EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
COMMONWEALTH OF MASSACHUSETTS
OFFICE OF MEDICAID
ONE ASHBURTON PLACE, BOSTON, MA 02108

MAURA T. HEALEY
GOVERNOR

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR

KIAME MAHANIAH, MD, MBA
SECRETARY

RYAN SCHWARZ, MD, MBA
ASSISTANT SECRETARY
FOR MASSHEALTH

Administrative Bulletin 26-16

101 CMR 347.00:
Rates for Freestanding Ambulatory Surgery Center Services

Effective January 1, 2026

2026 and 2025 Current Procedural Terminology/ Healthcare Common Procedure Coding System (CPT/HCPCS) Procedure Code Updates

In accordance with 101 CMR 347.01(5): *Coding Updates and Corrections*, the Executive Office of Health and Human Services (EOHHS) is adding new procedure codes; deleting outdated codes; cross-walking deleted codes to new and existing codes; and revising the code descriptions for freestanding ambulatory surgery center services, effective for dates of service on and after January 1, 2026. Part I: 2026 CPT Coding Updates lists the added codes, deleted codes, cross-walked codes, and codes with updated code descriptions based on 2026 CPT/HCPCS coding updates. Part II: 2026 Reclassification of CMS Inpatient-Only Codes lists the codes that were previously listed in the Centers for Medicare & Medicaid Services (CMS) Inpatient-Only (IPO) list and are reclassified to the CMS Ambulatory Surgical Centers (ASC) Addendum AA for use in freestanding ambulatory surgery centers (FASCs) as of January 2026. Part III: 2025 CPT/HCPCS Code Updates lists added and deleted codes issued by CMS in calendar year 2025 after January 2025.

In accordance with 101 CMR 347.01(5)(a), rates for the existing and new codes that replace deleted codes are set at the rate of the code that is being replaced. Under 101 CMR 347.01(5)(d), for all new codes that require pricing and that have Medicare rates, corresponding rates are calculated in accordance with the rate methodology used in setting current rates for the freestanding ambulatory surgery center facility component. Rates in this administrative bulletin apply until EOHHS issues revised rates. Deleted codes are not available for use for dates of service after December 31, 2025.

Part I: 2026 CPT Coding Updates

2026 Added Codes

Code	Rate	Code Description
37254	$1,820.48	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel
37255	$0.00	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)
37256	$1,820.48	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel
37257	$0.00	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)
37258	$5,252.88	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel

Code	Rate	Code Description
37259	$0.00	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)
37260	$5,252.88	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel
37261	$0.00	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)
37263	$2,651.96	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel
37265	$2,651.96	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel

Code	Rate	Code Description
37267	$5,478.11	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel
37269	$5,478.11	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel
37271	$5,674.09	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel
37273	$5,674.09	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel
37275	$9,300.44	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel

Code	Rate	Code Description
37277	$9,300.44	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel
37280	$4,819.83	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel
37281	$0.00	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)
37282	$4,819.83	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel
37283	$0.00	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, complex lesion, each additional vessel (List separately in addition to code for primary procedure)

Code	Rate	Code Description
37284	$8,586.45	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel
37285	$0.00	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)
37286	$8,586.45	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel
37287	$0.00	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)
37288	$8,743.73	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel

Code	Rate	Code Description
37289	$0.00	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)
37290	$8,743.73	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel
37291	$0.00	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)
37292	$9,052.07	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel

Code	Rate	Code Description
37293	$0.00	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)
37294	$9,052.07	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel
37295	$0.00	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)
55707	$671.25	Biopsy, prostate, transrectal, ultrasound-guided (ie, sextant, ultrasound-localized discrete lesion[s])
55708	$671.25	Biopsy, prostate, transrectal, ultrasound-guided (ie, sextant) with MRI-fusion-guidance, first targeted lesion
55709	$671.25	Biopsy, prostate, transperineal, ultrasound-guided (ie, sextant, ultrasound-localized discrete lesion[s])
55710	$671.25	Biopsy, prostate, transperineal, ultrasound-guided (ie, sextant) with MRI-fusion-guidance biopsy, first targeted lesion

Code	Rate	Code Description
55711	$671.25	Biopsy, prostate, transrectal, MRI-ultrasound-fusion guided, targeted lesion(s) only, first targeted lesion
55712	$671.25	Biopsy, prostate, transperineal, MRI-ultrasound-fusion guided, targeted lesion(s) only, first targeted lesion
55714	$671.25	Biopsy, prostate, in-bore CT- or MRI-guided targeted lesion(s) only, first targeted lesion
92930	$0.00	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); 2 or more distinct coronary lesions with 2 or more coronary stents deployed in 2 or more coronary segments, or a bifurcation lesion requiring angioplasty and/or stenting in both the main artery and the side branch

2026 Description Updates

Code	Description
92920	Percutaneous transluminal coronary angioplasty, single major coronary artery and/or its branch(es)
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); 1 lesion involving 1 or more coronary segments

2026 Crosswalks

Deleted Code	Crosswalk to Newly Added Codes	Crosswalk to Existing Codes
37220	37254, 37256	
37221	37258, 37260	
37222	37255, 37257	
37223	37259, 37261	
37224	37263, 37265	
37225	37271, 37273	
37226	37267, 37269	
37227	37275, 37277	
37228	37280, 37282	
37229	37288, 37290	

Deleted Code	Crosswalk to Newly Added Codes	Crosswalk to Existing Codes
37230	37284, 37286	
37231	37292, 37294	
37232	37281, 37283	
37233	37289, 37291	
37234	37285, 37287	
37235	37293, 37295	
55700	55707, 55708, 55709, 55710, 55711, 55712, 55714	55705
92921		92920
92929	92930	92928

2026 Deleted Codes

Code	Code Description
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, when performed
37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)
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 vessel, when performed

Code	Code Description
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
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, when performed
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)
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)

Code	Code Description
52647	Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)
55700	Biopsy, prostate; needle or punch, single or multiple, any approach
92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)
92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)

Part II: 2026 Reclassification of CMS Inpatient-Only Codes to CMS ASC Addendum AA[1]

In accordance with 101 CMR 347.01(5), EOHHS is adding codes that were previously listed in the CMS IPO list and are reclassified to the CMS ASC Addendum AA for use in freestanding ambulatory surgery centers, effective January 1, 2026. The following codes were removed from the CMS IPO list and added to the CMS ASC Addendum AA as of January 2026.

