114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Section

47.01: General Provisions

(1) Scope, Purpose and Effective Date. 114.3 CMR 47.00 governs the rates of payment to eligible freestanding ambulatory surgical facilities to be used by all Governmental Units for services provided to Publicly-aided Individuals. Rates for purchases under the Worker's Compensation Act, M.G.L. c. 152, are set forth in 114.3 CMR 40.00. 114.3 CMR 47.00 shall be effective January 1, 2010.

(2) Coverage. 114.3 CMR 47.00 and the rates of payment contained in 114.3 CMR 47.00 are full compensation for facility services furnished in connection with surgical procedures that can be performed safely on an ambulatory basis in an ambulatory surgical center under the scope of covered services and condition for payment for facility services by the governmental purchaser. Payment from any other sources shall be used to offset the amount of the purchasing Governmental Unit's obligation for services rendered to the Publicly-aided Individuals. 114.3 CMR 47.00 does not cover professional services which are billed by a physician, dentist or podiatrist separately from the health care facility and who receives no other compensation for professional services rendered. Covered ambulatory surgical facility services do not include services performed in a hospital-based facility or medical, dental or podiatric surgical procedures that are customarily performed in an office setting.

(3) Disclaimer of Authorization of Services. 114.3 CMR 47.00 is not authorization for or approval of the procedures for which rates are determined pursuant to 114.3 CMR 47.00. Governmental Units that purchase care are responsible for the definition, authorization, and approval of care and services extended to Publicly-aided Individuals.

(4) Coding Updates and Corrections. The Division may publish procedure code updates and corrections in the form of an Administrative Bulletin. Updates may reference coding systems including but not limited to the American Medical Association's *Current Procedural Terminology* (CPT). The publication of such updates and corrections will list:

(a) codes for which only the code numbers change, with the corresponding cross references between existing and new codes;
(b) codes for which the code number remains the same but the description has changed;
(c) deleted codes for which there are no corresponding new codes; and

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

(d) codes for entirely new services that require pricing. The Division will list these codes and apply individual consideration (I.C.) reimbursement for these codes until appropriate rates can be developed.

(5) Administrative Bulletins. The Division may issue administrative bulletins to clarify its policy on and understanding of substantive provisions of 114.3 CMR 47.00.

(6) Authority. 114.3 CMR 47.00 is adopted pursuant to M.G.L. c.118G.

47.02: Definitions

Meaning of Terms. The descriptions and five-digit codes included in 114.3 CMR 47.00 utilize the Healthcare Common Procedure Code System (HCPCS) for Level I and Level II coding. Level 1 CPT 4 codes are obtained from the Physicians' *Current Procedural Terminology*© *2009* by the American Medical Association, unless otherwise specified. Level II codes are obtained from 2009 HCPCS maintained jointly by the Centers for Medicare and Medicaid Services (CMS), the Blue Cross and Blue Shield Association, and the Health Insurance Association of America. HCPCS is a listing of descriptive terms and identifying codes and modifiers for reporting medical services and procedures performed by physicians and other healthcare professionals, as well as associated non-physician services. 114.3 CMR 47.00 includes only HCPCS numeric and alpha-numeric identifying codes and modifiers for reporting medical services and procedures that were selected by the Division. Any use of CPT outside the fee schedule should refer to the Physicians' *Current Procedural Terminology*© *2009*.

In addition, terms used in 114.3 CMR 47.00 shall have the meanings set forth in 114.3 CMR 47.02.

Division. The Division of Health Care Finance and Policy established under M.G.L. c.118G.

Eligible Provider. A licensed ambulatory freestanding surgical facility that meets the conditions of participation adopted by a Governmental Unit.

Facility Component. Rate of payment for a freestanding surgical facility's costs. The facility component does not include payment for physician, dentist or podiatrist's services in performing a surgical procedure.

Freestanding Ambulatory Surgical Center (FASC). A distinct entity that operates exclusively for the purpose of providing surgical services that do not require the availability of hospital facilities, is licensed by the Massachusetts Department of Public Health and meets the conditions for payment by the purchaser for facility services.

Governmental Unit. The Commonwealth of Massachusetts or any of its departments, agencies, boards, commissions or political subdivisions.

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Individual Consideration (I.C.). Freestanding facility services which are authorized but not listed in 114.3 CMR 47.00, and FASC services performed in unusual circumstances and services whose fees are designated by the letters "I.C." are individually considered items. The Governmental Unit or purchaser shall analyze the Eligible Provider's operative report which shall contain a diagnosis, a pertinent medical history, a description of the services rendered and the length of time spent with the patient. In making the determination of whether the service is appropriately classified as an individually considered item the following criteria shall be used:

(a) policies, procedures and practices of other third party purchasers of care, both governmental and private;

(b) the severity and complexity of the patient's disorder or disability;

(c) prevailing provider ethics and accepted practice;

(d) time, degree of skill, and cost including equipment cost required to perform the procedure(s).

Publicly-aided Individual. A person who receives health care and services for which a Governmental Unit is in whole or in part liable under a statutory program of public assistance.

Separate Procedure. Some of the listed procedures are commonly carried out as an integral part of a total service and as such, do not warrant a separate identification. When, however, such a procedure is performed independently of, and is not immediately related to, other services, it may be listed as a separate procedure in the procedure description. Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be considered to be a separate procedure.

47.03: General Rate Provisions and Payment

(1) Rate Determination. Rates of payment for authorized freestanding ambulatory surgical facility services to which 114.3 CMR 47.00 applies shall be the lower of:

(a) the Eligible Provider's usual charge to the general public; or

(b) the schedule of allowable rates set forth in 114.3 CMR 47.03.

(2) Maximum Allowable Rates. Rates of payment will be for the facility component only. The payment rate for each FASC procedure is listed next to the HCPCS code and its description as described in 114.3 CMR 47.03(5).

(3) Individual Consideration and Non-listed Procedures. Rates of payment to Eligible Providers for freestanding facility services which are authorized but not listed herein; services performed in unusual circumstances; and services whose fees are designated by the letters "I.C." shall be determined on an Individual Consideration basis.

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

(4) Modifiers.

-50: Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by the appropriate service code describing the first procedure. The second bilateral procedure is identified by adding the modifier '-50' to the end of the service code. If a reimbursable surgical procedure provided in a single operative session is performed bilaterally, the full maximum fee is 150% of the payment group contained in 114.3 CMR 47.00 for the operative procedure.

-51: Multiple Procedures. This modifier must be used to report multiple procedures performed at the same operative session. The service code for the major procedure or service must be reported without a modifier and will receive 100% of the payment for the procedure with the highest fee. The secondary, additional or lesser procedure(s) must be identified by adding the modifier '-51' to the end of the service code for the secondary procedure(s). The addition of the modifier '-51' to the second and subsequent procedure codes allows 50% of the allowable fee contained in 114.3 CMR 47.00 to be paid to the Eligible Provider.
NOTE: This modifier should not be used with designated "add-on" codes or with codes in which the narrative contains the words "each additional".

-73: Discountinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia. Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of the modifier '-73'. Note: the elective anesthesia and/or surgical preparation of the patient should not be reported.

-74: Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia. Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc.). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of the modifier '-74'. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.

Terminated Procedures.The purchaser shall determine payment on an individual consideration (I.C.) basis for any procedure that has been terminated after the procedure has been initiated.

(5) Fee Schedules.

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

(a) Surgical Services.

Code	Fee	Description
10021	52.03	Fine needle aspiration; without imaging guidance
10022	162.48	Fine needle aspiration; with imaging guidance
10040	30.08	Acne surgery (e.g., marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)
10060	45.77	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
10061	51.32	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple
10080	51.32	Incision and drainage of pilonidal cyst; simple
10081	118.15	Incision and drainage of pilonidal cyst; complicated
10120	64.27	Incision and removal of foreign body, subcutaneous tissues; simple
10121	484.44	Incision and removal of foreign body, subcutaneous tissues; complicated
10140	68.17	Incision and drainage of hematoma, seroma or fluid collection
10160	51.32	Puncture aspiration of abscess, hematoma, bulla, or cyst
10180	547.84	Incision and drainage, complex, postoperative wound infection
11000	22.08	Debridement of extensive eczematous or infected skin; up to 10% of body surface
11001	7.47	Debridement of extensive eczematous or infected skin; each additional 10% of the body surface (List separately in addition to code for primary procedure)
11010	191.66	Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin and subcutaneous tissues
11011	191.66	Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, and muscle
11012	191.66	Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, muscle, and bone
11040	20.12	Debridement; skin, partial thickness
11041	22.40	Debridement; skin, full thickness
11042	121.71	Debridement; skin, and subcutaneous tissue
11043	121.71	Debridement; skin, subcutaneous tissue, and muscle

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
11044	316.91	Debridement; skin, subcutaneous tissue, muscle, and bone
11055	23.70	Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion
11056	25.97	Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); two to four lesions
11057	30.08	Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); more than four lesions
11100	55.11	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion
11101	12.99	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)
11200	30.08	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
11201	5.19	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional ten lesions (List separately in addition to code for primary procedure)
11300	30.08	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less
11301	30.08	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm
11302	30.08	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm
11303	55.11	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm
11305	30.08	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
11306	30.08	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm
11307	30.08	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm
11308	30.08	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm
11310	30.08	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
11311	30.08	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm
11312	30.08	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm
11313	30.08	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm
11400	62.00	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less
11401	69.79	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm
11402	76.61	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm
11403	81.80	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm
11404	434.86	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm
11406	484.44	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm
11420	58.10	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421	70.43	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm
11422	76.93	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm
11423	85.70	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm
11424	484.44	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm
11426	592.43	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
11440	66.55	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
11441	76.93	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm
11442	84.72	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm
11443	93.81	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm
11444	296.08	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm
11446	592.43	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm
11450	592.43	Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair
11451	592.43	Excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair
11462	592.43	Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with simple or intermediate repair
11463	592.43	Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with complex repair
11470	592.43	Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with simple or intermediate repair
11471	592.43	Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with complex repair
11600	87.32	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.5 cm or less
11601	105.82	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
11602	116.53	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm
11603	123.67	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm
11604	333.59	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm
11606	484.44	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm
11620	90.24	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11621	107.12	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm
11622	119.12	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm
11623	128.21	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm
11624	484.44	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm
11626	592.43	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm
11640	95.44	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less
11641	112.64	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm
11642	125.62	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm
11643	135.36	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm
11644	484.44	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm
11646	592.43	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm
11719	11.03	Trimming of nondystrophic nails, any number
11720	13.64	Debridement of nail(s) by any method(s); one to five

