procedure, hemic or lymphatic system	
39499	Unlisted procedure, mediastinum	
39501	Repair, laceration of diaphragm, any approach	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
39503	Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia	
39540	Repair, diaphragmatic hernia (other than neonatal), traumatic; acute	
39541	Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic	
39599	Unlisted procedure, diaphragm	
40799	Unlisted procedure, lips	
40899	Unlisted procedure, vestibule of mouth	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
41019	Placement of needles, catheters, and other devices into the head and/or neck region	
41599	Unlisted procedure, tongue, floor of mouth	
41820	Gingivectomy, excision gingiva, each quadrant	
41874	Alveoloplasty, each quadrant (specify)	
41899	Unlisted procedure, dentoalveolar structures	
42140	EXCISION OF UVULA	

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42145	Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty)	
42160	Destruction of lesion, palate or uvula (thermal, cryo or chemical)	
42299	Unlisted procedure, palate, uvula	
42699	Unlisted procedure, salivary glands or ducts	
42820	Excision and Destruction Procedures on the Pharynx, Adenoids, and Tonsils	
42950	Pharyngoplasty (plastic or reconstructive operation on pharynx)	

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42999	Unlisted procedure, pharynx, adenoids, or tonsils	
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	
43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	
43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	
43263	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi	
43264	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)	

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43265	Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)	
43274	Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent	
43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	
43276	Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged	
43277	Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct	
43278	Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor (s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed	

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43279	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed	
43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)	
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	
43289	Unlisted laparoscopy procedure, esophagus	
43337	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
43499	Unlisted procedure, esophagus	
43631	Gastrectomy, partial, distal; with gastroduodenostomy	
43632	Gastrectomy, partial, distal; with gastrojejunostomy	
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	
43634	Gastrectomy, partial, distal; with formation of intestinal pouch	
43659	Unlisted laparoscopy procedure, stomach	

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43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	
43860	REVISE STOMACH-BOWEL FUSION	
43865	REVISE STOMACH-BOWEL FUSION	
43999	Unlisted procedure, stomach	
44139	Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)	
44140	Colectomy, partial; with anastomosis	

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44141	Colectomy, partial; with skin level cecostomy or colostomy	
44143	Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)	
44144	Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula	
44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)	
44146	Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy	
44147	Colectomy, partial; abdominal and transanal approach	

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44150	Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy	
44151	Colectomy, total, abdominal, without proctectomy; with continent ileostomy	
44155	Colectomy, total, abdominal, with proctectomy; with ileostomy	
44156	Colectomy, total, abdominal, with proctectomy; with continent ileostomy	
44157	Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy, when performed	
44158	Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, creation of ileal reservoir (S or J), includes loop ileostomy, and rectal mucosectomy, when performed	

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44204	Laparoscopy, surgical; colectomy, partial, with anastomosis	
44206	Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)	
44207	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)	
44208	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy	
44210	Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy	
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	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
44212	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy	
44213	Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)	
44238	Unlisted laparoscopy procedure, intestine (except rectum)	
44626	Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)	
44650	Closure of enteroenteric or enterocolic fistula	
44799	Unlisted procedure, intestine	

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44899	Unlisted procedure, Meckel's diverticulum and the mesentery	
44979	Unlisted laparoscopy procedure, appendix	
45121	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with subtotal or total colectomy, with multiple biopsies	
45399	Unlisted procedure, colon	
45999	Unlisted procedure, rectum	
46601	Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed	

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46607	Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple	
46707	Repair anorectal fist w/plug	
46999	Unlisted procedure, anus	
47379	Unlisted laparoscopic procedure, live	
47399	Unlisted procedure, liver	
47562	Laparoscopy, surgical; cholecystectomy	

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47563	Laparoscopy, surgical; cholecystectomy with cholangiography	
47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct	
47579	Unlisted laparoscopy procedure, biliary tract	
47600	Cholecystectomy	
47605	Cholecystectomy; with cholangiography	
47610	Cholecystectomy with exploration of common duct	

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47612	Cholecystectomy with exploration of common duct; with choledochoenterostomy	
47620	Cholecystectomy with exploration of common duct; with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography	
47999	Unlisted procedure, biliary tract	
48999	Unlisted procedure, pancreas	
49000	Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)	
49062	Open drainage of extraperitoneal lymphocele to peritoneal cavity	

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49203	Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less	
49204	Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5.1-10.0 cm diameter	
49205	Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor greater than 10.0 cm diameter	
49320	Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	
49323	Laparoscopy, surgical; with drainage of lymphocele to peritoneal cavity	
49329	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum	

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49411	Placement of interstitial device(s) for radiation therapy guidance, Open, Intra-abdominal, Intra-pelvic and/or retroperitoneum, including image guidance, single or multiple	
49412	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	
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; reducibl	
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	
49500	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducibl	
49501	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; incarcerated or strangulated	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
49505	Repair initial inguinal hernia, age 5 years or older; reducible	
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	
49520	Repair recurrent inguinal hernia, any age; reducible	
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	
49525	Repair inguinal hernia, sliding, any age	
49540	Repair lumbar hernia	

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49550	Repair initial femoral hernia, any age; reducible	
49553	Repair initial femoral hernia, any age; incarcerated or strangulated	
49555	Repair recurrent femoral hernia; reducible	
49557	Repair recurrent femoral hernia; incarcerated or strangulated	
49591	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect (s); less than 3 cm, reducible	
49592	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect (s); less than 3 cm, incarcerated or strangulated	

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49593	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect (s); 3 cm to 10 cm, reducible	
49594	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect (s); 3 cm to 10 cm, incarcerated or strangulated	
49595	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect (s); greater than 10 cm, reducible	
49596	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect (s); greater than 10 cm, incarcerated or strangulated	
49613	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect (s); less than 3 cm, reducible	
49614	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect (s); less than 3 cm, incarcerated or strangulated	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
49615	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect (s); 3 cm to 10 cm, reducible	
49616	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect (s); 3 cm to 10 cm, incarcerated or strangulated	
49617	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect (s); greater than 10 cm, reducible	
49618	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect (s); greater than 10 cm, incarcerated or strangulated	
49621	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; reducible	
49622	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; incarcerated or strangulated	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
49623	Removal of total or near total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach (ie, open, laparoscopic, robotic) (List separately in addition to code for primary procedure)	
49650	Laparoscopy, surgical; repair initial inguinal hernia	
49651	Laparoscopy, surgical; repair recurrent inguinal hernia	
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	
49999	Unlisted procedure, abdomen, peritoneum and omentum	
50220	Nephrectomy, including partial ureterectomy, any open approach including rib resection	

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50225	Nephrectomy, including partial ureterectomy, any open approach including rib resection; complicated because of previous surgery on same kidney	
50230	Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy	
50234	Nephrectomy with total ureterectomy and bladder cuff; through same incision	
50236	Nephrectomy with total ureterectomy and bladder cuff; through separate incision	
50240	Nephrectomy, partial	
50541	Laparoscopy, surgical; ablation of renal cysts	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
50543	Laparoscopy, surgical; partial nephrectomy	
50544	Laparoscopy, surgical; pyeloplasty	
50545	Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)	
50546	Laparoscopy, surgical; nephrectomy, including partial ureterectomy	
50548	Laparoscopy, surgical; nephrectomy with total ureterectomy	
50549	Unlisted laparoscopy procedure, renal	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
50949	Unlisted laparoscopy procedure, ureter	
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	
52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)	
52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)	
52240	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)	