2026 Reclassified Codes

Code	Rate	Code Description
20661	$940.05	Application of halo, including removal; cranial
20664	$940.05	Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta)
20802	$11,843.21	Replantation, arm (includes surgical neck of humerus through elbow joint), complete amputation
20805	$11,843.21	Replantation, forearm (includes radius and ulna to radial carpal joint), complete amputation
20808	$11,843.21	Replantation, hand (includes hand through metacarpophalangeal joints), complete amputation
20816	$940.05	Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon), complete amputation

[1] CMS-1834-FC: Hospital Outpatient Prospective Payment- Notice of Final Rulemaking (NFRM)

Code	Rate	Code Description
20824	$940.05	Replantation, thumb (includes carpometacarpal joint to MP joint), complete amputation
20827	$741.94	Replantation, thumb (includes distal tip to MP joint), complete amputation
20838	$11,843.21	Replantation, foot, complete amputation
20955	$3,979.95	Bone graft with microvascular anastomosis; fibula
20956	$3,979.95	Bone graft with microvascular anastomosis; iliac crest
20957	$3,979.95	Bone graft with microvascular anastomosis; metatarsal
20962	$3,979.95	Bone graft with microvascular anastomosis; other than fibula, iliac crest, or metatarsal
20969	$3,979.95	Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, metatarsal, or great toe
20970	$3,979.95	Free osteocutaneous flap with microvascular anastomosis; iliac crest
21045	$2,571.78	Excision of malignant tumor of mandible; radical resection
21145	$3,406.21	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
21146	$3,258.47	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)
21147	$3,258.47	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
21151	$3,258.47	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)
21154	$3,258.47	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I
21155	$3,258.47	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I
21159	$3,258.47	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I

Code	Rate	Code Description
21160	$3,258.47	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I
21179	$3,258.47	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	$3,258.47	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21182	$3,258.47	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	$3,258.47	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
21184	$3,258.47	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	$3,258.47	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
21247	$2,571.78	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)
21268	$3,258.47	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach
21343	$3,466.25	Open treatment of depressed frontal sinus fracture
21344	$2,571.78	Open treatment of complicated (eg, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches
21348	$3,258.47	Open treatment of nasomaxillary complex fracture (LeFort II type); with bone grafting (includes obtaining graft)
21423	$4,113.74	Open treatment of palatal or maxillary fracture (LeFort I type); complicated (comminuted or involving cranial nerve foramina), multiple approaches
21431	$3,258.47	Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint

Code	Rate	Code Description
21432	$3,258.47	Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation
21433	$3,258.47	Open treatment of craniofacial separation (LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches
21435	$3,258.47	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	$3,258.47	Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)
21510	$1,398.14	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax
21602	$3,979.95	Excision of chest wall tumor involving rib(s), with plastic reconstruction; without mediastinal lymphadenectomy
21603	$3,979.95	Excision of chest wall tumor involving rib(s), with plastic reconstruction; with mediastinal lymphadenectomy
21615	$3,141.20	Excision first and/or cervical rib;
21616	$3,141.20	Excision first and/or cervical rib; with sympathectomy
21620	$1,398.14	Ostectomy of sternum, partial
21627	$1,398.14	Sternal debridement
21630	$3,141.20	Radical resection of sternum
21705	$3,141.20	Division of scalenus anticus; with resection of cervical rib
21740	$3,979.95	Reconstructive repair of pectus excavatum or carinatum; open
21750	$3,979.95	Closure of median sternotomy separation with or without debridement (separate procedure)
21825	$3,979.95	Open treatment of sternum fracture with or without skeletal fixation
22010	$3,141.20	Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic
22015	$3,141.20	Incision and drainage, open, of deep abscess (subfascial), posterior spine; lumbar, sacral, or lumbosacral
22110	$3,141.20	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical

Code	Rate	Code Description
22112	$3,141.20	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; thoracic
22114	$3,141.20	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; lumbar
22116	$0.00	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)
22206	$3,141.20	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); thoracic
22207	$3,141.20	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); lumbar
22208	$0.00	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)
22210	$3,979.95	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical
22212	$4,826.26	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic
22214	$4,816.79	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar
22216	$0.00	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (List separately in addition to primary procedure)
22220	$5,311.10	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical
22222	$3,141.20	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic
22224	$3,141.20	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar
22226	$0.00	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)

Code	Rate	Code Description
22318	$5,783.77	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	$8,069.87	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	$7,909.46	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar
22326	$5,783.77	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; cervical
22327	$8,073.85	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; thoracic
22328	$0.00	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)
22532	$5,783.77	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic
22533	$7,867.46	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
22534	$0.00	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)
22548	$8,069.87	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process
22556	$11,345.82	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic

Code	Rate	Code Description
22558	$17,086.05	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
22586	$11,843.21	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace
22590	$7,410.29	Arthrodesis, posterior technique, craniocervical (occiput-C2)
22595	$5,783.77	Arthrodesis, posterior technique, atlas-axis (C1-C2)
22600	$11,137.78	Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment
22610	$11,162.17	Arthrodesis, posterior or posterolateral technique, single interspace; thoracic (with lateral transverse technique, when performed)
22800	$11,465.08	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments
22802	$11,843.21	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments
22804	$11,843.21	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments
22808	$11,660.24	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments
22810	$11,843.21	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments
22812	$11,843.21	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments
22818	$7,867.46	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments
22819	$7,867.46	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments
22830	$4,261.87	Exploration of spinal fusion
22836	$11,843.21	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments
22837	$11,843.21	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments