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
11721	16.55	Debridement of nail(s) by any method(s); six or more
11730	30.08	Avulsion of nail plate, partial or complete, simple; single
11732	16.55	Avulsion of nail plate, partial or complete, simple; each additional nail plate (List separately in addition to code for primary procedure)
11740	15.19	Evacuation of subungual hematoma
11750	87.64	Excision of nail and nail matrix, partial or complete, (e.g., ingrown or deformed nail) for permanent removal;
11752	121.73	Excision of nail and nail matrix, partial or complete, (e.g., ingrown or deformed nail) for permanent removal; with amputation of tuft of distal phalanx
11755	60.70	Biopsy of nail unit (e.g., plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)
11760	125.01	Repair of nail bed
11762	111.66	Reconstruction of nail bed with graft
11765	30.08	Wedge excision of skin of nail fold (e.g., for ingrown toenail)
11770	620.52	Excision of pilonidal cyst or sinus; simple
11771	620.52	Excision of pilonidal cyst or sinus; extensive
11772	620.52	Excision of pilonidal cyst or sinus; complicated
11900	27.59	Injection, intralesional; up to and including seven lesions
11901	30.08	Injection, intralesional; more than seven lesions
11920	87.32	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	96.08	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922	31.16	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm (List separately in addition to code for primary procedure)
11950	31.82	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
11951	39.60	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
11952	47.67	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
11954	47.67	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
11960	578.32	Insertion of tissue expander(s) for other than breast, including subsequent expansion

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
11970	1,047.54	Replacement of tissue expander with permanent prosthesis
11971	542.85	Removal of tissue expander(s) without insertion of prosthesis
11976	58.10	Removal, implantable contraceptive capsules
11980	23.47	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
11981	23.47	Insertion, non-biodegradable drug delivery implant
11982	23.47	Removal, non-biodegradable drug delivery implant
11983	23.47	Removal with reinsertion, non-biodegradable drug delivery implant
12001	47.67	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
12002	47.67	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm
12004	47.67	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm
12005	63.87	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm
12006	63.87	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm
12007	63.87	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm
12011	47.67	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12013	47.67	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm
12014	47.67	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm
12015	47.67	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm
12016	63.87	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
12017	63.87	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm
12018	63.87	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm
12020	120.51	Treatment of superficial wound dehiscence; simple closure
12021	102.54	Treatment of superficial wound dehiscence; with packing
12031	47.67	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less
12032	125.01	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm
12034	63.87	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm
12035	63.87	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm
12036	102.54	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm
12037	204.36	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); over 30.0 cm
12041	47.67	Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less
12042	47.67	Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm
12044	63.87	Layer closure of wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm
12045	102.54	Layer closure of wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm
12046	102.54	Layer closure of wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm
12047	204.36	Layer closure of wounds of neck, hands, feet and/or external genitalia; over 30.0 cm
12051	47.67	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12052	47.67	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
12053	47.67	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm
12054	63.87	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm
12055	102.54	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm
12056	102.54	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm
12057	204.36	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm
13100	222.33	Repair, complex, trunk; 1.1 cm to 2.5 cm
13101	222.33	Repair, complex, trunk; 2.6 cm to 7.5 cm
13102	120.51	Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)
13120	102.54	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm
13121	102.54	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm
13122	102.54	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)
13131	102.54	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
13132	102.54	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm
13133	102.54	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)
13150	222.33	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less
13151	222.33	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm
13152	222.33	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm
13153	102.54	Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)
13160	578.32	Secondary closure of surgical wound or dehiscence, extensive or complicated
14000	485.86	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	513.94	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
		30.0 sq cm
14020	513.94	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
14021	513.94	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
14040	485.86	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	513.94	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
14060	513.94	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14061	513.94	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm
14300	659.06	Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area
14350	606.40	Filleted finger or toe flap, including preparation of recipient site
15002	222.33	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children
15003	222.33	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)
15004	222.33	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children
15005	222.33	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
15040	102.54	Harvest of skin for tissue cultured skin autograft, 100 sq cm or less
15050	222.33	Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area (except on face), up to defect size 2 cm diameter
15100	578.32	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)
15101	606.40	Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15110	276.17	Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children
15111	226.59	Epidermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15115	276.17	Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children
15116	226.59	Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15120	578.32	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)
15121	606.40	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15130	485.86	Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children
15131	436.27	Dermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15135	485.86	Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
		1% of body area of infants and children
15136	436.27	Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15150	276.17	Tissue cultured epidermal autograft, trunk, arms, legs; first 25 sq cm or less
15151	226.59	Tissue cultured epidermal autograft, trunk, arms, legs; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)
15152	226.59	Tissue cultured epidermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15155	276.17	Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 25 sq cm or less
15156	226.59	Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)
15157	226.59	Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15170	125.01	Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children
15171	125.01	Acellular dermal replacement, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15175	160.95	Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
15176	160.95	Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15200	513.94	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less
15201	432.01	Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm (List separately in addition to code for primary procedure)
15220	485.86	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less
15221	222.33	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm (List separately in addition to code for primary procedure)
15240	513.94	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less
15241	222.33	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; each additional 20 sq cm (List separately in addition to code for primary procedure)
15260	485.86	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less
15261	432.01	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; each additional 20 sq cm (List separately in addition to code for primary procedure)
15300	222.33	Allograft skin for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children
15301	222.33	Allograft skin for temporary wound closure, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15320	222.33	Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
15321	222.33	Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15330	222.33	Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children
15331	222.33	Acellular dermal allograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15335	222.33	Acellular dermal allograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children
15336	222.33	Acellular dermal allograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15340	125.01	Tissue cultured allogeneic skin substitute; first 25 sq cm or less
15341	125.01	Tissue cultured allogeneic skin substitute; each additional 25 sq cm
15360	125.01	Tissue cultured allogeneic dermal substitute, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children
15361	125.01	Tissue cultured allogeneic dermal substitute, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15365	125.01	Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children
15366	125.01	Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15400	222.33	Xenograft, skin (dermal), for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
15401	222.33	Xenograft, skin (dermal), for temporary wound closure, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15420	222.33	Xenograft skin (dermal), for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children
15421	222.33	Xenograft skin (dermal), for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15430	222.33	Acellular xenograft implant; first 100 sq cm or less, or 1% of body area of infants and children
15431	222.33	Acellular xenograft implant; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15570	606.40	Formation of direct or tubed pedicle, with or without transfer; trunk
15572	606.40	Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs
15574	606.40	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
15576	606.40	Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral
15600	606.40	Delay of flap or sectioning of flap (division and inset); at trunk
15610	606.40	Delay of flap or sectioning of flap (division and inset); at scalp, arms, or legs
15620	659.06	Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet
15630	606.40	Delay of flap or sectioning of flap (division and inset); at eyelids, nose, ears, or lips
15650	697.23	Transfer, intermediate, of any pedicle flap (e.g., abdomen to wrist, Walking tube), any location
15731	606.40	Forehead flap with preservation of vascular pedicle (e.g., axial pattern flap, paramedian forehead flap)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
15732	606.40	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (e.g., temporalis, masseter muscle, sternocleidomastoid, levator scapulae)
15734	606.40	Muscle, myocutaneous, or fasciocutaneous flap; trunk
15736	606.40	Muscle, myocutaneous, or fasciocutaneous flap; upper extremity
15738	606.40	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity
15740	485.86	Flap; island pedicle
15750	578.32	Flap; neurovascular pedicle
15760	578.32	Graft; composite (e.g., full thickness of external ear or nasal ala), including primary closure, donor area
15770	606.40	Graft; derma-fat-fascia
15775	165.69	Punch graft for hair transplant; 1 to 15 punch grafts
15776	165.69	Punch graft for hair transplant; more than 15 punch grafts
15780	369.40	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	162.59	Dermabrasion; segmental, face
15782	162.59	Dermabrasion; regional, other than face
15783	99.13	Dermabrasion; superficial, any site, (e.g., tattoo removal)
15786	30.08	Abrasion; single lesion (e.g., keratosis, scar)
15787	27.27	Abrasion; each additional four lesions or less (List separately in addition to code for primary procedure)
15788	30.08	Chemical peel, facial; epidermal
15789	55.11	Chemical peel, facial; dermal
15792	55.11	Chemical peel, nonfacial; epidermal
15793	30.08	Chemical peel, nonfacial; dermal
15819	125.01	Cervicoplasty
15820	606.40	Blepharoplasty, lower eyelid;
15821	606.40	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	606.40	Blepharoplasty, upper eyelid;
15823	697.23	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	606.40	Rhytidectomy; forehead
15825	606.40	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	606.40	Rhytidectomy; glabellar frown lines
15828	606.40	Rhytidectomy; cheek, chin, and neck
15829	697.23	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
15830	620.52	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	620.52	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	620.52	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	620.52	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	538.59	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	512.53	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	577.49	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	577.49	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	512.53	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15840	659.06	Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)
15841	659.06	Graft for facial nerve paralysis; free muscle graft (including obtaining graft)
15842	765.23	Graft for facial nerve paralysis; free muscle flap by microsurgical technique
15845	659.06	Graft for facial nerve paralysis; regional muscle transfer
15847	620.52	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15850	99.13	Removal of sutures under anesthesia (other than local), same surgeon
15851	45.12	Removal of sutures under anesthesia (other than local), other surgeon
15852	23.47	Dressing change (for other than burns) under anesthesia (other than local)
15860	23.47	Intravenous injection of agent (e.g., fluorescein) to test vascular flow in flap or graft
15876	606.40	Suction assisted lipectomy; head and neck
15877	606.40	Suction assisted lipectomy; trunk
15878	606.40	Suction assisted lipectomy; upper extremity
15879	606.40	Suction assisted lipectomy; lower extremity