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52250	Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration	
52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder	
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included	
52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	
52450	Transurethral incision of prostate	
52500	Transurethral resection of bladder neck (separate procedure)	

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52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	
52630	Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	
52640	Transurethral resection; of postoperative bladder neck contracture	
52648	Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	
52700	Transurethral drainage of prostatic abscess	

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53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	
53852	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy	
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	
53899	Unlisted procedure, urinary system	
54120	Amputation of penis; partial	
54125	Amputation of penis; complete	

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54130	Amputation of penis, radical; with bilateral inguinofemoral lymphadenectomy	
54135	Amputation of penis, radical; in continuity with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	
54162	Lysis or excision of penile post-circumcision adhesions	
54163	Repair incomplete circumcision	
54438	Replantation, penis, complete amputation including urethral repair	

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54699	Unlisted laparoscopy procedure, testis	
55720	Prostatotomy, external drainage of prostatic abscess, any approach; simple	
55725	Prostatotomy, external drainage of prostatic abscess, any approach; complicated	
55867	Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed	
55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or out cytosocopy	
55876	Fiducial marker placement in the prostate	

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55899	Unlisted procedure, male genital system	
55920	Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application	
56620	Vulvectomy simple; partial	
56630	Vulvectomy, radical, partial	
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)	
57110	Vaginectomy, complete removal of vaginal wall	

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57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy	
57156	Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy	
57250	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	
57280	Colpopexy, abdominal approach	
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)	
57283	Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)	

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57300	Closure of rectovaginal fistula; vaginal or transanal approach	
57530	Trachelectomy (cervicectomy), amputation of cervix (separate procedure)	
57700	Cerclage of uterine cervix, nonobstetrical	
58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	
58140	Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; abdominal approach	
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	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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	
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)	
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)	
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	
58200	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)	
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)	

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58240	Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof	
58260	Vaginal hysterectomy, for uterus 250 g or less	
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)	
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele	
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele	

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58275	Vaginal hysterectomy, with total or partial vaginectomy	
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele	
58285	Vaginal hysterectomy, radical (Schauta type operation)	
58290	Vaginal hysterectomy, for uterus greater than 250 g	
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele	

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58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele	
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography	Excluded from coverage with ICD-10 codes: N970 – N979; Z31.41; Z31.49; Z30.2
58346	Insertion of Heyman capsulesfor clinical brachytherapy	
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less	
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g	

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58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	
58545	Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 g or less and/or removal of surface myomas	
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	
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less	
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g	

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58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	
58555	Hysteroscopy, diagnostic (separate procedure)	
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	
58559	Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)	
58561	Hysteroscopy, surgical; with removal of leiomyomata	
58562	Hysteroscopy, surgical; with removal of impacted foreign body	

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58563	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less	
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g	
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	
58575	Laparoscopy, surgical, total hysterectomy for resection of malignancy (tumor debulking), with omentectomy including salpingo-oophorectomy, unilateral or bilateral, when performed	

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58578	Unlisted laparoscopy procedure, uterus	
58579	Unlisted hysteroscopy procedure, uterus	
58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure	
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	
58662	Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method	
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	

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58679	Unlisted laparoscopy procedure, oviduct, ovary	
58700	Salpingectomy, unilateral or bilateral	
58720	Salpingo-oophorectomy, unilateral or bilateral	
58740	Lysis of adhesions (salpngolysis, ovariolysis)	
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	
58953	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking	

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58954	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy	
58956	Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy	
58999	Unlisted procedure, female genital system (nonobstetrical)	
60699	Unlisted procedure, endocrine system	
61304	Craniectomy or craniotomy, exploratory; supratentorial	
61305	Craniectomy or craniotomy, exploratory; infratentorial (posterior fossa)	

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61312	Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural	
61313	Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebral	
61314	Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural	
61315	Craniectomy or craniotomy for evacuation of hematoma, infratentorial; intracerebellar	
61316	Incision and subcutaneous placement of cranial bone graft (List separately in addition to code for primary procedure)	
61320	Craniectomy or craniotomy, drainage of intracranial abscess; supratentorial	

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61321	Craniectomy or craniotomy, drainage of intracranial abscess; infratentorial	
61322	Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; without lobectomy	
61323	Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; with lobectomy	
61330	Decompression of orbit only, transcranial approach	
61333	Exploration of orbit (transcranial approach), with removal of lesion	
61340	Subtemporal cranial decompression (pseudotumor cerebri, slit ventricle syndrome)	

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61343	Craniectomy, suboccipital with cervical laminectomy for decompression of medulla and spinal cord, with or without dural graft (eg, Arnold-Chiari malformation)	
61345	Other cranial decompression, posterior fossa	
61450	Craniectomy, subtemporal, for section, compression, or decompression of sensory root of gasserian ganglion	
61458	Craniectomy, suboccipital; for exploration or decompression of cranial nerves	
61460	Craniectomy, suboccipital; for section of 1 or more cranial nerves	
61500	Craniectomy; with excision of tumor or other bone lesion of skull	

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61501	Craniectomy; for osteomyelitis	
61510	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	
61512	Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial	
61514	Craniectomy, trephination, bone flap craniotomy; for excision of brain abscess, supratentorial	
61516	Craniectomy, trephination, bone flap craniotomy; for excision or fenestration of cyst, supratentorial	
61518	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull	

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61519	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; meningioma	
61520	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; cerebellopontine angle tumor	
61521	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; midline tumor at base of skull	
61522	Craniectomy, infratentorial or posterior fossa; for excision of brain abscess	
61524	Craniectomy, infratentorial or posterior fossa; for excision or fenestration of cyst	
61526	Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
61530	Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor; combined with middle/posterior fossa craniotomy/craniectomy	
61537	Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, without electrocorticography during surgery	
61538	Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, with electrocorticography during surgery	
61539	Craniotomy with elevation of bone flap; for lobectomy, other than temporal lobe, partial or total, with electrocorticography during surgery	
61540	Craniotomy with elevation of bone flap; for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery	
61541	Craniotomy with elevation of bone flap; for transection of corpus callosum	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
61543	Craniotomy with elevation of bone flap; for partial or subtotal (functional) hemispherectomy	
61544	Craniotomy with elevation of bone flap; for excision or coagulation of choroid plexus	
61545	Craniotomy with elevation of bone flap; for excision of craniopharyngioma	
61546	Craniotomy for hypophysectomy or excision of pituitary tumor, intracranial approach	
61548	Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic	
61550	Craniectomy for craniosynostosis; single cranial suture	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
61552	Craniectomy for craniosynostosis; multiple cranial sutures	
61556	Craniotomy for craniosynostosis; frontal or parietal bone flap	
61557	Craniotomy for craniosynostosis; bifrontal bone flap	
61558	Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); not requiring bone grafts	
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)	
61563	Excision, intra and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); without optic nerve decompression	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
61564	Excision, intra and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); with optic nerve decompression	
61566	Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy	
61567	Craniotomy with elevation of bone flap; for multiple subpial transections, with electrocorticography during surgery	
61570	Craniectomy or craniotomy; with excision of foreign body from brain	
61571	Craniectomy or craniotomy; with treatment of penetrating wound of brain	
61575	Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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)	
61736	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole (s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion	
61737	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole (s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)	
61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical	Device Donation Required - any component of Stimulator requires donation, otherwise Not a Covered Benefit
61860	Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical	Device Donation Required - any component of Stimulator requires donation, otherwise Not a Covered Benefit
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	Device Donation Required - any component of Stimulator requires donation, otherwise Not a Covered Benefit