Code	Rate	Code Description
22838	$11,843.21	Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed
22841	$0.00	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)
22843	$0.00	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)
22844	$0.00	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure)
22846	$0.00	Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)
22847	$0.00	Anterior instrumentation; 8 or more vertebral segments (List separately in addition to code for primary procedure)
22849	$7,833.24	Reinsertion of spinal fixation device
22850	$3,141.20	Removal of posterior nonsegmental instrumentation (eg, Harrington rod)
22852	$3,141.20	Removal of posterior segmental instrumentation
22855	$3,141.20	Removal of anterior instrumentation
22857	$10,794.89	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar
22860	$0.00	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)
22861	$9,938.34	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
22862	$11,843.21	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar
22864	$3,141.20	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
22865	$3,141.20	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar
23200	$3,141.20	Radical resection of tumor; clavicle

Code	Rate	Code Description
23210	$3,141.20	Radical resection of tumor; scapula
23220	$3,141.20	Radical resection of tumor, proximal humerus
23335	$4,247.25	Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid components (eg, total shoulder)
23474	$8,496.31	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component
23900	$5,783.77	Interthoracoscapular amputation (forequarter)
23920	$5,783.77	Disarticulation of shoulder;
24900	$5,783.77	Amputation, arm through humerus; with primary closure
24920	$5,783.77	Amputation, arm through humerus; open, circular (guillotine)
24930	$3,141.20	Amputation, arm through humerus; re-amputation
24931	$8,069.87	Amputation, arm through humerus; with implant
24940	$8,069.87	Cineplasty, upper extremity, complete procedure
25900	$3,141.20	Amputation, forearm, through radius and ulna;
25905	$3,141.20	Amputation, forearm, through radius and ulna; open, circular (guillotine)
25915	$3,141.20	Krukenberg procedure
25920	$1,398.14	Disarticulation through wrist;
25924	$1,398.14	Disarticulation through wrist; re-amputation
25927	$1,398.14	Transmetacarpal amputation;
26551	$3,979.95	Transfer, toe-to-hand with microvascular anastomosis; great toe wrap-around with bone graft
26553	$3,979.95	Transfer, toe-to-hand with microvascular anastomosis; other than great toe, single
26554	$3,979.95	Transfer, toe-to-hand with microvascular anastomosis; other than great toe, double
26556	$3,979.95	Transfer, free toe joint, with microvascular anastomosis
26992	$1,398.14	Incision, bone cortex, pelvis and/or hip joint (eg, osteomyelitis or bone abscess)
27005	$1,398.14	Tenotomy, hip flexor(s), open (separate procedure)
27025	$1,786.39	Fasciotomy, hip or thigh, any type
27030	$3,141.20	Arthrotomy, hip, with drainage (eg, infection)

Code	Rate	Code Description
27036	$3,141.20	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)
27054	$1,398.14	Arthrotomy with synovectomy, hip joint
27070	$2,282.78	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial
27071	$1,398.14	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); deep (subfascial or intramuscular)
27075	$3,979.95	Radical resection of tumor; wing of ilium, 1 pubic or ischial ramus or symphysis pubis
27076	$3,141.20	Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum
27077	$3,141.20	Radical resection of tumor; innominate bone, total
27078	$3,141.20	Radical resection of tumor; ischial tuberosity and greater trochanter of femur
27090	$3,141.20	Removal of hip prosthesis; (separate procedure)
27091	$5,783.77	Removal of hip prosthesis; complicated, including total hip prosthesis, methylmethacrylate with or without insertion of spacer
27120	$8,069.87	Acetabuloplasty; (eg, Whitman, Colonna, Haygroves, or cup type)
27122	$3,141.20	Acetabuloplasty; resection, femoral head (eg, Girdlestone procedure)
27125	$7,355.00	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)
27132	$8,251.21	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft
27134	$7,926.90	Revision of total hip arthroplasty; both components, with or without autograft or allograft
27137	$7,598.60	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft
27138	$7,746.56	Revision of total hip arthroplasty; femoral component only, with or without allograft

Code	Rate	Code Description
27140	$3,141.20	Osteotomy and transfer of greater trochanter of femur (separate procedure)
27146	$3,979.95	Osteotomy, iliac, acetabular or innominate bone;
27147	$3,979.95	Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip
27151	$3,979.95	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy
27156	$3,979.95	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip
27158	$3,979.95	Osteotomy, pelvis, bilateral (eg, congenital malformation)
27161	$3,979.95	Osteotomy, femoral neck (separate procedure)
27165	$3,979.95	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast
27170	$4,099.26	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)
27175	$1,398.14	Treatment of slipped femoral epiphysis; by traction, without reduction
27176	$1,771.45	Treatment of slipped femoral epiphysis; by single or multiple pinning, in situ
27177	$1,771.45	Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft (includes obtaining graft)
27178	$1,771.45	Open treatment of slipped femoral epiphysis; closed manipulation with single or multiple pinning
27181	$3,979.95	Open treatment of slipped femoral epiphysis; osteotomy and internal fixation
27185	$1,771.45	Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur
27187	$4,541.63	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femoral neck and proximal femur
27222	$115.21	Closed treatment of acetabulum (hip socket) fracture(s); with manipulation, with or without skeletal traction
27226	$4,823.82	Open treatment of posterior or anterior acetabular wall fracture, with internal fixation
27227	$4,162.84	Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation