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
15920	191.66	Excision, coccygeal pressure ulcer, with coccygectomy; with primary suture
15922	659.06	Excision, coccygeal pressure ulcer, with coccygectomy; with flap closure
15931	620.52	Excision, sacral pressure ulcer, with primary suture;
15933	620.52	Excision, sacral pressure ulcer, with primary suture; with ostectomy
15934	606.40	Excision, sacral pressure ulcer, with skin flap closure;
15935	659.06	Excision, sacral pressure ulcer, with skin flap closure; with ostectomy
15936	566.60	Excision, sacral pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure;
15937	659.06	Excision, sacral pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure; with ostectomy
15940	620.52	Excision, ischial pressure ulcer, with primary suture;
15941	620.52	Excision, ischial pressure ulcer, with primary suture; with ostectomy (ischiectomy)
15944	606.40	Excision, ischial pressure ulcer, with skin flap closure;
15945	659.06	Excision, ischial pressure ulcer, with skin flap closure; with ostectomy
15946	659.06	Excision, ischial pressure ulcer, with ostectomy, in preparation for muscle or myocutaneous flap or skin graft closure
15950	620.52	Excision, trochanteric pressure ulcer, with primary suture;
15951	673.17	Excision, trochanteric pressure ulcer, with primary suture; with ostectomy
15952	513.94	Excision, trochanteric pressure ulcer, with skin flap closure;
15953	566.60	Excision, trochanteric pressure ulcer, with skin flap closure; with ostectomy
15956	513.94	Excision, trochanteric pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure;
15958	566.60	Excision, trochanteric pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure; with ostectomy
16000	24.35	Initial treatment, first degree burn, when no more than local treatment is required
16020	37.01	Dressings and/or debridement of partial thickness burns, initial or subsequent; small (less than 5% total body surface area)
16025	57.00	Dressings and/or debridement of partial thickness burns, initial or subsequent; medium (e.g., whole face or whole extremity, or 5% to 10% total body surface area)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
16030	71.36	Dressings and/or debridement of partial thickness burns, initial or subsequent; large (e.g., more than one extremity, or greater than 10% total body surface area)
16035	55.11	Escharotomy; initial incision
17000	30.08	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); first lesion
17004	78.55	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses), 15 or more lesions
17106	99.13	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm
17107	99.13	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 to 50.0 sq cm
17108	99.13	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq cm
17110	30.08	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions; up to 14 lesions
17111	55.11	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions; 15 or more lesions
17250	41.55	Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)
17260	44.47	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5 cm or less
17261	55.11	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm
17262	55.11	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm
17263	55.11	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 2.1 to 3.0 cm
17264	55.11	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs;

Code	Fee	Description
		lesion diameter 3.1 to 4.0 cm
17266	99.13	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter over 4.0 cm
17270	55.11	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
17271	55.11	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm
17272	55.11	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm
17273	99.13	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 2.1 to 3.0 cm
17274	99.13	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 3.1 to 4.0 cm
17276	99.13	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter over 4.0 cm
17280	55.11	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
17281	82.13	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm
17282	93.81	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
17283	99.13	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 2.1 to 3.0 cm
17284	99.13	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 3.1 to 4.0 cm
17286	99.13	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 4.0 cm
17311	163.64	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks
17312	163.64	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)
17313	163.64	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks
17314	163.64	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
17315	37.01	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure)
17340	13.31	Cryotherapy (CO2 slush, liquid N2) for acne
17360	30.08	Chemical exfoliation for acne (e.g., acne paste, acid)
17380	30.08	Electrolysis epilation, each 30 minutes
19000	62.65	Puncture aspiration of cyst of breast;
19001	8.44	Puncture aspiration of cyst of breast; each additional cyst (List separately in addition to code for primary procedure)
19020	547.84	Mastotomy with exploration or drainage of abscess, deep
19100	186.55	Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)
19101	585.94	Biopsy of breast; open, incisional
19102	239.50	Biopsy of breast; percutaneous, needle core, using imaging guidance
19103	419.18	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
19105	1,219.63	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma
19110	585.94	Nipple exploration, with or without excision of a solitary lactiferous duct or a papilloma lactiferous duct
19112	614.03	Excision of lactiferous duct fistula
19120	614.03	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, one or more lesions
19125	614.03	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion
19126	614.03	Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker (List separately in addition to code for primary procedure)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
19296	1,679.45	Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy
19297	1,679.45	Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure)
19298	1,679.45	Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance
19300	666.68	Mastectomy for gynecomastia
19301	614.03	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy);
19302	1,172.72	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy
19303	886.26	Mastectomy, simple, complete
19304	886.26	Mastectomy, subcutaneous
19316	886.26	Mastopexy
19318	1,012.55	Reduction mammaplasty
19324	1,012.55	Mammaplasty, augmentation; without prosthetic implant
19325	1,679.45	Mammaplasty, augmentation; with prosthetic implant
19328	755.94	Removal of intact mammary implant
19330	755.94	Removal of mammary implant material
19340	931.82	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	1,315.68	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350	666.68	Nipple/areola reconstruction
19355	886.26	Correction of inverted nipples
19357	1,406.51	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19366	924.44	Breast reconstruction with other technique
19370	886.26	Open periprosthetic capsulotomy, breast
19371	886.26	Periprosthetic capsulectomy, breast

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
19380	1,050.73	Revision of reconstructed breast
19396	1,219.63	Preparation of moulage for custom breast implant
20000	51.32	Incision of soft tissue abscess (e.g., secondary to osteomyelitis); superficial
20005	591.31	Incision of soft tissue abscess (e.g., secondary to osteomyelitis); deep or complicated
20103	580.31	Exploration of penetrating wound (separate procedure); extremity
20150	1,647.51	Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision
20200	484.44	Biopsy, muscle; superficial
20205	512.53	Biopsy, muscle; deep
20206	239.50	Biopsy, muscle, percutaneous needle
20220	260.33	Biopsy, bone, trocar, or needle; superficial (e.g., ilium, sternum, spinous process, ribs)
20225	472.37	Biopsy, bone, trocar, or needle; deep (e.g., vertebral body, femur)
20240	592.43	Biopsy, bone, open; superficial (e.g., ilium, sternum, spinous process, ribs, trochanter of femur)
20245	620.52	Biopsy, bone, open; deep (e.g., humerus, ischium, femur)
20250	619.40	Biopsy, vertebral body, open; thoracic
20251	619.40	Biopsy, vertebral body, open; lumbar or cervical
20500	51.29	Injection of sinus tract; therapeutic (separate procedure)
20520	86.35	Removal of foreign body in muscle or tendon sheath; simple
20525	620.52	Removal of foreign body in muscle or tendon sheath; deep or complicated
20526	27.92	Injection, therapeutic (e.g., local anesthetic, corticosteroid), carpal tunnel
20550	21.10	Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar fascia)
20551	20.77	Injection(s); single tendon origin/insertion
20552	20.12	Injection(s); single or multiple trigger point(s), one or two muscle(s)
20553	22.40	Injection(s); single or multiple trigger point(s), three or more muscle(s)
20555	1,085.48	Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)
20600	21.42	Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
20605	24.02	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)
20610	33.76	Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa)
20612	22.73	Aspiration and/or injection of ganglion cyst(s) any location
20615	95.11	Aspiration and injection for treatment of bone cyst
20650	619.40	Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)
20662	791.22	Application of halo, including removal; pelvic
20663	791.22	Application of halo, including removal; femoral
20665	23.47	Removal of tongs or halo applied by another physician
20670	434.86	Removal of implant; superficial, (e.g., buried wire, pin or rod) (separate procedure)
20680	620.52	Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate)
20690	738.44	Application of a uniplane (pins or wires in one plane), unilateral, external fixation system
20692	766.53	Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (e.g., Ilizarov, Monticelli type)
20693	619.40	Adjustment or revision of external fixation system requiring anesthesia (e.g., new pin(s) or wire(s) and/or new ring(s) or bar(s))
20694	541.73	Removal, under anesthesia, of external fixation system
20696	1,085.48	Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (e.g., spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment
20697	721.89	Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (e.g., spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each
20822	1,017.11	Replantation, digit, excluding thumb (includes distal tip to sublimis tendon insertion), complete amputation
20900	766.53	Bone graft, any donor area; minor or small (e.g., dowel or button)
20902	819.18	Bone graft, any donor area; major or large
20910	606.40	Cartilage graft; costochondral

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
20912	606.40	Cartilage graft; nasal septum
20920	566.60	Fascia lata graft; by stripper
20922	513.94	Fascia lata graft; by incision and area exposure, complex or sheet
20924	819.18	Tendon graft, from a distance (e.g., palmaris, toe extensor, plantaris)
20926	356.91	Tissue grafts, other (e.g., paratenon, fat, dermis)
20950	51.32	Monitoring of interstitial fluid pressure (includes insertion of device, e.g., wick catheter technique, needle manometer technique) in detection of muscle compartment syndrome
20972	1,717.92	Free osteocutaneous flap with microvascular anastomosis; metatarsal
20973	1,717.92	Free osteocutaneous flap with microvascular anastomosis; great toe with web space
20979	21.10	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)
20982	1,647.51	Ablation, bone tumor(s) (e.g., osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance
21010	645.34	Arthrotomy, temporomandibular joint
21015	536.92	Radical resection of tumor (e.g., malignant neoplasm), soft tissue of face or scalp
21025	956.26	Excision of bone (e.g., for osteomyelitis or bone abscess); mandible
21026	956.26	Excision of bone (e.g., for osteomyelitis or bone abscess); facial bone(s)
21029	956.26	Removal by contouring of benign tumor of facial bone (e.g., fibrous dysplasia)
21030	225.59	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage
21031	186.64	Excision of torus mandibularis
21032	190.22	Excision of maxillary torus palatinus
21034	984.35	Excision of malignant tumor of maxilla or zygoma
21040	645.34	Excision of benign tumor or cyst of mandible, by enucleation and/or curettage
21044	956.26	Excision of malignant tumor of mandible;
21046	956.26	Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (e.g., locally aggressive or destructive lesion(s))
21047	956.26	Excision of benign tumor or cyst of mandible; requiring extra-oral osteotomy and partial mandibulectomy (e.g., locally aggressive or destructive lesion(s))