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
61864	each additional array (List separately in addition to primary procedure	Device Donation Required - any component of Stimulator requires donation, otherwise Not a Covered Benefit
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	Device Donation Required - any component of Stimulator requires donation, otherwise Not a Covered Benefit
61868	each additional array (List separately in addition to primary procedure)	Device Donation Required - any component of Stimulator requires donation, otherwise Not a Covered Benefit
61880	Revision or removal of intracranial neurostimulator electrodes	Device Donation Required - any component of Stimulator requires donation, otherwise Not a Covered Benefit
61885	Insertion or replacement of cranial neurostimulat or pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	Device Donation Required - any component of Stimulator requires donation, otherwise Not a Covered Benefit
61886	Insertion or replacement of cranial neurostimulat or pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays	Device Donation Required - any component of Stimulator requires donation, otherwise Not a Covered Benefit

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
61888	Revision or removal of cranial neurostimulator pulse generator or receiver	Device Donation Required - any component of Stimulator requires donation, otherwise Not a Covered Benefit
62000	Elevation of depressed skull fracture; simple, extradural	
62005	Elevation of depressed skull fracture; compound or comminuted, extradural	
62010	Elevation of depressed skull fracture; with repair of dura and/or debridement of brain	
62263	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days	
62264	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	

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62284	Injection procedure for myelography and/or computed tomography, lumbar	
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar (e.g., manual or automated percutaneous diskectomy, percutaneous laser diskectomy)	
62290	Injection procedure for discography, each level; lumbar	
62291	Injection procedure for discography, each level; cervical or thoracic	
62302	Myelography via lumbar injection, including radiological supervision and interpretation; cervical	
62303	Myelography via lumbar injection, including radiological supervision and interpretation; thoracic	

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62304	Myelography via lumbar injection, including radiological supervision and interpretation; lumbosacral	
62305	Myelography via lumbar injection, including radiological supervision and interpretation; 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)	
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar	
63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (e.g., spinal stenosis), one or two vertebral segments; lumbar, except for spondylolisthesis	
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)	
63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (e.g., spinal stenosis), more than 2 vertebral segments; lumbar	

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63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar (including open or endoscopically-assisted approach)	
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; lumbar	
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (e.g., spinal or lateral recess stenosis)), single vertebral segment; lumbar	
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 vertebral segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)	
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disk), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (e.g., far lateral herniated intervertebral disk)	
63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disk), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)	
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment	
63082	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)	
63087	Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment	
63088	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)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
63090	Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment	
63091	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)	
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array	
64721	Neuroplasty and transposition of median nerve at carpal tunnel	
64804	Sympathectomy, cervicothoracic	
64999	Unlisted procedure, nervous system	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
65400	Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium	
65420	Excision or transposition of pterygium; without graft	
65426	Excision or transposition of pterygium; with graft	
66170	Creation of eye fluid drainage tract	
66174	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without retention of device or stent	
66175	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); with retention of device or stent	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
66179	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft	
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	
66184	Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft	
66761	Iridotomy/iridectomy by laser surgery	
66820	Removal of recurring cataract in lens capsule	
66821	Post-Cataract Laser Surgery	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
66825	Repositioning of lens prosthesis	
66830	Removal of lens lesion	
66840	Aspiration removal of lens material	
66850	Fragmenting, aspiration, and removal of lens material	
66852	Removal of lens material	
66982	Removal of cataract with insertion of lens, Extracapsular cataract removal; CATARACT SURGERY COMPLEX	Member is responsible for cost of IOL

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
66983	Removal of cataract with insertion of lens, Intracapsular cataract extraction	Member is responsible for cost of IOL
66984	Removal of cataract with insertion of lens, Extracapsular cataract removal	Member is responsible for cost of IOL
66985	Insertion of lens prosthesis	Member is responsible for cost of lens
66999	Unlisted procedure, anterior segment of eye	
67010	Removal of vitreous, anterior approach (open sky technique or limbal incision); subtotal removal with mechanical vitrectomy	
67036	Vitrectomy, mechanical, pars plana approach	

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67039	Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation	
67040	Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation	
67041	Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker)	
67042	Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)	
67043	Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation	
67107	Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
67108	Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique	
67113	Repair of complex retinal detachment	
67145	Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage , 1 or more sessions ; photocoagulation	
67210	Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation	
67220	Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions	
67228	Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
67299	Unlisted procedure, posterior segment	
67399	Unlisted procedure, ocular muscle	
67400	Orbitotomy without bone flap (frontal or transconjunctival approach); for exploration, with or without biopsy	
67420	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of lesion	
67560	Orbital implant (implant outside muscle cone); removal or revision	When request is for revision, if a new implant is required, patient is required to pay for cost of implant prior to procedure.
67599	Unlisted procedure, orbit	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)	Patient is required to pay for cost of weight, prior to procedure. (weight not a covered benefit)
67914	Repair of ectropion; suture	
67915	Repair of ectropion; thermocauterization	
67916	Repair of ectropion; excision tarsal wedge	
67917	Repair of ectropion; extensive (eg, tarsal strip operations)	
67921	Repair of entropion; suture	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
67922	Repair of entropion; thermocauterization	
67923	Repair of entropion; excision tarsal wedge	
67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)	
67938	Removal of embedded foreign body, eyelid	
67950	Canthoplasty (reconstruction of canthus)	
67999	Unlisted procedure, eyelids	

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68320	Conjunctivoplasty; with conjunctival graft or extensive rearrangement	
68325	Conjunctivoplasty; with buccal mucous membrane graft (includes obtaining graft)	
68326	Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement	
68328	Conjunctivoplasty, reconstruction cul-de-sac; with buccal mucous membrane graft (includes obtaining graft)	
68899	Unlisted procedure, lacrimal system	
69150	Radical excision external auditory canal lesion; without neck dissection	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
69155	Radical excision external auditory canal lesion; with neck dissection	
69399	Unlisted procedure, external ear	
69501	Transmastoid antrotomy (simple mastoidectomy)	
69502	Mastoidectomy; complete	
69505	Mastoidectomy; modified radical	
69511	Mastoidectomy; radical	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
69530	Petrous apicectomy including radical mastoidectomy	
69535	Resection temporal bone, external approach	
69540	Excision aural polyp	
69550	Excision aural glomus tumor; transcanal	
69552	Excision aural glomus tumor; transmastoid	
69554	Excision aural glomus tumor; extended (extratemporal)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
69601	Revision mastoidectomy; resulting in complete mastoidectomy	
69602	Revision mastoidectomy; resulting in modified radical mastoidectomy	
69603	Revision mastoidectomy; resulting in radical mastoidectomy	
69604	Revision mastoidectomy; resulting in tympanoplasty	
69610	Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch	
69620	Myringoplasty (surgery confined to drumhead and donor area)	