Code	Rate	Code Description
27228	$4,522.96	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
27232	$741.94	Closed treatment of femoral fracture, proximal end, neck; with manipulation, with or without skeletal traction
27236	$4,149.32	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement
27240	$741.94	Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with manipulation, with or without skin or skeletal traction
27244	$4,066.79	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage
27245	$4,106.83	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage
27248	$3,141.20	Open treatment of greater trochanteric fracture, includes internal fixation, when performed
27253	$1,398.14	Open treatment of hip dislocation, traumatic, without internal fixation
27254	$3,141.20	Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation
27258	$1,398.14	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc);
27259	$1,771.45	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc); with femoral shaft shortening
27268	$741.94	Closed treatment of femoral fracture, proximal end, head; with manipulation
27269	$3,979.95	Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed
27280	$11,737.50	Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed
27282	$1,771.45	Arthrodesis, symphysis pubis (including obtaining graft)

Code	Rate	Code Description
27284	$8,069.87	Arthrodesis, hip joint (including obtaining graft);
27286	$8,069.87	Arthrodesis, hip joint (including obtaining graft); with subtrochanteric osteotomy
27290	$7,867.46	Interpelviabdominal amputation (hindquarter amputation)
27295	$7,867.46	Disarticulation of hip
27303	$1,771.45	Incision, deep, with opening of bone cortex, femur or knee (eg, osteomyelitis or bone abscess)
27365	$1,398.14	Radical resection of tumor, femur or knee
27448	$3,141.20	Osteotomy, femur, shaft or supracondylar; without fixation
27450	$3,979.95	Osteotomy, femur, shaft or supracondylar; with fixation
27454	$3,979.95	Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft (eg, Sofield type procedure)
27455	$3,141.20	Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus [bowleg] or genu valgus [knock-knee]); before epiphyseal closure
27457	$3,141.20	Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus [bowleg] or genu valgus [knock-knee]); after epiphyseal closure
27465	$3,979.95	Osteoplasty, femur; shortening (excluding 64876)
27466	$3,979.95	Osteoplasty, femur; lengthening
27470	$3,141.20	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)
27472	$4,094.12	Repair, nonunion or malunion, femur, distal to head and neck; with iliac or other autogenous bone graft (includes obtaining graft)
27486	$5,783.77	Revision of total knee arthroplasty, with or without allograft; 1 component
27487	$11,869.64	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component
27488	$8,069.87	Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee
27495	$4,226.16	Prophylactic treatment (nailing, pinning, plating, or wiring) with or without methylmethacrylate, femur
27506	$3,994.28	Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws

Code	Rate	Code Description
27507	$4,298.66	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage
27511	$7,868.11	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed
27513	$7,676.32	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed
27514	$7,853.17	Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed
27519	$3,979.95	Open treatment of distal femoral epiphyseal separation, includes internal fixation, when performed
27535	$4,301.10	Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed
27536	$4,285.95	Open treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal fixation
27540	$3,141.20	Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed
27556	$3,141.20	Open treatment of knee dislocation, includes internal fixation, when performed; without primary ligamentous repair or augmentation/reconstruction
27557	$3,979.95	Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair
27558	$3,979.95	Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair, with augmentation/reconstruction
27580	$7,477.05	Arthrodesis, knee, any technique
27590	$1,398.14	Amputation, thigh, through femur, any level;
27591	$1,398.14	Amputation, thigh, through femur, any level; immediate fitting technique including first cast
27592	$1,398.14	Amputation, thigh, through femur, any level; open, circular (guillotine)
27596	$1,398.14	Amputation, thigh, through femur, any level; re-amputation
27598	$1,398.14	Disarticulation at knee
27645	$1,398.14	Radical resection of tumor; tibia
27646	$1,398.14	Radical resection of tumor; fibula

Code	Rate	Code Description
27703	$11,921.82	Arthroplasty, ankle; revision, total ankle
27712	$8,069.87	Osteotomy; multiple, with realignment on intramedullary rod (eg, Sofield type procedure)
27715	$8,069.87	Osteoplasty, tibia and fibula, lengthening or shortening
27724	$4,228.04	Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)
27725	$4,080.87	Repair of nonunion or malunion, tibia; by synostosis, with fibula, any method
27727	$1,398.14	Repair of congenital pseudarthrosis, tibia
27880	$3,141.20	Amputation, leg, through tibia and fibula;
27881	$1,398.14	Amputation, leg, through tibia and fibula; with immediate fitting technique including application of first cast
27882	$1,398.14	Amputation, leg, through tibia and fibula; open, circular (guillotine)
27886	$1,398.14	Amputation, leg, through tibia and fibula; re-amputation
27888	$1,398.14	Amputation, ankle, through malleoli of tibia and fibula (eg, Syme, Pirogoff type procedures), with plastic closure and resection of nerves
28800	$1,398.14	Amputation, foot; midtarsal (eg, Chopart type procedure)
35372	$3,570.82	Thromboendarterectomy, including patch graft, if performed; deep (profunda) femoral
35800	$2,709.26	Exploration for postoperative hemorrhage, thrombosis or infection; neck
37182	$11,291.21	Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)
37617	$2,709.26	Ligation, major artery (eg, post-traumatic, rupture); abdomen
38562	$2,695.78	Limited lymphadenectomy for staging (separate procedure); pelvic and para-aortic
43840	$1,688.57	Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury
44300	$760.18	Placement, enterostomy or cecostomy, tube open (eg, for feeding or decompression) (separate procedure)
44314	$1,649.66	Revision of ileostomy; complicated (reconstruction in-depth) (separate procedure)

Code	Rate	Code Description
44345	$1,649.66	Revision of colostomy; complicated (reconstruction in-depth) (separate procedure)
44346	$1,649.66	Revision of colostomy; with repair of paracolostomy hernia (separate procedure)
44602	$1,688.57	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; single perforation
49010	$2,860.35	Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)
49255	$2,860.35	Omentectomy, epiploectomy, resection of omentum (separate procedure)
51840	$1,951.22	Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); simple
56630	$1,951.22	Vulvectomy, radical, partial;
61624	$10,847.78	Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), including all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention, percutaneous, any method; central nervous system (intracranial, spinal cord)
G0412	$4,669.06	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
G0414	$4,567.33	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	$1,398.14	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)

Part III: 2025 CPT/HCPCS Code Updates

In accordance with 101 CMR 347.01(5), EOHHS is adding new codes and deleting codes that were updated in the CMS ASC Addendum AA after January 1, 2025, for freestanding ambulatory surgery center services. These coding updates are effective for dates of service on and after January 1, 2026. Under 101 CMR 347.01(5)(d), for new codes that require pricing and that have Medicare rates, corresponding rates are calculated in accordance with the rate methodology

used in setting current rates for the freestanding ambulatory surgery center facility component. Rates in this administrative bulletin apply until EOHHS issues revised rates. Deleted codes are not available for use for dates of service after December 31, 2025.