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
21048	1,521.12	Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (e.g., locally aggressive or destructive lesion(s))
21050	984.35	Condylectomy, temporomandibular joint (separate procedure)
21060	956.26	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)
21070	984.35	Coronoidectomy (separate procedure)
21073	175.28	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)
21076	304.15	Impression and custom preparation; surgical obturator prosthesis
21077	735.22	Impression and custom preparation; orbital prosthesis
21079	526.50	Impression and custom preparation; interim obturator prosthesis
21080	603.76	Impression and custom preparation; definitive obturator prosthesis
21081	556.36	Impression and custom preparation; mandibular resection prosthesis
21082	529.43	Impression and custom preparation; palatal augmentation prosthesis
21083	521.63	Impression and custom preparation; palatal lift prosthesis
21084	600.18	Impression and custom preparation; speech aid prosthesis
21085	238.26	Impression and custom preparation; oral surgical splint
21086	518.71	Impression and custom preparation; auricular prosthesis
21087	519.36	Impression and custom preparation; nasal prosthesis
21088	1,521.12	Impression and custom preparation; facial prosthesis
21100	956.26	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)
21110	273.65	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
21120	886.24	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	886.24	Genioplasty; sliding osteotomy, single piece
21122	886.24	Genioplasty; sliding osteotomies, two or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
21123	886.24	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	886.24	Augmentation, mandibular body or angle; prosthetic material
21127	1,348.10	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
21137	899.28	Reduction forehead; contouring only
21138	1,521.12	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	1,521.12	Reduction forehead; contouring and setback of anterior frontal sinus wall
21150	1,521.12	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)
21181	886.24	Reconstruction by contouring of benign tumor of cranial bones (e.g., fibrous dysplasia), extracranial
21198	1,521.12	Osteotomy, mandible, segmental;
21199	1,521.12	Osteotomy, mandible, segmental; with genioglossus advancement
21206	1,075.18	Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)
21208	1,197.16	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	1,075.18	Osteoplasty, facial bones; reduction
21210	1,197.16	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21215	1,197.16	Graft, bone; mandible (includes obtaining graft)
21230	1,197.16	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21235	886.24	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21240	1,037.00	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)
21242	1,075.18	Arthroplasty, temporomandibular joint, with allograft
21243	1,075.18	Arthroplasty, temporomandibular joint, with prosthetic joint replacement
21244	1,197.16	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)
21245	1,197.16	Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246	1,197.16	Reconstruction of mandible or maxilla, subperiosteal implant; complete
21248	1,197.16	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
21249	1,197.16	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete
21260	1,521.12	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
21267	1,197.16	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
21270	1,075.18	Malar augmentation, prosthetic material
21275	1,197.16	Secondary revision of orbitocraniofacial reconstruction
21280	1,075.18	Medial canthopexy (separate procedure)
21282	627.75	Lateral canthopexy
21295	282.94	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach
21296	595.76	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); intraoral approach
21310	86.31	Closed treatment of nasal bone fracture without manipulation
21315	379.27	Closed treatment of nasal bone fracture; without stabilization
21320	508.83	Closed treatment of nasal bone fracture; with stabilization
21325	726.08	Open treatment of nasal fracture; uncomplicated
21330	764.25	Open treatment of nasal fracture; complicated, with internal and/or external skeletal fixation
21335	886.24	Open treatment of nasal fracture; with concomitant open treatment of fractured septum
21336	738.59	Open treatment of nasal septal fracture, with or without stabilization
21337	508.83	Closed treatment of nasal septal fracture, with or without stabilization
21338	726.08	Open treatment of nasoethmoid fracture; without external fixation
21339	764.25	Open treatment of nasoethmoid fracture; with external fixation
21340	1,037.00	Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus
21345	886.24	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint
21355	984.35	Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation
21356	673.43	Open treatment of depressed zygomatic arch fracture (e.g., Gillies approach)
21360	899.28	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod
21390	1,521.12	Open treatment of orbital floor blowout fracture; periorbital approach, with alloplastic or other implant

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
21400	332.52	Closed treatment of fracture of orbit, except blowout; without manipulation
21401	536.92	Closed treatment of fracture of orbit, except blowout; with manipulation
21406	1,521.12	Open treatment of fracture of orbit, except blowout; without implant
21407	1,521.12	Open treatment of fracture of orbit, except blowout; with implant
21421	726.08	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint
21440	305.78	Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21445	726.08	Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21450	126.20	Closed treatment of mandibular fracture; without manipulation
21451	340.49	Closed treatment of mandibular fracture; with manipulation
21452	508.83	Percutaneous treatment of mandibular fracture, with external fixation
21453	984.35	Closed treatment of mandibular fracture with interdental fixation
21454	764.25	Open treatment of mandibular fracture with external fixation
21461	1,037.00	Open treatment of mandibular fracture; without interdental fixation
21462	1,075.18	Open treatment of mandibular fracture; with interdental fixation
21465	1,037.00	Open treatment of mandibular condylar fracture
21480	86.31	Closed treatment of temporomandibular dislocation; initial or subsequent
21485	508.83	Closed treatment of temporomandibular dislocation; complicated (e.g., recurrent requiring intermaxillary fixation or splinting), initial or subsequent
21490	984.35	Open treatment of temporomandibular dislocation
21495	626.27	Open treatment of hyoid fracture
21497	508.83	Interdental wiring, for condition other than fracture
21501	547.84	Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax;
21502	591.31	Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax; with partial rib ostectomy
21550	577.49	Biopsy, soft tissue of neck or thorax
21555	592.43	Excision tumor, soft tissue of neck or thorax; subcutaneous
21556	592.43	Excision tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular
21557	793.47	Radical resection of tumor (e.g., malignant neoplasm), soft tissue of neck or thorax

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
21600	738.44	Excision of rib, partial
21610	738.44	Costotransversectomy (separate procedure)
21685	273.65	Hyoid myotomy and suspension
21700	591.31	Division of scalenus anticus; without resection of cervical rib
21720	619.40	Division of sternocleidomastoid for torticollis, open operation; without cast application
21725	64.48	Division of sternocleidomastoid for torticollis, open operation; with cast application
21800	74.48	Closed treatment of rib fracture, uncomplicated, each
21805	657.85	Open treatment of rib fracture without fixation, each
21820	74.48	Closed treatment of sternum fracture
21920	132.44	Biopsy, soft tissue of back or flank; superficial
21925	592.43	Biopsy, soft tissue of back or flank; deep
21930	592.43	Excision, tumor, soft tissue of back or flank
21935	620.52	Radical resection of tumor (e.g., malignant neoplasm), soft tissue of back or flank
22102	1,765.70	Partial excision of posterior vertebral component (e.g., spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; lumbar
22103	1,765.70	Partial excision of posterior vertebral component (e.g., spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; each additional segment (List separately in addition to code for primary procedure)
22305	74.48	Closed treatment of vertebral process fracture(s)
22310	157.13	Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing
22315	406.41	Closed treatment of vertebral fracture(s) and/or dislocation(s) requiring casting or bracing, with and including casting and/or bracing, with or without anesthesia, by manipulation or traction
22505	478.45	Manipulation of spine requiring anesthesia, any region
22520	1,130.28	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic
22521	1,130.28	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
22522	1,130.28	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)
22523	3,145.69	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); thoracic
22524	3,145.69	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); lumbar
22525	3,145.69	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)
22900	673.17	Excision, abdominal wall tumor, subfascial (e.g., desmoid)
23000	484.44	Removal of subdeltoid calcareous deposits, open
23020	1,019.46	Capsular contracture release (e.g., Sever type procedure)
23030	498.25	Incision and drainage, shoulder area; deep abscess or hematoma
23031	575.92	Incision and drainage, shoulder area; infected bursa
23035	619.40	Incision, bone cortex (e.g., osteomyelitis or bone abscess), shoulder area
23040	766.53	Arthrotomy, glenohumeral joint, including exploration, drainage, or removal of foreign body
23044	819.18	Arthrotomy, acromioclavicular, sternoclavicular joint, including exploration, drainage, or removal of foreign body
23065	91.54	Biopsy, soft tissue of shoulder area; superficial
23066	592.43	Biopsy, soft tissue of shoulder area; deep
23075	484.44	Excision, soft tissue tumor, shoulder area; subcutaneous
23076	592.43	Excision, soft tissue tumor, shoulder area; deep, subfascial, or intramuscular
23077	620.52	Radical resection of tumor (e.g., malignant neoplasm), soft tissue of shoulder area
23100	591.31	Arthrotomy, glenohumeral joint, including biopsy
23101	979.34	Arthrotomy, acromioclavicular joint or sternoclavicular joint, including biopsy and/or excision of torn cartilage
23105	819.18	Arthrotomy; glenohumeral joint, with synovectomy, with or without

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
		biopsy
23106	819.18	Arthrotomy; sternoclavicular joint, with synovectomy, with or without biopsy
23107	819.18	Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body
23120	857.36	Claviculectomy; partial
23125	857.36	Claviculectomy; total
23130	1,138.37	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release
23140	672.05	Excision or curettage of bone cyst or benign tumor of clavicle or scapula;
23145	857.36	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with autograft (includes obtaining graft)
23146	857.36	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with allograft
23150	819.18	Excision or curettage of bone cyst or benign tumor of proximal humerus;
23155	857.36	Excision or curettage of bone cyst or benign tumor of proximal humerus; with autograft (includes obtaining graft)
23156	857.36	Excision or curettage of bone cyst or benign tumor of proximal humerus; with allograft
23170	738.44	Sequestrectomy (e.g., for osteomyelitis or bone abscess), clavicle
23172	738.44	Sequestrectomy (e.g., for osteomyelitis or bone abscess), scapula
23174	738.44	Sequestrectomy (e.g., for osteomyelitis or bone abscess), humeral head to surgical neck
23180	819.18	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis), clavicle
23182	819.18	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis), scapula
23184	819.18	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis), proximal humerus
23190	819.18	Ostectomy of scapula, partial (e.g., superior medial angle)
23195	857.36	Resection, humeral head
23330	296.08	Removal of foreign body, shoulder; subcutaneous
23331	542.85	Removal of foreign body, shoulder; deep (e.g., Neer hemiarthroplasty removal)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
23395	1,138.37	Muscle transfer, any type, shoulder or upper arm; single
23397	2,009.45	Muscle transfer, any type, shoulder or upper arm; multiple
23400	979.34	Scapulopexy (e.g., Sprengels deformity or for paralysis)
23405	738.44	Tenotomy, shoulder area; single tendon
23406	738.44	Tenotomy, shoulder area; multiple tendons through same incision
23410	1,138.37	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; acute
23412	1,260.35	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic
23415	1,138.37	Coracoacromial ligament release, with or without acromioplasty
23420	1,260.35	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)
23430	1,100.20	Tenodesis of long tendon of biceps
23440	1,100.20	Resection or transplantation of long tendon of biceps
23450	1,887.46	Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation
23455	2,009.45	Capsulorrhaphy, anterior; with labral repair (e.g., Bankart procedure)
23460	1,887.46	Capsulorrhaphy, anterior, any type; with bone block
23462	1,260.35	Capsulorrhaphy, anterior, any type; with coracoid process transfer
23465	1,887.46	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block
23466	1,260.35	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability
23480	1,100.20	Osteotomy, clavicle, with or without internal fixation;
23485	2,009.45	Osteotomy, clavicle, with or without internal fixation; with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation)
23490	1,047.54	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; clavicle
23491	1,796.63	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; proximal humerus
23500	74.48	Closed treatment of clavicular fracture; without manipulation
23505	406.41	Closed treatment of clavicular fracture; with manipulation
23515	1,360.23	Open treatment of clavicular fracture, with or without internal or external fixation
23520	157.13	Closed treatment of sternoclavicular dislocation; without manipulation
23525	157.13	Closed treatment of sternoclavicular dislocation; with manipulation