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69631	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction	
69632	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg, postfenestration)	
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])	
69635	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction	
69636	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction	
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])	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
69641	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction	
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	
69643	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction	
69644	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction	
69645	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction	
69646	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
69650	Stapes mobilization	
69660	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material	
69661	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material; with footplate drill out	
69662	Revision of stapedectomy or stapedotomy	
69666	Repair oval window fistula	
69667	Repair round window fistula	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
69799	Unlisted procedure, middle ear	
69949	Unlisted procedure, inner ear	
69979	Unlisted procedure, temporal bone, middle fossa approach	
70328	Radiologic examination, temporomandibular joint, open and closed mouth; unilatera	
70332	Temporomandibular joint arthrography, radiological supervision and interpretation	
70336	MRI (e.g., proton) imaging, temporomandibular joint(s)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
70450	Computed tomography (CT), head or brain; without contrast material	
70460	Computed tomography (CT), head or brain; with contrast material(s)	
70470	Computed tomography (CT), head or brain; without contrast material, followed by contrast material(s) and further sections	
70480	Computed tomography (CT), orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	
70481	Computed tomography (CT), orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)	
70482	Computed tomography (CT), orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
70486	Computed tomography (CT), maxillofacial area; without contrast material	
70487	Computed tomography (CT), maxillofacial area; with contrast material(s)	
70488	Computed tomography (CT), maxillofacial area; without contrast material, followed by contrast material(s) and further sections	
70490	Computed tomography (CT), soft tissue neck; without contrast material	
70491	Computed tomography (CT), soft tissue neck; with contrast material(s)	
70492	Computed tomography (CT), soft tissue neck; without contrast material followed by contrast material(s) and further sections	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing	
70498	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing	
70540	MRI orbit, face, neck, without contrast materials	
70542	MRI, orbit, face and neck, with contrast materials	
70543	MRI, orbit, face and neck, without contrast material(s), followed by contrast material(s) and further sequences	
70544	MRA, head; without contrast materials	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
70545	MRA, head; with contrast material(s)	
70546	MRA, head; without contrast material(s), followed by contrast material(s) and further sequences	
70547	MRA, neck; without contrast material(s)	
70548	MRA, neck; with contrast material(s)	
70549	MRA, neck; without contrast material(s), followed by contrast material(s) and further sequences	
70551	MRI, brain, including brain stem; without contrast material(s)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
70552	MRI brain, including brain stem; with contrast material(s)	
70553	MRI, brain, including brain stem; without contrast material(s), followed by contrast material(s) and further sequences	
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	
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	
71250	Computed tomography, thorax, diagnostic; without contrast material	
71260	Computed tomography, thorax, diagnostic; with contrast material(s)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
71270	Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections	
71275	Computed tomographic angiography, chest (noncoronary), with contrast material (s), including noncontrast images, if performed, and image postprocessing	
71550	MRI, chest (e.g., for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)	
71551	MRI, chest (e.g., for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)	
71552	MRI, chest (e.g., for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences	
71555	MRA, chest (excluding myocardium), with or without contrast materials	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
72125	Computed tomography (CT), cervical spine; without contrast material	
72126	Computed tomography (CT), cervical spine; with contrast material	
72127	Computed tomography (CT), cervical spine; without contrast material, followed by contrast material(s) and further sections	
72128	Computed tomography (CT), thoracic spine; without contrast material	
72129	Computed tomography (CT), thoracic spine; with contrast material	
72130	Computed tomography (CT), thoracic spine; without contrast material, followed by contrast material(s) and further sections	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
72131	Computed tomography (CT), lumbar spine; without contrast material	
72132	Computed tomography (CT), lumbar spine; with contrast material	
72133	Computed tomography (CT), lumbar spine; without contrast material, followed by contrast material(s) and further sections	
72141	MRI, spinal canal and contents, cervical; without contrast material	
72142	MRI, spinal canal and contents, cervical; with contrast material(s)	
72146	MRI, spinal canal and contents, thoracic; without contrast material	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
72147	MRI spinal canal and contents, thoracic; with contrast material(s)	
72148	MRI spinal canal and contents, lumbar; without contrast material	
72149	MRI, spinal canal and contents, lumbar; with contrast material(s)	
72156	MRI, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical	
72157	MRI, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic	
72158	MRI, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
72159	MRA, spinal canal and contents, with or without contrast material(s)	
72191	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	
72192	Computed tomography (CT), pelvis; without contrast material	
72193	Computed tomography (CT), pelvis; with contrast material(s)	
72194	Computed tomography (CT), pelvis; without contrast material, followed by contrast material(s) and further sections	
72195	MRI, pelvis; without contrast material(s)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
72196	MRI, pelvis; with contrast material(s)	
72197	MRI, pelvis; without contrast material(s), followed by contrast material(s) and further sequences	
72198	MRA, pelvis, with or without contrast material(s)	
72285	Discography, cervical or thoracic, radiological supervision and interpretation	
73040	Radiologic examination, shoulder, arthrography, radiological supervision and interpretation	
73085	Radiologic examination, elbow, arthrography, radiological supervision and interpretation	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
73115	Radiologic examination, wrist, arthrography, radiological supervision and interpretation	
73200	Computed tomography (CT), upper extremity; without contrast material	
73201	Computed tomography (CT), upper extremity; with contrast material(s)	
73202	Computed tomography (CT), upper extremity; without contrast material, followed by contrast material(s) and further sections	
73206	Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing	
73218	MRI, upper extremity, other than joint; without contrast material(s)	