2025 Added Codes

Code	Rate	Code Description
20100	$251.15	Exploration of penetrating wound (separate procedure); neck
20101	$959.28	Exploration of penetrating wound (separate procedure); chest
20102	$959.28	Exploration of penetrating wound (separate procedure); abdomen/flank/back
20660	$741.94	Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)
21049	$2,571.78	Excision of benign tumor or cyst of maxilla; requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion[s])
21141	$2,571.78	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
21142	$3,299.22	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft
21143	$2,571.78	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft
21172	$2,571.78	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	$2,571.78	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21193	$2,571.78	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft

Code	Rate	Code Description
21196	$2,571.78	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21255	$3,258.47	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21256	$3,285.94	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)
21261	$2,571.78	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach
21263	$2,571.78	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement
21346	$2,571.78	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation
21347	$3,292.81	Open treatment of nasomaxillary complex fracture (LeFort II type); requiring multiple open approaches
21366	$3,258.47	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	$2,571.78	Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation)
21386	$2,571.78	Open treatment of orbital floor blowout fracture; periorbital approach
21387	$2,571.78	Open treatment of orbital floor blowout fracture; combined approach
21395	$2,571.78	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)
21408	$2,571.78	Open treatment of fracture of orbit, except blowout; with bone grafting (includes obtaining graft)

Code	Rate	Code Description
21422	$3,337.33	Open treatment of palatal or maxillary fracture (LeFort I type);
21470	$3,326.70	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints
21601	$1,061.11	Excision of chest wall tumor including rib(s)
21742	$1,771.45	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy
21743	$1,771.45	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy
22100	$3,141.20	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical
22101	$3,141.20	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; thoracic
22630	$17,729.77	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar;
22632	$0.00	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar; each additional interspace (List separately in addition to code for primary procedure)
22633	$17,715.21	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;
22848	$0.00	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)

Code	Rate	Code Description
23473	$7,981.70	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component
24150	$3,141.20	Radical resection of tumor, shaft or distal humerus
24935	$3,141.20	Stump elongation, upper extremity
25170	$3,141.20	Radical resection of tumor, radius or ulna
25909	$3,141.20	Amputation, forearm, through radius and ulna; re-amputation
27027	$3,141.20	Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral
27057	$1,002.93	Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle, unilateral
27179	$3,141.20	Open treatment of slipped femoral epiphysis; osteoplasty of femoral neck (Heyman type procedure)
27235	$3,141.20	Percutaneous skeletal fixation of femoral fracture, proximal end, neck
27477	$4,316.52	Arrest, epiphyseal, any method (eg, epiphysiodesis); tibia and fibula, proximal
27485	$3,141.20	Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (eg, genu varus or valgus)
27722	$4,027.02	Repair of nonunion or malunion, tibia; with sliding graft
28360	$3,979.95	Reconstruction, cleft foot

Code	Rate	Code Description
28805	$1,398.14	Amputation, foot; transmetatarsal
31241	$717.20	Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery
31292	$2,083.37	Nasal/sinus endoscopy, surgical, with orbital decompression; medial or inferior wall
31293	$2,083.37	Nasal/sinus endoscopy, surgical, with orbital decompression; medial and inferior wall
31294	$2,083.37	Nasal/sinus endoscopy, surgical, with optic nerve decompression
31584	$2,571.78	Laryngoplasty; with open reduction and fixation of (eg, plating) fracture, includes tracheostomy, if performed
31587	$2,571.78	Laryngoplasty, cricoid split, without graft placement
31600	$1,258.43	Tracheostomy, planned (separate procedure);
31601	$2,571.78	Tracheostomy, planned (separate procedure); younger than 2 years
31610	$2,571.78	Tracheostomy, fenestration procedure with skin flaps
31660	$3,266.29	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe
31661	$2,986.88	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes
31785	$2,571.78	Excision of tracheal tumor or carcinoma; cervical

Code	Rate	Code Description
32551	$552.49	Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)
32560	$292.89	Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax)
32561	$292.89	Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day
32562	$292.89	Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day
32601	$2,576.32	Thoracoscopy, diagnostic (separate procedure); lungs, pericardial sac, mediastinal or pleural space, without biopsy
32604	$4,352.43	Thoracoscopy, diagnostic (separate procedure); pericardial sac, with biopsy
32606	$2,576.32	Thoracoscopy, diagnostic (separate procedure); mediastinal space, with biopsy
32607	$4,352.43	Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral
32608	$4,352.43	Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral
32609	$2,576.32	Thoracoscopy; with biopsy(ies) of pleura
33244	$1,778.37	Removal of single or dual chamber implantable defibrillator electrode(s); by transvenous extraction
33272	$1,778.37	Removal of subcutaneous implantable defibrillator electrode
34101	$2,709.26	Embolectomy or thrombectomy, with or without catheter; axillary, brachial, innominate, subclavian artery, by arm incision

Code	Rate	Code Description
34111	$2,709.26	Embolectomy or thrombectomy, with or without catheter; radial or ulnar artery, by arm incision
34201	$3,432.67	Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision
34203	$3,432.67	Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision
34421	$2,189.08	Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by leg incision
34471	$292.89	Thrombectomy, direct or with catheter; subclavian vein, by neck incision
34501	$2,709.26	Valvuloplasty, femoral vein
34510	$2,709.26	Venous valve transposition, any vein donor
34520	$2,709.26	Cross-over vein graft to venous system
34530	$1,380.14	Saphenopopliteal vein anastomosis
35011	$2,709.26	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision
35045	$2,709.26	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery
35180	$552.49	Repair, congenital arteriovenous fistula; head and neck