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
23530	1,002.36	Open treatment of sternoclavicular dislocation, acute or chronic;
23532	738.59	Open treatment of sternoclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)
23540	74.48	Closed treatment of acromioclavicular dislocation; without manipulation
23545	157.13	Closed treatment of acromioclavicular dislocation; with manipulation
23550	1,002.36	Open treatment of acromioclavicular dislocation, acute or chronic;
23552	1,055.02	Open treatment of acromioclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)
23570	74.48	Closed treatment of scapular fracture; without manipulation
23575	157.13	Closed treatment of scapular fracture; with manipulation, with or without skeletal traction (with or without shoulder joint involvement)
23585	1,360.23	Open treatment of scapular fracture (body, glenoid or acromion) with or without internal fixation
23600	58.04	Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation
23605	406.41	Closed treatment of proximal humeral (surgical or anatomical neck) fracture; with manipulation, with or without skeletal traction
23615	1,412.88	Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(s);
23616	1,412.88	Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(s); with proximal humeral prosthetic replacement
23620	58.04	Closed treatment of greater humeral tuberosity fracture; without manipulation
23625	406.41	Closed treatment of greater humeral tuberosity fracture; with manipulation
23630	1,451.06	Open treatment of greater humeral tuberosity fracture, with or without internal or external fixation
23650	74.48	Closed treatment of shoulder dislocation, with manipulation; without anesthesia
23655	428.87	Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia
23660	1,002.36	Open treatment of acute shoulder dislocation

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
23665	157.13	Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation
23670	1,360.23	Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with or without internal or external fixation
23675	74.48	Closed treatment of shoulder dislocation, with surgical or anatomical neck fracture, with manipulation
23680	1,002.36	Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, with or without internal or external fixation
23700	428.87	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)
23800	1,849.28	Arthrodesis, glenohumeral joint;
23802	1,260.35	Arthrodesis, glenohumeral joint; with autogenous graft (includes obtaining graft)
23921	432.01	Disarticulation of shoulder; secondary closure or scar revision
23930	498.25	Incision and drainage, upper arm or elbow area; deep abscess or hematoma
23931	547.84	Incision and drainage, upper arm or elbow area; bursa
23935	591.31	Incision, deep, with opening of bone cortex (e.g., for osteomyelitis or bone abscess), humerus or elbow
24000	819.18	Arthrotomy, elbow, including exploration, drainage, or removal of foreign body
24006	819.18	Arthrotomy of the elbow, with capsular excision for capsular release (separate procedure)
24065	126.92	Biopsy, soft tissue of upper arm or elbow area; superficial
24066	484.44	Biopsy, soft tissue of upper arm or elbow area; deep (subfascial or intramuscular)
24075	484.44	Excision, tumor, soft tissue of upper arm or elbow area; subcutaneous
24076	592.43	Excision, tumor, soft tissue of upper arm or elbow area; deep (subfascial or intramuscular)
24077	620.52	Radical resection of tumor (e.g., malignant neoplasm), soft tissue of upper arm or elbow area
24100	541.73	Arthrotomy, elbow; with synovial biopsy only
24101	819.18	Arthrotomy, elbow; with joint exploration, with or without biopsy, with or without removal of loose or foreign body
24102	819.18	Arthrotomy, elbow; with synovectomy

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
24105	619.40	Excision, olecranon bursa
24110	591.31	Excision or curettage of bone cyst or benign tumor, humerus;
24115	766.53	Excision or curettage of bone cyst or benign tumor, humerus; with autograft (includes obtaining graft)
24116	766.53	Excision or curettage of bone cyst or benign tumor, humerus; with allograft
24120	619.40	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process;
24125	766.53	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with autograft (includes obtaining graft)
24126	766.53	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with allograft
24130	766.53	Excision, radial head
24134	738.44	Sequestrectomy (e.g., for osteomyelitis or bone abscess), shaft or distal humerus
24136	738.44	Sequestrectomy (e.g., for osteomyelitis or bone abscess), radial head or neck
24138	738.44	Sequestrectomy (e.g., for osteomyelitis or bone abscess), olecranon process
24140	766.53	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis), humerus
24145	766.53	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis), radial head or neck
24147	738.44	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis), olecranon process
24149	1,085.48	Radical resection of capsule, soft tissue, and heterotopic bone, elbow, with contracture release (separate procedure)
24152	1,647.51	Radical resection for tumor, radial head or neck;
24153	3,145.69	Radical resection for tumor, radial head or neck; with autograft (includes obtaining graft)
24155	1,047.54	Resection of elbow joint (arthrectomy)
24160	738.44	Implant removal; elbow joint
24164	766.53	Implant removal; radial head
24200	92.84	Removal of foreign body, upper arm or elbow area; subcutaneous
24201	484.44	Removal of foreign body, upper arm or elbow area; deep (subfascial or

Code	Fee	Description
		intramuscular)
24300	565.50	Manipulation, elbow, under anesthesia
24301	819.18	Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331)
24305	819.18	Tendon lengthening, upper arm or elbow, each tendon
24310	619.40	Tenotomy, open, elbow to shoulder, each tendon
24320	1,047.54	Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure)
24330	1,796.63	Flexor-plasty, elbow (e.g., Steindler type advancement);
24331	1,047.54	Flexor-plasty, elbow (e.g., Steindler type advancement); with extensor advancement
24332	791.22	Tenolysis, triceps
24340	1,047.54	Tenodesis of biceps tendon at elbow (separate procedure)
24341	1,047.54	Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)
24342	1,047.54	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
24343	1,085.48	Repair lateral collateral ligament, elbow, with local tissue
24344	3,145.69	Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)
24345	738.44	Repair medial collateral ligament, elbow, with local tissue
24346	1,647.51	Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)
24357	1,085.48	Tenotomy, elbow, lateral or medial (e.g., epicondylitis, tennis elbow, golfer's elbow); percutaneous
24358	1,085.48	Tenotomy, elbow, lateral or medial (e.g., epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open
24359	1,085.48	Tenotomy, elbow, lateral or medial (e.g., epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment
24360	1,001.75	Arthroplasty, elbow; with membrane (e.g., fascial)
24361	5,477.06	Arthroplasty, elbow; with distal humeral prosthetic replacement
24362	1,280.22	Arthroplasty, elbow; with implant and fascia lata ligament reconstruction

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
24363	5,599.04	Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (e.g., total elbow)
24365	1,001.75	Arthroplasty, radial head;
24366	5,477.06	Arthroplasty, radial head; with implant
24400	819.18	Osteotomy, humerus, with or without internal fixation
24410	819.18	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)
24420	1,047.54	Osteoplasty, humerus (e.g., shortening or lengthening) (excluding 64876)
24430	1,796.63	Repair of nonunion or malunion, humerus; without graft (e.g., compression technique)
24435	1,849.28	Repair of nonunion or malunion, humerus; with iliac or other autograft (includes obtaining graft)
24470	1,047.54	Hemiepiphyseal arrest (e.g., cubitus varus or valgus, distal humerus)
24495	738.44	Decompression fasciotomy, forearm, with brachial artery exploration
24498	1,796.63	Prophylactic treatment (nailing, pinning, plating or wiring), with or without methylmethacrylate, humeral shaft
24500	74.48	Closed treatment of humeral shaft fracture; without manipulation
24505	74.48	Closed treatment of humeral shaft fracture; with manipulation, with or without skeletal traction
24515	1,412.88	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage
24516	1,412.88	Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws
24530	74.48	Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; without manipulation
24535	157.13	Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; with manipulation, with or without skin or skeletal traction
24538	657.85	Percutaneous skeletal fixation of supracondylar or transcondylar humeral fracture, with or without intercondylar extension
24545	1,412.88	Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation; without intercondylar extension
24546	1,451.06	Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation; with intercondylar

Code	Fee	Description
		extension
24560	74.48	Closed treatment of humeral epicondylar fracture, medial or lateral; without manipulation
24565	74.48	Closed treatment of humeral epicondylar fracture, medial or lateral; with manipulation
24566	657.85	Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation
24575	1,360.23	Open treatment of humeral epicondylar fracture, medial or lateral, with or without internal or external fixation
24576	74.48	Closed treatment of humeral condylar fracture, medial or lateral; without manipulation
24577	157.13	Closed treatment of humeral condylar fracture, medial or lateral; with manipulation
24579	1,360.23	Open treatment of humeral condylar fracture, medial or lateral, with or without internal or external fixation
24582	657.85	Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral, with manipulation
24586	1,412.88	Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius);
24587	1,451.06	Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius); with implant arthroplasty
24600	74.48	Treatment of closed elbow dislocation; without anesthesia
24605	478.45	Treatment of closed elbow dislocation; requiring anesthesia
24615	1,360.23	Open treatment of acute or chronic elbow dislocation
24620	406.41	Closed treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with manipulation
24635	1,360.23	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with or without internal or external fixation
24640	50.31	Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation
24650	58.04	Closed treatment of radial head or neck fracture; without manipulation
24655	157.13	Closed treatment of radial head or neck fracture; with manipulation