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CPT, HCPCS or Revenue Code	Description	Comments
73219	MRI, upper extremity, other than joint; with contrast material(s)	
73220	MRI, upper extremity, other than joint; without contrast material(s), followed by contrast material(s) and further sequences	
73221	MRI, any joint of upper extremity; without contrast material(s)	
73222	MRI, any joint of upper extremity; with contrast material(s)	
73223	MRI, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences	
73225	MRA, upper extremity, with or without contrast material(s)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
73525	Radiologic examination, hip, arthrography, radiological supervision and interpretation	
73580	Radiologic examination, knee, arthrography, radiological supervision and interpretation	
73615	Radiologic examination, ankle, arthrography, radiological supervision and interpretation	
73700	Computed tomography (CT), lower extremity; without contrast material	
73701	Computed tomography (CT), lower extremity; with contrast material(s)	
73702	Computed tomography (CT), lower extremity; without contrast material, followed by contrast material(s) and further sections	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
73706	Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing	
73718	MRI, lower extremity other than joint; without contrast material(s)	
73719	MRI, lower extremity other than joint; with contrast material(s)	
73720	MRI, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences	
73721	MRI, any joint of lower extremity; without contrast material	
73722	MRI, any joint of lower extremity; with contrast material(s)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
73723	MRI, any joint of lower extremity; without contrast material(s), followed by contrast material(s) and further sequences	
73725	MRA, lower extremity, with or without contrast material(s)	
74150	Computed tomography (CT), abdomen; without contrast material	
74160	Computed tomography (CT), abdomen; with contrast material(s)	
74170	Computed tomography (CT), abdomen; without contrast material, followed by contrast material(s) and further sections	
74174	Computed tomographic angiography, abdomen and pelvis, with contrast material (s), including noncontrast images, if performed, and image postprocessing	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing	
74176	Computed tomography, abdomen and pelvis; without contrast material	
74177	Computed tomography, abdomen and pelvis; with contrast material(s)	
74178	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions	
74181	MRI, abdomen; without contrast material(s)	
74182	MRI, abdomen; with contrast material(s)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
74183	MRI, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences	
74185	MRA, abdomen, with or without contrast material(s)	
74740	Hysterosalpingography, radiological supervision and interpretation	Excluded from coverage with ICD-10 codes: N970 – N979; Z31.41; Z31.49; Z30.2 Z98.51
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material	
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s) and further sequences	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s) and further sequences; with stress imaging	
75565	Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure)	
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of left ventricular [LV] cardiac function, right ventricular [RV] structure and function and evaluation of vascular structures, if performed)	
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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	
76380	Computed tomography (CT), limited or localized follow-up study	
76390	Magnetic resonance spectroscopy (MRS)	
76497	IMRT Planning	
76498	Unlisted magnetic resonance procedure (e.g., diagnostic, interventional)	
76499	Unlisted diagnostic radiographic procedure	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
76831	Saline infusion sonohysterography (SIS), including color flow Doppler, when performed	
76873	US transrectal prostate volume study for brachytherapy	
77011	Computed Tomography Guidance for Stereotactic Localization	
77014	CT guidance for placement of radiation therapy fields	
77046	Magnetic resonance imaging, breast, without contrast material; unilateral	
77047	Magnetic resonance imaging, breast, without contrast material; bilateral	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral	
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral	
77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	
77080	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton	
77081	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	
77084	Magnetic resonance (eg, proton) imaging, bone marrow blood supply	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment	
77086	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)	
77261	Therapeutic Radiology treatment planning; simple	
77262	Therapeutic Radiology treatment planning; intermediate	
77263	Therapeutic Radiology treatment planning; complex	
77280	Therapeutic Radiology Simulation; simple	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
77285	Therapeutic Radiology Simulation; intermediate	
77290	Therapeutic Radiology Simulation; complex	
77293	Respiratory motion management simulation	
77295	Therapeutic Radiology Simulation 3-Dimensional	
77299	Unlisted procedure; Therapeutic Radiology treatment planning	
77300	Basic Radiation Dosimetry	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	
78201	Nuclear imaging of liver	
78202	Liver imaging; with vascular flow	
78215	Liver and spleen imaging; static only	
78216	Liver and spleen imaging; with vascular flow	
78226	Hepatobiliary system imaging, including gallbladder when present	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
78227	Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed	
78261	Gastric mucosa imaging	
78262	Gastroesophageal reflux study	
78264	Gastric emptying imaging study (eg, solid, liquid, or both);	
78265	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit	
78266	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
78278	Acute gastrointestinal blood loss imaging	
78290	Intestine imaging (eg, ectopic gastric mucosa, Meckel's localization, volvulus)	
78300	Bone and/or joint imaging; limited area	
78305	Bone and/or joint imaging; multiple areas	
78306	Bone and/or joint imaging; whole body	
78315	Bone and/or joint imaging; 3 phase study	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine	
78451	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	
78452	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	
78453	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	
78454	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	
78456	Acute venous thrombosis imaging, peptide	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
78466	Myocardial imaging, infarct avid, planar; qualitative or quantitative	
78468	Myocardial imaging, infarct avid, planar; with ejection fraction by first pass technique	
78469	Myocardial imaging, infarct avid, planar; tomographic SPECT with or without quantification	
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	
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	
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	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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	
78494	Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing	
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)	
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine	
78598	Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed	
78700	Kidney imaging morphology	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
78701	Kidney imaging morphology; with vascular flow	
78707	Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention	
78708	Kidney imaging morphology; with vascular flow and function, single study, with pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)	
78709	Kidney imaging morphology; with vascular flow and function, multiple studies, with and without pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)	
78725	Kidney function study, non-imaging radioisotopic study	
78800	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
78801	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); multiple areas	
78802	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging	
78803	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), single area (eg, head, neck, chest, pelvis) or acquisition, single day imaging	
78804	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring 2 or more days imaging	
78830	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis) or acquisition, single day imaging	Covered when provided at Ascension Seton Facility
78831	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, chest and abdomen) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition over 2 or more days	Covered when provided at Ascension Seton Facility

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
78832	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, chest and abdomen) or separate acquisitions (eg, lung ventilation and perfusion)	Covered when provided at Ascension Seton Facility
78835	Radiopharmaceutical quantification measurement(s) single area (List separately in addition to code for primary procedure)	Covered when provided at Ascension Seton Facility
79005	Radiopharmaceutical therapy, by oral administration	
84999	Unlisted chemistry procedure	
85999	Unlisted hematology or coag procedure	
86486	Skin test; unlisted antigen, each	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
90281	Immune globulin, IM use	
90283	Immune globulin (IgIV), human, for intravenous use	
90284	Immune globulin, subcut infusions; 100 mg each	
90378	Respiratory syncytial virus immune globulin (RSV-IgIM), for intramuscular use, 50 mg, each	
90678	Respiratory syncytial virus vaccine, preF, subunit, bivalent, for intramuscular use	
91299	Unlisted diagnostic gastroenterology procedure	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
92499	Unlisted ophthalmological service or procedure	
92700	Unlisted otorhinolaryngological service or procedure	
92972	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)	
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report	
93016	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report	
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	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
93018	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only	
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	
93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data	
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete	
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	
93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	
93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	
93313	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only	
93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only	
93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	

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CPT, HCPCS or Revenue Code	Description	Comments
93316	Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only	
93317	Interpretation and report of congenital heart ultrasound examination using esophageal probe	
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	
93319	3D echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging)	
93350	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report;	
93351	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)	
93503	Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes	
93505	Endomyocardial biopsy	
93569	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, unilateral (List separately in addition to code for primary procedure)	
93573	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, bilateral (List separately in addition to code for primary procedure)	
93574	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary venous angiography of each distinct pulmonary vein during cardiac catheterization (List separately in addition to code for primary procedure)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
93575	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its systemic branches, during cardiac catheterization for congenital heart defects, each distinct vessel (List separately in addition to code for primary procedure)	
93580	Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant	
93582	Percutaneous transcatheter closure pat duct arteriosus	
93583	Percutaneous transcatheter septal reduction therapy	
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
93592	Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)	
93953	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections	
93593	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections	
93594	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; abnormal native connections	
93595	Left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone, normal or abnormal native connections	
93596	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone (s); normal native connections	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
93597	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone (s); abnormal native connections	
93598	Cardiac output measurement(s), thermodilution or other indicator dilution method, performed during cardiac catheterization for the evaluation of congenital heart defects (List separately in addition to code for primary procedure)	
93600	Bundle of His recording	
93602	Intra-atrial recording	
93603	Right ventricular recording	
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)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
93610	Intra-atrial pacing	
93612	Intraventricular pacing	
93613	Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)	
93615	Esophageal recording of atrial electrogram with or without ventricular electrogram (s	
93616	Esophageal recording of atrial electrogram with or without ventricular electrogram (s); with pacing	
93618	Induction of arrhythmia by electrical pacing	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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	
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)	
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)	
93623	Programmed stimulation and pacing after intravenous drug infusion (List separately in addition to code for primary procedure)	
93624	Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia	
93631	Intra-operative epicardial and endocardial pacing and mapping to localize the site of tachycardia or zone of slow conduction for surgical correction	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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	
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	
93642	Electrophysiologic evaluation of single or dual chamber transvenous 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)	
93644	Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	
93650	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	
93653	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of	