Code	Rate	Code Description
35184	$1,380.14	Repair, congenital arteriovenous fistula; extremities
35190	$2,709.26	Repair, acquired or traumatic arteriovenous fistula; extremities
35201	$2,709.26	Repair blood vessel, direct; neck
35206	$1,380.14	Repair blood vessel, direct; upper extremity
35226	$330.27	Repair blood vessel, direct; lower extremity
35231	$1,380.14	Repair blood vessel with vein graft; neck
35236	$2,709.26	Repair blood vessel with vein graft; upper extremity
35256	$2,709.26	Repair blood vessel with vein graft; lower extremity
35261	$1,380.14	Repair blood vessel with graft other than vein; neck
35266	$2,709.26	Repair blood vessel with graft other than vein; upper extremity
35286	$2,709.26	Repair blood vessel with graft other than vein; lower extremity
35321	$2,709.26	Thromboendarterectomy, including patch graft, if performed; axillary-brachial
35860	$1,380.14	Exploration for postoperative hemorrhage, thrombosis or infection; extremity

Code	Rate	Code Description
35879	$2,709.26	Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplasty
35881	$3,432.67	Revision, lower extremity arterial bypass, without thrombectomy, open; with segmental vein interposition
35883	$2,709.26	Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium)
35884	$2,709.26	Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with autogenous vein patch graft
35903	$1,380.14	Excision of infected graft; extremity
36460	$207.74	Transfusion, intrauterine, fetal
36838	$2,709.26	Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)
37183	$3,016.27	Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation)
37191	$3,708.04	Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed
37195	$154.16	Thrombolysis, cerebral, by intravenous infusion
37213	$1,380.14	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;

Code	Rate	Code Description
37214	$1,380.14	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method
37244	$5,836.52	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation
37565	$1,380.14	Ligation, internal jugular vein
37600	$1,380.14	Ligation; external carotid artery
37605	$1,380.14	Ligation; internal or common carotid artery
37606	$1,380.14	Ligation; internal or common carotid artery, with gradual occlusion, as with Selverstone or Crutchfield clamp
37615	$1,380.14	Ligation, major artery (eg, post-traumatic, rupture); neck
37619	$2,709.26	Ligation of inferior vena cava
38120	$4,352.43	Laparoscopy, surgical, splenectomy
38207	$207.74	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage
38208	$207.74	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor

Code	Rate	Code Description
38209	$207.74	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor
38210	$207.74	Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion
38211	$207.74	Transplant preparation of hematopoietic progenitor cells; tumor cell depletion
38212	$207.74	Transplant preparation of hematopoietic progenitor cells; red blood cell removal
38213	$207.74	Transplant preparation of hematopoietic progenitor cells; platelet depletion
38214	$207.74	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion
38215	$207.74	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer
38240	$11,808.48	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor
38720	$2,420.97	Cervical lymphadenectomy (complete)
39401	$2,576.32	Mediastinoscopy; includes biopsy(ies) of mediastinal mass (eg, lymphoma), when performed
39402	$2,576.32	Mediastinoscopy; with lymph node biopsy(ies) (eg, lung cancer staging)
42842	$2,571.78	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure
42844	$2,571.78	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with local flap (eg, tongue, buccal)

Code	Rate	Code Description
43020	$560.29	Esophagotomy, cervical approach, with removal of foreign body
43280	$4,352.43	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)
43281	$4,352.43	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh
43282	$4,352.43	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh
43420	$1,258.43	Closure of esophagostomy or fistula; cervical approach
43497	$2,396.56	Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])
43510	$423.17	Gastrotomy; with esophageal dilation and insertion of permanent intraluminal tube (eg, Celestin or Mousseaux-Barbin)
43647	$8,497.78	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43648	$4,352.43	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum
43651	$2,576.32	Laparoscopy, surgical; transection of vagus nerves, truncal
43652	$2,576.32	Laparoscopy, surgical; transection of vagus nerves, selective or highly selective
43770	$5,514.58	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
43772	$1,688.57	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only

Code	Rate	Code Description
43773	$2,576.32	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
43830	$760.18	Gastrostomy, open; without construction of gastric tube (eg, Stamm procedure) (separate procedure)
43831	$423.17	Gastrostomy, open; neonatal, for feeding
44180	$2,576.32	Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)
44186	$2,576.32	Laparoscopy, surgical; jejunostomy (eg, for decompression or feeding)
44950	$2,860.35	Appendectomy;
44955	$0.00	Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure)
44970	$2,576.32	Laparoscopy, surgical, appendectomy
47370	$4,352.43	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency
47371	$4,352.43	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical
47490	$1,482.59	Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation
47550	$0.00	Biliary endoscopy, intraoperative (choledochoscopy) (List separately in addition to code for primary procedure)

Code	Rate	Code Description
49185	$630.73	Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed
49323	$2,576.32	Laparoscopy, surgical; with drainage of lymphocele to peritoneal cavity
49405	$630.73	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous
49491	$2,576.32	Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; reducible
49492	$1,482.59	Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; incarcerated or strangulated
50020	$851.66	Drainage of perirenal or renal abscess, open
50541	$4,352.43	Laparoscopy, surgical; ablation of renal cysts
50542	$4,352.43	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed
50543	$4,352.43	Laparoscopy, surgical; partial nephrectomy
50544	$4,352.43	Laparoscopy, surgical; pyeloplasty
50945	$2,576.32	Laparoscopy, surgical; ureterolithotomy
51060	$851.66	Transvesical ureterolithotomy