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
24665	1,055.02	Open treatment of radial head or neck fracture, with or without internal fixation or radial head excision;
24666	1,412.88	Open treatment of radial head or neck fracture, with or without internal fixation or radial head excision; with radial head prosthetic replacement
24670	74.48	Closed treatment of ulnar fracture, proximal end (olecranon process); without manipulation
24675	74.48	Closed treatment of ulnar fracture, proximal end (olecranon process); with manipulation
24685	1,002.36	Open treatment of ulnar fracture proximal end (olecranon process), with or without internal or external fixation
24800	1,100.20	Arthrodesis, elbow joint; local
24802	1,138.37	Arthrodesis, elbow joint; with autogenous graft (includes obtaining graft)
24925	619.40	Amputation, arm through humerus; secondary closure or scar revision
25000	619.40	Amputation, arm through humerus; secondary closure or scar revision
25001	791.22	Incision, flexor tendon sheath, wrist (e.g., flexor carpi radialis)
25020	619.40	Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; without debridement of nonviable muscle and/or nerve
25023	766.53	Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; with debridement of nonviable muscle and/or nerve
25024	766.53	Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; without debridement of nonviable muscle and/or nerve
25025	766.53	Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve
25028	541.73	Incision and drainage, forearm and/or wrist; deep abscess or hematoma
25031	591.31	Incision and drainage, forearm and/or wrist; bursa
25035	591.31	Incision, deep, bone cortex, forearm and/or wrist (e.g., osteomyelitis or bone abscess)
25040	857.36	Arthrotomy, radiocarpal or midcarpal joint, with exploration, drainage, or removal of foreign body
25065	128.86	Biopsy, soft tissue of forearm and/or wrist; superficial
25066	592.43	Biopsy, soft tissue of forearm and/or wrist; deep (subfascial or intramuscular)
25075	484.44	Excision, tumor, soft tissue of forearm and/or wrist area; subcutaneous

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
25076	620.52	Excision, tumor, soft tissue of forearm and/or wrist area; deep (subfascial or intramuscular)
25077	620.52	Radical resection of tumor (e.g., malignant neoplasm), soft tissue of forearm and/or wrist area
25085	619.40	Capsulotomy, wrist (e.g., contracture)
25100	591.31	Arthrotomy, wrist joint; with biopsy
25101	766.53	Arthrotomy, wrist joint; with joint exploration, with or without biopsy, with or without removal of loose or foreign body
25105	819.18	Arthrotomy, wrist joint; with synovectomy
25107	766.53	Arthrotomy, distal radioulnar joint including repair of triangular cartilage, complex
25109	791.22	Excision of tendon, forearm and/or wrist, flexor or extensor, each
25110	619.40	Excision, lesion of tendon sheath, forearm and/or wrist
25111	619.40	Excision of ganglion, wrist (dorsal or volar); primary
25112	672.05	Excision of ganglion, wrist (dorsal or volar); recurrent
25115	672.05	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (e.g., tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors
25116	672.05	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (e.g., tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum
25118	738.44	Synovectomy, extensor tendon sheath, wrist, single compartment;
25119	766.53	Synovectomy, extensor tendon sheath, wrist, single compartment; with resection of distal ulna
25120	766.53	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process);
25125	766.53	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with autograft (includes obtaining graft)
25126	766.53	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with allograft
25130	766.53	Excision or curettage of bone cyst or benign tumor of carpal bones;
25135	766.53	Excision or curettage of bone cyst or benign tumor of carpal bones; with autograft (includes obtaining graft)
25136	766.53	Excision or curettage of bone cyst or benign tumor of carpal bones; with

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
		allograft
25145	738.44	Sequestrectomy (e.g., for osteomyelitis or bone abscess), forearm and/or wrist
25150	738.44	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis); ulna
25151	738.44	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis); radius
25210	766.53	Carpectomy; one bone
25215	819.18	Carpectomy; all bones of proximal row
25230	819.18	Radial styloidectomy (separate procedure)
25240	819.18	Excision distal ulna partial or complete (e.g., Darrach type or matched resection)
25248	591.31	Exploration with removal of deep foreign body, forearm or wrist
25250	688.86	Removal of wrist prosthesis; (separate procedure)
25251	688.86	Removal of wrist prosthesis; complicated, including total wrist
25259	721.89	Manipulation, wrist, under anesthesia
25260	819.18	Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle
25263	738.44	Repair, tendon or muscle, flexor, forearm and/or wrist; secondary, single, each tendon or muscle
25265	766.53	Repair, tendon or muscle, flexor, forearm and/or wrist; secondary, with free graft (includes obtaining graft), each tendon or muscle
25270	819.18	Repair, tendon or muscle, extensor, forearm and/or wrist; primary, single, each tendon or muscle
25272	766.53	Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, single, each tendon or muscle
25274	819.18	Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, with free graft (includes obtaining graft), each tendon or muscle
25275	819.18	Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (e.g., for extensor carpi ulnaris subluxation)
25280	819.18	Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single, each tendon
25290	766.53	Tenotomy, open, flexor or extensor tendon, forearm and/or wrist, single, each tendon
25295	619.40	Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each

Code	Fee	Description
		tendon
25300	766.53	Tenodesis at wrist; flexors of fingers
25301	766.53	Tenodesis at wrist; extensors of fingers
25310	1,047.54	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon
25312	1,100.20	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; with tendon graft(s) (includes obtaining graft), each tendon
25315	1,047.54	Flexor origin slide (e.g., for cerebral palsy, Volkmann contracture), forearm and/or wrist;
25316	1,796.63	Flexor origin slide (e.g., for cerebral palsy, Volkmann contracture), forearm and/or wrist; with tendon(s) transfer
25320	1,047.54	Capsulorrhaphy or reconstruction, wrist, open (e.g., capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability
25332	1,001.75	Arthroplasty, wrist, with or without interposition, with or without external or internal fixation
25335	1,047.54	Centralization of wrist on ulna (e.g., radial club hand)
25337	1,138.37	Reconstruction for stabilization of unstable distal ulna or distal radioulnar joint, secondary by soft tissue stabilization (e.g., tendon transfer, tendon graft or weave, or tenodesis) with or without open reduction of distal radioulnar joint
25350	1,796.63	Osteotomy, radius; distal third
25355	1,047.54	Osteotomy, radius; middle or proximal third
25360	766.53	Osteotomy; ulna
25365	766.53	Osteotomy; radius AND ulna
25370	1,047.54	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna
25375	1,100.20	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius AND ulna
25390	766.53	Osteoplasty, radius OR ulna; shortening
25391	1,100.20	Osteoplasty, radius OR ulna; lengthening with autograft
25392	766.53	Osteoplasty, radius AND ulna; shortening (excluding 64876)
25393	1,100.20	Osteoplasty, radius AND ulna; lengthening with autograft
25394	1,647.51	Osteoplasty, carpal bone, shortening

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
25400	1,047.54	Repair of nonunion or malunion, radius OR ulna; without graft (e.g., compression technique)
25405	1,849.28	Repair of nonunion or malunion, radius OR ulna; with autograft (includes obtaining graft)
25415	1,796.63	Repair of nonunion or malunion, radius AND ulna; without graft (e.g., compression technique)
25420	1,849.28	Repair of nonunion or malunion, radius AND ulna; with autograft (includes obtaining graft)
25425	1,047.54	Repair of defect with autograft; radius OR ulna
25426	1,100.20	Repair of defect with autograft; radius AND ulna
25430	1,647.51	Insertion of vascular pedicle into carpal bone (e.g., Hori procedure)
25431	1,647.51	Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone
25440	1,849.28	Repair of nonunion, scaphoid carpal (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)
25441	5,477.06	Arthroplasty with prosthetic replacement; distal radius
25442	5,477.06	Arthroplasty with prosthetic replacement; distal ulna
25443	1,280.22	Arthroplasty with prosthetic replacement; scaphoid carpal (navicular)
25444	1,280.22	Arthroplasty with prosthetic replacement; lunate
25445	1,280.22	Arthroplasty with prosthetic replacement; trapezium
25446	5,599.04	Arthroplasty with prosthetic replacement; distal radius and partial or entire carpus (total wrist)
25447	1,001.75	Arthroplasty, interposition, intercarpal or carpometacarpal joints
25449	1,001.75	Revision of arthroplasty, including removal of implant, wrist joint
25450	1,047.54	Epiphyseal arrest by epiphysiodesis or stapling; distal radius OR ulna
25455	1,047.54	Epiphyseal arrest by epiphysiodesis or stapling; distal radius AND ulna
25490	1,047.54	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radius
25491	1,047.54	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; ulna
25492	1,047.54	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radius AND ulna
25500	58.04	Closed treatment of radial shaft fracture; without manipulation
25505	157.13	Closed treatment of radial shaft fracture; with manipulation