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CPT, HCPCS or Revenue Code	Description	Comments
93654	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of	
93655	Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)	
93656	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording	
93657	Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)	
93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention	
93662	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
93799	Unlisted cardiovascular service or procedure	
94799	Unlisted pulmonary service or procedure	
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	
95966	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)	
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)	
95970	Electronic analysis of implanted neurostimulator pulse generator system; simple or complex brain, spinal cord, or peripheral, without reprogramming	when performed by contracted providers only

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
95971	Electronic analysis of implanted neurostimulator pulse generator system; simple spinal cord, or peripheral, with intraoperative or subsequent programming	
95972	Electronic analysis of implanted neurostimulator pulse generator system; complex spinal cord, or peripheral, with intraoperative or subsequent programming, first hour	
95973	Electronic analysis of implanted neurostimulator pulse generator system; simple or complex brain, spinal cord, or peripheral, with intraoperative or subsequent programming, each additional 30 minutes after first hour	
95999	Unlisted neurological or neuromuscular diagnostic procedure	
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion	
96446	Chemotherapy administration into the peritoneal cavity via implanted port or catheter	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
96999	Unlisted special dermatological service or procedure	
99601	Home infusion procedures and services	
0193T	Transurethral, radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	
0714T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume less than 50 mL	
0730T	Trabeculotomy by laser, including optical coherence tomography (OCT) guidance	
0735T	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with primary craniotomy (List separately in addition to code for primary procedure)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
0738T	Treatment planning for magnetic field induction ablation of malignant prostate tissue, using data from previously performed magnetic resonance imaging (MRI) examination	
0739T	Ablation of malignant prostate tissue by magnetic field induction, including all intraprocedural, transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring, thermal dosimetry, bladder irrigation, and magnetic field nanoparticle activation	
0742T	Absolute quantitation of myocardial blood flow (AQMBF), single-photon emission computed tomography (SPECT), with exercise or pharmacologic stress, and at rest, when performed (List separately in addition to code for primary procedure)	
0743T	Bone strength and fracture risk using finite element analysis of functional data and bone mineral density (BMD), with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and BMD and classification of any vertebral fractures, with overall fracture-risk assessment, interpretation and report	
0744T	Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium), when performed	
0745T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization and mapping of arrhythmia site (nidus), derived from anatomical image data (eg, CT, MRI, or myocardial perfusion scan) and electrical data (eg, 12-lead ECG data), and identification of areas of avoidance	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
0746T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan	
0747T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy, arrhythmia	
0749T	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone strength and fracture risk and BMD, interpretation and report	
0750T	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone strength and fracture risk and BMD, interpretation and report; with single-view digital X-ray examination of the hand taken for the purpose of DXR-BMD	
0776T	Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (eg, vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment	
0777T	Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
5015F	Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis (OP)	
HCPCS Codes		
A4604	Tubing with integrated heating element for use with positive airway pressure device	REPLACE AS NEEDED, NO MORE THAN 1 PER YEAR
A5500	Diabetic Shoes	
A5512	Multi den insert direct form	
A7027	Combination oral/nasal mask, used with continuous positive airway pressure device, each	REPLACE WHEN NEEDED BUT NO MORE THAN 1 PER 12 MONTHS

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
A7030	Full face mask used with positive airway pressure device, each	REPLACE AS NEEDED, NO MORE THAN 1 PER YEAR
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap	REPLACE WHEN NEEDED BUT NO MORE THAN 1 PER 12 MONTHS
A7035	Headgear used with positive airway pressure device	REPLACE WHEN NEEDED BUT NO MORE THAN 1 PER 12 MONTHS
A7036	Chinstrap used with positive airway pressure device	REPLACE WHEN NEEDED BUT NO MORE THAN 1 PER 12 MONTHS
A7037	Tubing used with positive airway pressure device	REPLACE WHEN NEEDED BUT NO MORE THAN 1 PER 12 MONTHS
A7044	Oral interface used with positive airway pressure device, each	REPLACE WHEN NEEDED BUT NO MORE THAN 1 PER 12 MONTHS

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each	REPLACE WHEN NEEDED BUT NO MORE THAN 1 PER 12 MONTHS
B4034	Enteral feeding supply kit; syringe fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tap	Long term therapy not covered. 3 month maximum
B4035	Enteral feeding supply kit; pump fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape	Long term therapy not covered. 3 month maximum
B4036	Enteral feeding supply kit; gravity fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape	Long term therapy not covered. 3 month maximum
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	Long term therapy not covered. 3 month maximum
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	Long term therapy not covered. 3 month maximum

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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	Long term therapy not covered. 3 month maximum
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	Long term therapy not covered. 3 month maximum
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	Long term therapy not covered. 3 month maximum
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	Long term therapy not covered. 3 month maximum
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	Long term therapy not covered. 3 month maximum
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	Long term therapy not covered. 3 month maximum

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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	Long term therapy not covered. 3 month maximum
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	Long term therapy not covered. 3 month maximum
B9002	Enteral nutrition infusion pump, any type	Long term therapy not covered. 3 month maximum
B9004	Parenteral nutrition infusion pump, portable	Long term therapy not covered. 3 month maximum
B9006	Parenteral nutrition infusion pump, stationary	Long term therapy not covered. 3 month maximum
B9998	Noc for enteral supplies	Long term therapy not covered. 3 month maximum

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
B9999	Noc for parenteral supplies	Long term therapy not covered. 3 month maximum
C1764	Event recorder, cardiac (implantable)	Limit 8 cases/year. Authorize procedure in provider's office only
C5271	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	
C5272	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	
C5273	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	
C5274	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
C5275	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	
C5276	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	
C5277	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	
C5278	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	
C7500	Debridement, bone including epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed, first 20 sq cm or less with manual preparation and insertion of deep (eg, subfacial) drug-delivery device(s)	
C7504	Percutaneous vertebroplasties (bone biopsies included when performed), first cervicothoracic and any additional cervicothoracic or lumbosacral vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
C7505	Percutaneous vertebroplasties (bone biopsies included when performed), first lumbosacral and any additional cervicothoracic or lumbosacral vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance	
C7506	Arthrodesis, interphalangeal joints, with or without internal fixation	
C7516	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (ivus) or optical coherence tomography (oct) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report	
C7517	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, with iliac and/or femoral artery angiography, non-selective, bilateral or ipsilateral to catheter insertion, performed at the same time as cardiac catheterization and/or coronary angiography, includes positioning or placement of the catheter in the distal aorta or ipsilateral femoral or iliac artery, injection of dye, production of permanent	
C7518	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (ivus) or optical coherence tomography (oct) during	
C7519	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
C7520	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) includes intraprocedural injection(s) for bypass graft angiography with iliac and/or femoral artery angiography, non-selective, bilateral or ipsilateral to catheter insertion, performed at the same time as cardiac	
C7521	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography with right heart catheterization with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (ivus) or optical coherence tomography (oct) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report	
C7522	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with right heart catheterization, with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress	
C7523	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (ivus) or optical coherence tomography (oct) during diagnostic evaluation and/or therapeutic intervention	
C7524	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced	
C7525	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft (s) (internal mammary, free arterial, venous grafts) with bypass graft angiography with endoluminal imaging of initial coronary vessel or graft using intravascular	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
C7526	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft (s) (internal mammary, free arterial, venous grafts) with bypass graft angiography with intravascular doppler velocity and/or pressure derived coronary flow reserve	
C7527	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (ivus) or optical coherence tomography (oct) during diagnostic evaluation and/or therapeutic	
C7528	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including	
C7529	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography with intravascular doppler velocity and/or pressure derived coronary	
C7531	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery (ies), unilateral, with transluminal angioplasty with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation	
C7532	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), initial artery, open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
C7533	Percutaneous transluminal coronary angioplasty, single major coronary artery or branch with transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy	
C7534	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery (ies), unilateral, with atherectomy, includes angioplasty within the same vessel, when performed with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation	
C7535	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery (ies), unilateral, with transluminal stent placement(s), includes angioplasty within the same vessel, when performed, with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation	
C7537	Insertion of new or replacement of permanent pacemaker with atrial transvenous electrode(s), with insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable debribrillator or pacemake pulse generator (eg, for upgrade to dual chamber system)	Device Donation Required
C7538	Insertion of new or replacement of permanent pacemaker with ventricular transvenous electrode(s), with insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defribrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system)	Device Donation Required
C7539	Insertion of new or replacement of permanent pacemaker with atrial and ventricular transvenous electrode(s), with insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system)	Device Donation Required