Code	Rate	Code Description
51845	$1,951.22	Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, Stamey, Raz, modified Pereyra)
51860	$4,246.43	Cystorrhaphy, suture of bladder wound, injury or rupture; simple
51990	$2,576.32	Laparoscopy, surgical; urethral suspension for stress incontinence
53500	$1,464.57	Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (eg, postsurgical obstruction, scarring)
54332	$1,464.57	1-stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap
54336	$1,464.57	1-stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap
54411	$15,358.85	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54417	$14,857.12	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54535	$1,464.57	Orchiectomy, radical, for tumor; with abdominal exploration
55866	$4,352.43	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed;
55867	$4,352.43	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

Code	Rate	Code Description
55970	$1,951.22	Intersex surgery; male to female
55980	$1,464.57	Intersex surgery; female to male
57106	$1,477.36	Vaginectomy, partial removal of vaginal wall;
57107	$1,477.36	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57109	$1,477.36	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)
57284	$2,577.09	Paravaginal defect repair (including repair of cystocele, if performed); open abdominal approach
57285	$2,743.28	Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach
57292	$1,951.22	Construction of artificial vagina; with graft
57330	$2,743.28	Closure of vesicovaginal fistula; transvesical and vaginal approach
57335	$1,951.22	Vaginoplasty for intersex state
57423	$4,352.43	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach
57555	$1,951.22	Excision of cervical stump, vaginal approach; with anterior and/or posterior repair
58263	$1,951.22	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele

Code	Rate	Code Description
58270	$1,951.22	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58290	$2,743.28	Vaginal hysterectomy, for uterus greater than 250 g;
58291	$1,951.22	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58292	$2,743.28	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58294	$1,951.22	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele
58770	$1,477.36	Salpingostomy (salpingoneostomy)
58920	$2,743.28	Wedge resection or bisection of ovary, unilateral or bilateral
58925	$1,951.22	Ovarian cystectomy, unilateral or bilateral
59030	$141.88	Fetal scalp blood sampling
59409	$1,477.36	Vaginal delivery only (with or without episiotomy and/or forceps);
59612	$1,477.36	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);
60252	$2,571.78	Thyroidectomy, total or subtotal for malignancy; with limited neck dissection
60271	$2,571.78	Thyroidectomy, including substernal thyroid; cervical approach

Code	Rate	Code Description
60502	$2,571.78	Parathyroidectomy or exploration of parathyroid(s); re-exploration
60520	$2,571.78	Thymectomy, partial or total; transcervical approach (separate procedure)
61623	$6,286.46	Endovascular temporary balloon arterial occlusion, head or neck (extracranial/intracranial) including selective catheterization of vessel to be occluded, positioning and inflation of occlusion balloon, concomitant neurological monitoring, and radiologic supervision and interpretation of all angiography required for balloon occlusion and to exclude vascular injury post occlusion
61626	$5,836.52	Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), including all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention, percutaneous, any method; non-central nervous system, head or neck (extracranial, brachiocephalic branch)
61720	$3,541.27	Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus
61891	$22,866.30	Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)
61892	$1,398.14	Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed
62000	$1,258.43	Elevation of depressed skull fracture; simple, extradural
62351	$3,979.95	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy
63011	$3,141.20	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; sacral

Code	Rate	Code Description
63012	$3,141.20	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
63015	$3,141.20	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; cervical
63016	$3,141.20	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; thoracic
63017	$3,141.20	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; lumbar
63035	$0.00	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)
63040	$3,141.20	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
63043	$0.00	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)
63048	$0.00	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)
63057	$0.00	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)

Code	Rate	Code Description
63064	$3,141.20	Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; single segment
63066	$0.00	Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; each additional segment (List separately in addition to code for primary procedure)
63075	$3,141.20	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
63076	$0.00	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)
63265	$3,141.20	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical
63266	$3,141.20	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic
63267	$3,141.20	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar
63268	$3,141.20	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral
63741	$4,511.85	Creation of shunt, lumbar, subarachnoid-peritoneal, -pleural, or other; percutaneous, not requiring laminectomy
64804	$806.36	Sympathectomy, cervicothoracic
64911	$4,600.61	Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve
69725	$2,571.78	Decompression facial nerve, intratemporal; including medial to geniculate ganglion
69955	$2,571.78	Total facial nerve decompression and/or repair (may include graft)

Code	Rate	Code Description
69960	$2,571.78	Decompression internal auditory canal
69970	$2,571.78	Removal of tumor, temporal bone
92924	$7,180.78	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed, single major coronary artery and/or its branch(es)
92930	$10,915.70	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); 2 or more distinct coronary lesions with 2 or more coronary stents deployed in 2 or more coronary segments, or a bifurcation lesion requiring angioplasty and/or stenting in both the main artery and the side branch
92933	$11,020.11	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed, single major coronary artery and/or its branch(es)
92937	$6,309.47	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed, single major coronary artery and/or its branches
92943	$6,700.69	Percutaneous transluminal revascularization of chronic total occlusion, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery branches of the bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; antegrade approach
92945	$6,322.56	Percutaneous transluminal revascularization of chronic total occlusion, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery branches of the bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; combined antegrade and retrograde approaches
92960	$309.03	Cardioversion, elective, electrical conversion of arrhythmia; external
92961	$309.03	Cardioversion, elective, electrical conversion of arrhythmia; internal (separate procedure)

Code	Rate	Code Description
92973	$0.00	Percutaneous transluminal coronary mechanical aspiration thrombectomy (List separately in addition to code for primary procedure)
92974	$0.00	Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to code for primary procedure)
93650	$5,051.72	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement
93653	$16,299.46	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 supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry
93654	$16,559.71	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 ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed
93655	$0.00	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)