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
25515	1,002.36	Open treatment of radial shaft fracture, with or without internal or external fixation
25520	157.13	Closed treatment of radial shaft fracture and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation)
25525	1,055.02	Open treatment of radial shaft fracture, with internal and/or external fixation and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation), with or without percutaneous skeletal fixation
25526	1,093.19	Open treatment of radial shaft fracture, with internal and/or external fixation and open treatment, with or without internal or external fixation of distal radioulnar joint (Galeazzi fracture/dislocation), includes repair of triangular fibrocartilage complex
25530	58.04	Closed treatment of ulnar shaft fracture; without manipulation
25535	74.48	Closed treatment of ulnar shaft fracture; with manipulation
25545	1,002.36	Open treatment of ulnar shaft fracture, with or without internal or external fixation
25560	58.04	Closed treatment of radial and ulnar shaft fractures; without manipulation
25565	157.13	Closed treatment of radial and ulnar shaft fractures; with manipulation
25574	1,360.23	Open treatment of radial AND ulnar shaft fractures, with internal or external fixation; of radius OR ulna
25575	1,360.23	Open treatment of radial AND ulnar shaft fractures, with internal or external fixation; of radius AND ulna
25600	58.04	Closed treatment of distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; without manipulation
25605	157.13	Closed treatment of distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation
25606	685.94	Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation
25607	1,451.06	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation
25608	1,451.06	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments
25609	1,451.06	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
25622	58.04	Closed treatment of carpal scaphoid (navicular) fracture; without manipulation
25624	157.13	Closed treatment of carpal scaphoid (navicular) fracture; with manipulation
25628	1,002.36	Open treatment of carpal scaphoid (navicular) fracture, with or without internal or external fixation
25630	58.04	Closed treatment of carpal bone fracture (excluding carpal scaphoid (navicular)); without manipulation, each bone
25635	157.13	Closed treatment of carpal bone fracture (excluding carpal scaphoid (navicular)); with manipulation, each bone
25645	1,002.36	Open treatment of carpal bone fracture (other than carpal scaphoid (navicular)), each bone
25650	58.04	Closed treatment of ulnar styloid fracture
25651	924.29	Percutaneous skeletal fixation of ulnar styloid fracture
25652	1,557.14	Open treatment of ulnar styloid fracture
25660	74.48	Closed treatment of radiocarpal or intercarpal dislocation, one or more bones, with manipulation
25670	685.94	Open treatment of radiocarpal or intercarpal dislocation, one or more bones
25671	608.27	Percutaneous skeletal fixation of distal radioulnar dislocation
25675	74.48	Closed treatment of distal radioulnar dislocation with manipulation
25676	657.85	Open treatment of distal radioulnar dislocation, acute or chronic
25680	74.48	Closed treatment of trans-scaphoperilunar type of fracture dislocation, with manipulation
25685	685.94	Open treatment of trans-scaphoperilunar type of fracture dislocation
25690	406.41	Closed treatment of lunate dislocation, with manipulation
25695	657.85	Open treatment of lunate dislocation
25800	1,849.28	Arthrodesis, wrist; complete, without bone graft (includes radiocarpal and/or intercarpal and/or carpometacarpal joints)
25805	1,138.37	Arthrodesis, wrist; with sliding graft
25810	1,887.46	Arthrodesis, wrist; with iliac or other autograft (includes obtaining graft)
25820	1,100.20	Arthrodesis, wrist; limited, without bone graft (e.g., intercarpal or radiocarpal)
25825	1,887.46	Arthrodesis, wrist; with autograft (includes obtaining graft)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
25830	1,887.46	Arthrodesis, distal radioulnar joint with segmental resection of ulna, with or without bone graft (e.g., Sauve-Kapandji procedure)
25907	619.40	Amputation, forearm, through radius and ulna; secondary closure or scar revision
25922	619.40	Disarticulation through wrist; secondary closure or scar revision
25929	513.94	Transmetacarpal amputation; secondary closure or scar revision
25931	791.22	Transmetacarpal amputation; re-amputation
26010	51.32	Drainage of finger abscess; simple
26011	374.89	Drainage of finger abscess; complicated (e.g., felon)
26020	497.43	Drainage of tendon sheath, digit and/or palm, each
26025	447.84	Drainage of palmar bursa; single, bursa
26030	497.43	Drainage of palmar bursa; multiple bursa
26034	497.43	Incision, bone cortex, hand or finger (e.g., osteomyelitis or bone abscess)
26035	603.45	Decompression fingers and/or hand, injection injury (e.g., grease gun)
26040	785.00	Fasciotomy, palmar (e.g., Dupuytrens contracture); percutaneous
26045	732.34	Fasciotomy, palmar (e.g., Dupuytrens contracture); open, partial
26055	497.43	Tendon sheath incision (e.g., for trigger finger)
26060	497.43	Tenotomy, percutaneous, single, each digit
26070	497.43	Arthrotomy, with exploration, drainage, or removal of loose or foreign body; carpometacarpal joint
26075	578.17	Arthrotomy, with exploration, drainage, or removal of loose or foreign body; metacarpophalangeal joint, each
26080	578.17	Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each
26100	497.43	Arthrotomy with biopsy; carpometacarpal joint, each
26105	447.84	Arthrotomy with biopsy; metacarpophalangeal joint, each
26110	447.84	Arthrotomy with biopsy; interphalangeal joint, each
26115	592.43	Excision, tumor or vascular malformation, soft tissue of hand or finger; subcutaneous
26116	592.43	Excision, tumor or vascular malformation, soft tissue of hand or finger; deep (subfascial or intramuscular)
26117	620.52	Radical resection of tumor (e.g., malignant neoplasm), soft tissue of hand or finger

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
26121	785.00	Fasciectomy, palm only, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft)
26123	785.00	Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft);
26125	578.17	Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft); each additional digit (List separately in addition to code for primary procedure)
26130	525.51	Synovectomy, carpometacarpal joint
26135	785.00	Synovectomy, metacarpophalangeal joint including intrinsic release and extensor hood reconstruction, each digit
26140	497.43	Synovectomy, proximal interphalangeal joint, including extensor reconstruction, each interphalangeal joint
26145	525.51	Synovectomy, tendon sheath, radical (tenosynovectomy), flexor tendon, palm and/or finger, each tendon
26160	525.51	Excision of lesion of tendon sheath or joint capsule (e.g., cyst, mucous cyst, or ganglion), hand or finger
26170	525.51	Excision of tendon, palm, flexor or extensor, single, each tendon
26180	525.51	Excision of tendon, finger, flexor or extensor, each tendon
26185	578.17	Sesamoidectomy, thumb or finger (separate procedure)
26200	497.43	Excision or curettage of bone cyst or benign tumor of metacarpal;
26205	732.34	Excision or curettage of bone cyst or benign tumor of metacarpal; with autograft (includes obtaining graft)
26210	497.43	Excision or curettage of bone cyst or benign tumor of proximal, middle, or distal phalanx of finger;
26215	525.51	Excision or curettage of bone cyst or benign tumor of proximal, middle, or distal phalanx of finger; with autograft (includes obtaining graft)
26230	737.42	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis); metacarpal
26235	525.51	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis); proximal or middle phalanx of finger
26236	525.51	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis); distal phalanx of finger

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
26250	525.51	Radical resection, metacarpal (e.g., tumor);
26255	732.34	Radical resection, metacarpal (e.g., tumor); with autograft (includes obtaining graft)
26260	525.51	Radical resection, proximal or middle phalanx of finger (e.g., tumor);
26261	525.51	Radical resection, proximal or middle phalanx of finger (e.g., tumor); with autograft (includes obtaining graft)
26262	497.43	Radical resection, distal phalanx of finger (e.g., tumor)
26320	484.44	Removal of implant from finger or hand
26340	223.33	Manipulation, finger joint, under anesthesia, each joint
26350	654.67	Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (e.g., no mans land); primary or secondary without free graft, each tendon
26352	785.00	Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (e.g., no mans land); secondary with free graft (includes obtaining graft), each tendon
26356	785.00	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (e.g., no mans land); primary, without free graft, each tendon
26357	785.00	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (e.g., no mans land); secondary, without free graft, each tendon
26358	785.00	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (e.g., no mans land); secondary, with free graft (includes obtaining graft), each tendon
26370	785.00	Repair or advancement of profundus tendon, with intact superficialis tendon; primary, each tendon
26372	785.00	Repair or advancement of profundus tendon, with intact superficialis tendon; secondary with free graft (includes obtaining graft), each tendon
26373	732.34	Repair or advancement of profundus tendon, with intact superficialis tendon; secondary without free graft, each tendon
26390	785.00	Excision flexor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod
26392	732.34	Removal of synthetic rod and insertion of flexor tendon graft, hand or finger (includes obtaining graft), each rod
26410	525.51	Repair, extensor tendon, hand, primary or secondary; without free graft, each tendon
26412	732.34	Repair, extensor tendon, hand, primary or secondary; with free graft (includes obtaining graft), each tendon

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
26415	785.00	Excision of extensor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod
26416	732.34	Removal of synthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each rod
26418	578.17	Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon
26420	785.00	Repair, extensor tendon, finger, primary or secondary; with free graft (includes obtaining graft) each tendon
26426	732.34	Repair of extensor tendon, central slip, secondary (e.g., boutonniere deformity); using local tissue(s), including lateral band(s), each finger
26428	732.34	Repair of extensor tendon, central slip, secondary (e.g., boutonniere deformity); with free graft (includes obtaining graft), each finger
26432	525.51	Closed treatment of distal extensor tendon insertion, with or without percutaneous pinning (e.g., mallet finger)
26433	525.51	Repair of extensor tendon, distal insertion, primary or secondary; without graft (e.g., mallet finger)
26434	732.34	Repair of extensor tendon, distal insertion, primary or secondary; with free graft (includes obtaining graft)
26437	525.51	Realignment of extensor tendon, hand, each tendon
26440	525.51	Tenolysis, flexor tendon; palm OR finger, each tendon
26442	732.34	Tenolysis, flexor tendon; palm AND finger, each tendon
26445	525.51	Tenolysis, extensor tendon, hand OR finger, each tendon
26449	732.34	Tenolysis, complex, extensor tendon, finger, including forearm, each tendon
26450	525.51	Tenotomy, flexor, palm, open, each tendon
26455	525.51	Tenotomy, flexor, finger, open, each tendon
26460	525.51	Tenotomy, extensor, hand or finger, open, each tendon
26471	497.43	Tenodesis; of proximal interphalangeal joint, each joint
26474	497.43	Tenodesis; of distal joint, each joint
26476	447.84	Lengthening of tendon, extensor, hand or finger, each tendon
26477	447.84	Shortening of tendon, extensor, hand or finger, each tendon
26478	447.84	Lengthening of tendon, flexor, hand or finger, each tendon
26479	447.84	Shortening of tendon, flexor, hand or finger, each tendon

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
26480	732.34	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon
26483	732.34	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; with free tendon graft (includes obtaining graft), each tendon
26485	704.26	Transfer or transplant of tendon, palmar; without free tendon graft, each tendon
26489	732.34	Transfer or transplant of tendon, palmar; with free tendon graft (includes obtaining graft), each tendon
26490	732.34	Opponensplasty; superficialis tendon transfer type, each tendon
26492	732.34	Opponensplasty; tendon transfer with graft (includes obtaining graft), each tendon
26494	732.34	Opponensplasty; hypothenar muscle transfer
26496	732.34	Opponensplasty; other methods
26497	732.34	Transfer of tendon to restore intrinsic function; ring and small finger
26498	785.00	Transfer of tendon to restore intrinsic function; all four fingers
26499	732.34	Correction claw finger, other methods
26500	578.17	Reconstruction of tendon pulley, each tendon; with local tissues (separate procedure)
26502	785.00	Reconstruction of tendon pulley, each tendon; with tendon or fascial graft (includes obtaining graft) (separate procedure)
26508	525.51	Release of thenar muscle(s) (e.g., thumb contracture)
26510	732.34	Cross intrinsic transfer, each tendon
26516	654.67	Capsulodesis, metacarpophalangeal joint; single digit
26517	732.34	Capsulodesis, metacarpophalangeal joint; two digits
26518	732.34	Capsulodesis, metacarpophalangeal joint; three or four digits
26520	525.51	Capsulectomy or capsulotomy; metacarpophalangeal joint, each joint
26525	525.51	Capsulectomy or capsulotomy; interphalangeal joint, each joint
26530	910.92	Arthroplasty, metacarpophalangeal joint; each joint
26531	1,402.21	Arthroplasty, metacarpophalangeal joint; with prosthetic implant, each joint
26535	1,001.75	Arthroplasty, interphalangeal joint; each joint
26536	1,280.22	Arthroplasty, interphalangeal joint; with prosthetic implant, each joint
26540	578.17	Repair of collateral ligament, metacarpophalangeal or interphalangeal joint