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
C7540	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator, dual lead system, with insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system)	Device Donation Required
C7541	Diagnostic endoscopic retrograde cholangiopancreatography (ercp), including collection of specimen(s) by brushing or washing, when performed, with endoscopic cannulation of papilla with direct visualization of pancreatic/common bile ducts(s)	
C7542	Endoscopic retrograde cholangiopancreatography (ercp) with biopsy, single or multiple, with endoscopic cannulation of papilla with direct visualization of pancreatic/common bile ducts(s)	
C7543	Endoscopic retrograde cholangiopancreatography (ercp) with sphincterotomy/papillotomy, with endoscopic cannulation of papilla with direct visualization of pancreatic/common bile ducts(s)	
C7544	Endoscopic retrograde cholangiopancreatography (ercp) with removal of calculi/debris from biliary/pancreatic duct(s), with endoscopic cannulation of papilla with direct visualization of pancreatic/common bile ducts(s)	
C7545	Percutaneous exchange of biliary drainage catheter (eg, external, internal-external, or conversion of internal-external to external only), with removal of calculi/debris from biliary duct(s) and/or gallbladder, including destruction of calculi by any method (eg, mechanical, electrohydraulic, lithotripsy) when performed, including diagnostic cholangiography(ies) when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
C7546	Removal and replacement of externally accessible nephroureteral catheter (eg, external/internal stent) requiring fluoroscopic guidance, with ureteral stricture balloon dilation, including imaging guidance and all associated radiological supervision and interpretation	
C7547	Convert nephrostomy catheter to nephroureteral catheter, percutaneous via pre-existing nephrostomy tract, with ureteral stricture balloon dialation, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	
C7548	Exchange nephrostomy catheter, percutaneous, with ureteral stricture balloon dilation, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	
C7549	Change of ureterostomy tube or externally accessible ureteral stent via ileal conduit with ureteral stricture balloon dilation, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	
C7550	Cystourethroscopy, with biopsy(ies) with adjuctive blue light cystoscopy with fluorescent imaging agent	
C7551	Excision of major peripheral nerve neuroma, except sciatic, with implantation of nerve end into bone or muscle	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
C7552	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or	
C7553	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography with pharmacologic agent administration (eg, inhaled nitric oxide	
C7554	Cystourethroscopy with adjunctive blue light cystoscopy with fluorescent imaging agent	
C9068	Copper cu-64, dotatate, diagnostic, 1 millicurie	
C9358	Dermal substitute, native, nondenatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 sq cm	
C9360	Dermal substitute, native, nondenatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 sq cm	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
C9399	Unclassified drugs or biologicals	
C9725	Placement of endorectal intracavitary applicator for high intensity brachytherapy	
D9220	Deep sedation/general anesthesia, first 30 minutes	Pre-certification of Anesthesia is only applicable when dental services are performed in a hospital/facility setting.
D9221	Deep sedation/general anesthesia, each additional 15 Minutes	Pre-certification of Anesthesia is only applicable when dental services are performed in a hospital/facility setting.
E0163	Commode chair, mobile or stationary, with fixed arms	PURCHASE ONLY
E0165	Commode chair, mobile or stationary, with detachable arms	PURCHASE ONLY

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
E0167	Pail or pan for use with commode chair, replacement only	PURCHASE ONLY
E0168	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each	PURCHASE ONLY
E0181	Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty	
E0182	Pump for alternating pressure pad, for replacement only	
E0184	Dry pressure mattress	
E0185	Gel or gel-like pressure pad for mattress, standard mattress length and width	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
E0186	Air pressure mattress	
E0187	Water pressure mattress	
E0196	Gel pressure mattress	
E0197	Air pressure pad for mattress, standard mattress length and width	
E0198	Water pressure pad for mattress, standard mattress length and width	
E0199	Dry pressure pad for mattress, standard mattress length and width	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
E0250	Hospital bed, fixed height, with any type side rails, with mattress	
E0251	Hospital bed, fixed height, with any type side rails, without mattress	
E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress	
E0256	Hospital bed, variable height, hi-lo, with any type side rails, without mattress	
E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	
E0261	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
E0265	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress	
E0266	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, without mattress	
E0270	Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress	
E0277	Powered pressure-reducing air mattress	
E0300	Pediatric crib, hospital grade, fully enclosed	
E0301	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	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
E0302	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress	
E0303	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	
E0304	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	
E0316	Safety enclosure frame/canopy for use with hospital bed, any type	
E0371	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width	
E0372	Powered air overlay for mattress, standard mattress length and width	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
E0373	Nonpowered advanced pressure reducing mattress	
E0424	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	
E0425	Stationary compressed gas system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing	
E0470	Bipap- Respiratory assist device, bi-level pressure capability	1) Approved for 3 months initial usage, then compliance report for continued rental of CPAP/ BIPAP. 2) Replacement 1 every 5 years
E0471	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)	1) Approved for 3 months initial usage, then compliance report for continued rental of CPAP/ BIPAP. 2) Replacement 1 every 5 years

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
E0472	Respiratory assist device, bi-level pressure capability, with backup rate feature	1) Approved for 3 months initial usage, then compliance report for continued rental of CPAP/ BIPAP. 2) Replacement 1 every 5 years
E0500	Ippb machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source	
E0600	Respiratory suction pump, home model, portable or stationary, electric	
E0601	Continuous positive airway pressure (cpap) device	1) Approved for 3 months initial usage, then compliance report for continued rental of CPAP/ BIPAP. 2) Replacement 1 every 5 years
E0621	Sling or seat, patient lift, canvas, or nylon	
E0630	Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s), or pad(s)	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
E1036	Multi-positional patient transfer system, extra-wide, with integrated seat, operated by caregiver, patient weight capacity greater than 300 pounds	
E1050	Fully reclining wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests	
E1060	Fully reclining wheelchair; detachable arms, desk or full-length, swing- away, detachable, elevating leg rests	
E1070	Fully reclining wheelchair; detachable arms, desk or full-length, swing- away, detachable footrests	
E1083	Hemi-wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests	
E1084	Hemi-wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating leg rests	