Code	Rate	Code Description
93656	$17,217.37	Comprehensive electrophysiologic evaluation with transseptal catheterizations, insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, and intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography with imaging supervision and interpretation, right ventricular pacing/recording, and His bundle recording, when performed
93657	$0.00	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)
C7508	$5,783.77	Percutaneous vertebral augmentations, first lumbar and any additional thoracic or lumbar vertebral bodies, including cavity creations (fracture reductions and bone biopsies included when performed) using mechanical device (e.g., kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance
C7511	$1,441.96	Bronchoscopy, rigid or flexible, with single or multiple bronchial or endobronchial biopsy(ies), single or multiple sites, with computer-assisted image-guided navigation, including fluoroscopic guidance when performed
C7518	$2,318.21	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 diagnostic evaluation and/or therapeutic intervention including imaging, supervision, interpretation and report
C7519	$2,318.21	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 angiography including pharmacologically induced stress

Code	Rate	Code Description
C7547	$1,464.57	Convert nephrostomy catheter to nephroureteral catheter, percutaneous via pre-existing nephrostomy tract, with ureteral stricture balloon dilation, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
C8004	$6,322.56	Simulation angiogram with use of a pressure-generating catheter (e.g., one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the angiogram, for subsequent therapeutic radioembolization of tumors
C8006	$3,624.09	Insertion of pleural-peritoneal shunt with intercostal pump chamber, including imaging, injection(s) of contrast with radiological supervision and interpretation, when performed
C9602	$11,225.17	Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch
C9603	$0.00	Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)
C9604	$6,251.15	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel
C9605	$0.00	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (list separately in addition to code for primary procedure)
C9607	$10,871.67	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel

Code	Rate	Code Description
C9608	$0.00	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)
C9758	$11,094.27	Blind procedure for NYHA Class III/IV heart failure; transcatheter implantation of interatrial shunt including right heart catheterization, transesophageal echocardiography (TEE)/intracardiac echocardiography (ICE), and all imaging with or without guidance (e.g., ultrasound, fluoroscopy), performed in an approved investigational device exemption (IDE) study
C9760	$12,558.47	Nonrandomized, nonblinded procedure for NYHA Class II, III, IV heart failure; transcatheter implantation of interatrial shunt, including right and left heart catheterization, transeptal puncture, transesophageal echocardiography (TEE)/intracardiac echocardiography (ICE), and all imaging with or without guidance (e.g., ultrasound, fluoroscopy), performed in an approved investigational device exemption (IDE) study
C9779	$1,688.57	Endoscopic submucosal dissection (ESD), including endoscopy or colonoscopy, mucosal closure, when performed
C9780	$5,497.72	Insertion of central venous catheter through central venous occlusion via inferior and superior approaches (e.g., inside-out technique), including imaging guidance
C9782	$10,125.75	Blinded procedure for New York Heart Association (NYHA) Class II or III heart failure, or Canadian Cardiovascular Society (CCS) Class III or IV chronic refractory angina; transcatheter intramyocardial transplantation of autologous bone marrow cells (e.g., mononuclear) or placebo control, autologous bone marrow harvesting and preparation for transplantation, left heart catheterization including ventriculography, all laboratory services, and all imaging with or without guidance (e.g., transthoracic echocardiography, ultrasound, fluoroscopy), performed in an approved investigational device exemption (IDE) study

Code	Rate	Code Description
C9783	$4,606.52	Blinded procedure for transcatheter implantation of coronary sinus reduction device or placebo control, including vascular access and closure, right heart catheterization, venous and coronary sinus angiography, imaging guidance and supervision and interpretation when performed in an approved investigational device exemption (IDE) study
C9785	$4,352.43	Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components
C9792	$4,452.69	Blinded or nonblinded procedure for symptomatic New York Heart Association (NYHA) Class II, III, IVA heart failure; transcatheter implantation of left atrial to coronary sinus shunt using jugular vein access, including all imaging necessary to intra procedurally map the coronary sinus for optimal shunt placement (e.g., transesophageal echocardiography (TTE), intracardiac echocardiography (ICE), fluoroscopy), performed under general anesthesia in an approved investigational device exemption (IDE) study
C9901	$5,745.51	Endoscopic defect closure within the entire gastrointestinal tract, including upper endoscopy (including diagnostic, if performed) or colonoscopy (including diagnostic, if performed), with all system and tissue anchoring components
D7440	$1,258.43	Excision of malignant tumor, lesion diameter up to 1.25 cm
D7441	$1,258.43	Excision of malignant tumor, lesion diameter greater than 1.25 cm
G0413	$3,955.87	Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, (includes ilium, sacroiliac joint and/or sacrum)

2025 Deleted Codes

Code	Code Description
10140	Incision and drainage of hematoma, seroma or fluid collection
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst

Code	Code Description
11000	Debridement of extensive eczematous or infected skin; up to 10% of body surface
11001	Debridement of extensive eczematous or infected skin; each additional 10% of the body surface, or part thereof (List separately in addition to code for primary procedure)
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
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less
76015	MR safety implant and/or foreign body assessment by trained clinical staff, including identification and verification of implant components from appropriate sources (eg, surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and systems, and consulting published professional guidance with written report; each additional 30 minutes (List separately in addition to code for primary procedure)
C7501	Percutaneous breast biopsies using stereotactic guidance, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, all lesions unilateral and bilateral (for single lesion biopsy, use appropriate code)
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
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
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 (e.g., for upgrade to dual chamber system)

Code	Code Description
C7548	Exchange nephrostomy catheter, percutaneous, with ureteral stricture balloon dilation, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
C7557	Catheter placement in coronary artery(s) 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 and intraprocedural coronary fractional flow reserve (FFR) with 3D functional mapping of color-coded FFR values for the coronary tree, derived from coronary angiogram data, for real-time review and interpretation of possible atherosclerotic stenosis(es) intervention
C7558	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, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed
C7560	Endoscopic retrograde cholangiopancreatography (ERCP) with removal of foreign body(ies) or stent(s) from biliary/pancreatic duct(s) and endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s)
C7563	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, initial artery and all additional arteries
C9790	Histotripsy (i.e., nonthermal ablation via acoustic energy delivery) of malignant renal tissue, including image guidance