SETON CHARITY PRIOR AUTHORIZATION LIST EFF: 10/01/2024 (updated 10/1/2024)		
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CPT, HCPCS or Revenue Code	**Description**	**Comments**
E1085	Hemi-wheelchair; fixed full-length arms, swing-away, detachable foot rests	
E1086	Hemi-wheelchair; detachable arms, desk or full-length, swing-away, detachable foot rests	
E1087	High-strength lightweight wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests	
E1088	High-strength lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating leg rests	
E1089	High-strength lightweight wheelchair; fixed-length arms, swing-away, detachable foot rests	
E1090	High-strength lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable foot rests	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
E1092	Wide, heavy-duty wheelchair; detachable arms, (desk or full-length); swing-away, detachable, elevating leg rests	
E1093	Wide, heavy-duty wheelchair; detachable arms, desk or full-length arms, swing-away, detachable foot rests	
E1100	Semi-reclining wheelchair; fixed full-length arms, swing-away, detachable, elevating leg res	
E1110	Semi-reclining wheelchair; detachable arms, (desk or full-length), elevating leg rest	
E1140	Wheelchair, detachable arms, desk or full length	
E1150	Wheelchair, detachable arms, desk or full length; detachable elevating leg rests	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
E1161	Manual adult size wheelchair, includes tilt in space	
E1170	Amputee wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests	
E1171	Amputee wheelchair; fixed full-length arms, without foot rests or leg rest	
E1172	Amputee wheelchair; detachable arms, desk or full-length, without foot rests or leg rest	
E1180	Amputee wheelchair; detachable arms, (desk or full-length), swing-away, detachable foot rests	
E1190	Amputee wheelchair; detachable arms, (desk or full-length), swing-away, detachable, elevating leg rests	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
E1195	Heavy duty wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests	
E1200	Amputee wheelchair; fixed full-length arms, swing-away, detachable foot rest	
E1220	Wheelchair; specially sized or constructed (indicate brand name, model number, if any, and justification)	
E1225	Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each	
E1226	Manual wheelchair accessory, manual fully-reclining back, (recline greater than 80 degrees), each	
E1229	Wheelchair, pediatric size, not otherwise specified	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
E1240	Lightweight wheelchair; detachable arms, (desk or full-length), swing- away, detachable, elevating leg rest	
E1250	Lightweight wheelchair; fixed full-length arms, swing-away, detachable foot rests	
E1260	Lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable foot rests	
E1270	Lightweight wheelchair; fixed full-length arms, swing-away, detachable elevating leg rests	
E1280	Heavy-duty wheelchair; detachable arms, (desk or full-length), elevating leg rests	
E1285	Heavy-duty wheelchair; fixed full-length arms, swing-away, detachable foot rests	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
E1290	Heavy-duty wheelchair; detachable arms, desk or full-length, swing-away, detachable foot rests	
E1295	Heavy-duty wheelchair; fixed full-length arms, elevating leg rests	
E1353	Oxygen supplies regulator	
E1390	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate	
E1405	Oxygen and water vapor enriching system with heated delivery	
E1406	Oxygen and water vapor enriching system without heated delivery	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
E2000	Gastric suction pump, home model, portable or stationary, electric	
E2402	Negative Pressure Wound Therapy (NPWT) Pumps	
E2601	General use wheelchair seat cushion, width less than 22 inches, any depth	
E2602	General use wheelchair seat cushion, width 22 inches or greater, any depth	
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
G0157	Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
G0160	Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
G0162	Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting)	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
G0164	Skilled services of a licensed nurse (LPN or RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
G0277	Hyperbaric Oxygen Therapy	
G0299	Direct skilled nursing services of a registered nurse (rn) in the home health or hospice setting, each 15 minutes	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
G0300	Direct skilled nursing services of a license practical nurse (lpn) in the home health or hospice setting, each 15 minutes	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
G0412	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral or bilateral for pelvic bone fracture patterns which do not disrupt the pelvic ring includes internal fixation, when performed	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
G0414	Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation when performed (includes pubic symphysis and/or superior/inferior rami)	
G0415	Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation, when performed (includes ilium, sacroiliac joint and/or sacrum)	
G0493	Skilled services of a registered nurse (rn) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
G0494	Skilled services of a licensed practical nurse (lpn) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
G0495	Skilled services of a registered nurse (rn), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
K0002	Standard hemi (low seat) wheelchair	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
K0003	Lightweight wheelchair	
K0004	High strength, lightweight wheelchair	
K0006	Heavy-duty wheelchair	
K0007	Extra heavy-duty wheelchair	
K0009	Other manual wheelchair/base	
K0056	Seat height less than 17 inches or equal to or greater than 21 inches for a high strength, lightweight, or ultralightweight wheelchair	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
K0108	Wheelchair component or accessory, not otherwise specified	
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, off-the-shelf	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
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 item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
L0455	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, off-the-shelf	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
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 item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
L0457	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, off-the-shelf	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
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	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
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	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
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, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
L0467	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, prefabricated, off-the-shelf	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
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, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
L0469	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, prefabricated, off-the-shelf	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
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, provides intracavitary pressure to reduce load on the intervertebral disks, includes fitting and shaping the frame	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
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	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
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	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
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	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
L0491	TLSO, sagittal-coronal 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 and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
L0970	TLSO, corset front	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
L0974	TLSO, full corset	If provided to member who is inpatient at SFH, Provider to obtain PO from facility, not approved through SHP.
L8600	Implant breast silicone	
L8603	Collagen implant, urinary tract, 2.5 ml syringe	
L8604	Dextranomer/hyaluronic acid copolymer implant, urinary tract, 1 ml	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
L8606	Synthetic implant, urinary tract, 1 ml syringe	
L8612	Aqueous shunt prosthesis	
L8670	Vascular graft, synthetic	
S2202	Echosclerotherapy	
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	
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	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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	
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)	
S5517	Home infusion therapy, all supplies necessary for restoration of catheter patency or declotting	
S5518	Home infusion therapy, all supplies necessary for catheter repair	
S5520	Home infusion therapy, all supplies (including catheter) necessary for a peripherally inserted central venous catheter (PICC) line insertion	
S5521	Home infusion therapy, all supplies (including catheter) necessary for a midline catheter insertion	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
S5522	Home infusion therapy, insertion of peripherally inserted central venous catheter (PICC), nursing services only (no supplies or catheter included)	
S5523	Home infusion therapy, insertion of midline venous catheter, nursing services only (no supplies or catheter included)	
S9097	Home visit for wound care	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
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)	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
S9124	Nursing care, in the home; by licensed practical nurse, per hour	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
S9128	Speech therapy, in the home, per diem	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
S9129	Occupational therapy, in the home, per diem	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
S9152	Speech therapy, re-evaluation	Telemedicine/virtual care Home Health services are not a covered benefit (modifier 95; POS 02)
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	Long term therapy not covered. 3 month maximum
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	Long term therapy not covered. 3 month maximum
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	Long term therapy not covered. 3 month maximum
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	Long term therapy not covered. 3 month maximum

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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)	
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)	
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	
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	
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	
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	

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CPT, HCPCS or Revenue Code	**Description**	**Comments**
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	
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	
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)	
S9497	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 3 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
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	
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	

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S9502	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9503	Home infusion therapy, antibiotic, antiviral, or antifungal; once every 6 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9504	Home infusion therapy, antibiotic, antiviral, or antifungal; once every 4 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
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	
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	
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	

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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	

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