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
26541	945.15	Reconstruction, collateral ligament, metacarpophalangeal joint, single; with tendon or fascial graft (includes obtaining graft)
26542	578.17	Reconstruction, collateral ligament, metacarpophalangeal joint, single; with local tissue (e.g., adductor advancement)
26545	785.00	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint
26546	785.00	Repair non-union, metacarpal or phalanx, (includes obtaining bone graft with or without external or internal fixation)
26548	785.00	Repair and reconstruction, finger, volar plate, interphalangeal joint
26550	704.26	Pollicization of a digit
26555	732.34	Transfer, finger to another position without microvascular anastomosis
26560	497.43	Repair of syndactyly (web finger) each web space; with skin flaps
26561	732.34	Repair of syndactyly (web finger) each web space; with skin flaps and grafts
26562	785.00	Repair of syndactyly (web finger) each web space; complex (e.g., involving bone, nails)
26565	823.17	Osteotomy; metacarpal, each
26567	823.17	Osteotomy; phalanx of finger, each
26568	732.34	Osteoplasty, lengthening, metacarpal or phalanx
26580	616.34	Repair cleft hand
26587	616.34	Reconstruction of polydactylous digit, soft tissue and bone
26590	616.34	Repair macrodactylia, each digit
26591	732.34	Repair, intrinsic muscles of hand, each muscle
26593	525.51	Release, intrinsic muscles of hand, each muscle
26596	497.43	Excision of constricting ring of finger, with multiple Z-plasties
26600	58.04	Closed treatment of metacarpal fracture, single; without manipulation, each bone
26605	74.48	Closed treatment of metacarpal fracture, single; with manipulation, each bone
26607	406.41	Closed treatment of metacarpal fracture, with manipulation, with external fixation, each bone
26608	738.59	Percutaneous skeletal fixation of metacarpal fracture, each bone
26615	1,055.02	Open treatment of metacarpal fracture, single, with or without internal or external fixation, each bone
26641	58.04	Closed treatment of carpometacarpal dislocation, thumb, with

Code	Fee	Description
		manipulation
26645	157.13	Closed treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation
26650	657.85	Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation, with or without external fixation
26665	1,055.02	Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external fixation
26670	58.04	Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; without anesthesia
26675	157.13	Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; requiring anesthesia
26676	657.85	Percutaneous skeletal fixation of carpometacarpal dislocation, other than thumb, with manipulation, each joint
26685	685.94	Open treatment of carpometacarpal dislocation, other than thumb; with or without internal or external fixation, each joint
26686	1,360.23	Open treatment of carpometacarpal dislocation, other than thumb; complex, multiple or delayed reduction
26700	58.04	Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia
26705	74.48	Closed treatment of metacarpophalangeal dislocation, single, with manipulation; requiring anesthesia
26706	406.41	Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation
26715	738.59	Open treatment of metacarpophalangeal dislocation, single, with or without internal or external fixation
26720	58.04	Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each
26725	58.04	Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; with manipulation, with or without skin or skeletal traction, each
26727	898.75	Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each
26735	738.59	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external fixation,

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
		each
26740	58.04	Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; without manipulation, each
26742	74.48	Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; with manipulation, each
26746	776.76	Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, with or without internal or external fixation, each
26750	58.04	Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each
26755	58.04	Closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, each
26756	657.85	Percutaneous skeletal fixation of distal phalangeal fracture, finger or thumb, each
26765	738.59	Open treatment of distal phalangeal fracture, finger or thumb, with or without internal or external fixation, each
26770	58.04	Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia
26775	155.16	Closed treatment of interphalangeal joint dislocation, single, with manipulation; requiring anesthesia
26776	657.85	Percutaneous skeletal fixation of interphalangeal joint dislocation, single, with manipulation
26785	657.85	Open treatment of interphalangeal joint dislocation, with or without internal or external fixation, single
26820	823.17	Fusion in opposition, thumb, with autogenous graft (includes obtaining graft)
26841	785.00	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation;
26842	785.00	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation; with autograft (includes obtaining graft)
26843	732.34	Arthrodesis, carpometacarpal joint, digit, other than thumb, each;
26844	732.34	Arthrodesis, carpometacarpal joint, digit, other than thumb, each; with autograft (includes obtaining graft)
26850	785.00	Arthrodesis, metacarpophalangeal joint, with or without internal fixation;

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
26852	785.00	Arthrodesis, metacarpophalangeal joint, with or without internal fixation; with autograft (includes obtaining graft)
26860	732.34	Arthrodesis, interphalangeal joint, with or without internal fixation;
26861	704.26	Arthrodesis, interphalangeal joint, with or without internal fixation; each additional interphalangeal joint (List separately in addition to code for primary procedure)
26862	785.00	Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft)
26863	732.34	Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft), each additional joint (List separately in addition to code for primary procedure)
26910	732.34	Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseous transfer
26951	497.43	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure
26952	578.17	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with local advancement flaps (V-Y, hood)
26990	541.73	Incision and drainage, pelvis or hip joint area; deep abscess or hematoma
26991	541.73	Incision and drainage, pelvis or hip joint area; infected bursa
27000	591.31	Tenotomy, adductor of hip, percutaneous (separate procedure)
27001	766.53	Tenotomy, adductor of hip, open
27003	766.53	Tenotomy, adductor, subcutaneous, open, with obturator neurectomy
27033	1,047.54	Arthrotomy, hip, including exploration or removal of loose or foreign body
27035	1,100.20	Denervation, hip joint, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral, or obturator nerves
27040	296.08	Biopsy, soft tissue of pelvis and hip area; superficial
27041	333.59	Biopsy, soft tissue of pelvis and hip area; deep, subfascial or intramuscular
27047	592.43	Excision, tumor, pelvis and hip area; subcutaneous tissue
27048	620.52	Excision, tumor, pelvis and hip area; deep, subfascial, intramuscular
27049	620.52	Radical resection of tumor, soft tissue of pelvis and hip area (e.g., malignant neoplasm)
27050	619.40	Arthrotomy, with biopsy; sacroiliac joint

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
27052	619.40	Arthrotomy, with biopsy; hip joint
27060	710.23	Excision; ischial bursa
27062	710.23	Excision; trochanteric bursa or calcification
27065	710.23	Excision of bone cyst or benign tumor; superficial (wing of ilium, symphysis pubis, or greater trochanter of femur) with or without autograft
27066	857.36	Excision of bone cyst or benign tumor; deep, with or without autograft
27067	857.36	Excision of bone cyst or benign tumor; with autograft requiring separate incision
27080	738.44	Coccygectomy, primary
27086	296.08	Removal of foreign body, pelvis or hip; subcutaneous tissue
27087	619.40	Removal of foreign body, pelvis or hip; deep (subfascial or intramuscular)
27097	766.53	Release or recession, hamstring, proximal
27098	766.53	Transfer, adductor to ischium
27100	1,100.20	Transfer external oblique muscle to greater trochanter including fascial or tendon extension (graft)
27105	1,100.20	Transfer paraspinal muscle to hip (includes fascial or tendon extension graft)
27110	1,100.20	Transfer iliopsoas; to greater trochanter of femur
27111	1,100.20	Transfer iliopsoas; to femoral neck
27193	74.48	Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulation
27194	478.45	Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation, requiring more than local anesthesia
27200	58.04	Closed treatment of coccygeal fracture
27202	974.28	Open treatment of coccygeal fracture
27220	58.04	Closed treatment of acetabulum (hip socket) fracture(s); without manipulation
27230	74.48	Closed treatment of femoral fracture, proximal end, neck; without manipulation
27238	157.13	Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; without manipulation
27246	157.13	Closed treatment of greater trochanteric fracture, without manipulation
27250	74.48	Closed treatment of hip dislocation, traumatic; without anesthesia
27252	478.45	Closed treatment of hip dislocation, traumatic; requiring anesthesia

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
27256	58.04	Treatment of spontaneous hip dislocation (developmental, including congenital or pathological), by abduction, splint or traction; without anesthesia, without manipulation
27257	506.54	Treatment of spontaneous hip dislocation (developmental, including congenital or pathological), by abduction, splint or traction; with manipulation, requiring anesthesia
27265	74.48	Closed treatment of post hip arthroplasty dislocation; without anesthesia
27266	478.45	Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia
27267	58.04	Closed treatment of femoral fracture, proximal end, head; without manipulation
27275	478.45	Manipulation, hip joint, requiring general anesthesia
27301	575.92	Incision and drainage, deep abscess, bursa, or hematoma, thigh or knee region
27305	591.31	Fasciotomy, iliotibial (tenotomy), open
27306	619.40	Tenotomy, percutaneous, adductor or hamstring; single tendon (separate procedure)
27307	619.40	Tenotomy, percutaneous, adductor or hamstring; multiple tendons
27310	819.18	Arthrotomy, knee, with exploration, drainage, or removal of foreign body (e.g., infection)
27323	296.08	Biopsy, soft tissue of thigh or knee area; superficial
27324	542.85	Biopsy, soft tissue of thigh or knee area; deep (subfascial or intramuscular)
27325	531.92	Neurectomy, hamstring muscle
27326	531.92	Neurectomy, popliteal (gastrocnemius)
27327	592.43	Excision, tumor, thigh or knee area; subcutaneous
27328	620.52	Excision, tumor, thigh or knee area; deep, subfascial, or intramuscular
27329	673.17	Radical resection of tumor (e.g., malignant neoplasm), soft tissue of thigh or knee area
27330	819.18	Arthrotomy, knee; with synovial biopsy only
27331	819.18	Arthrotomy, knee; including joint exploration, biopsy, or removal of loose or foreign bodies
27332	819.18	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral
27333	819.18	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral
27334	819.18	Arthrotomy, with synovectomy, knee; anterior OR posterior

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
27335	819.18	Arthrotomy, with synovectomy, knee; anterior AND posterior including popliteal area
27340	619.40	Excision, prepatellar bursa
27345	672.05	Excision of synovial cyst of popliteal space (e.g., Bakers cyst)
27347	672.05	Excision of lesion of meniscus or capsule (e.g., cyst, ganglion), knee
27350	819.18	Patellectomy or hemipatellectomy
27355	766.53	Excision or curettage of bone cyst or benign tumor of femur;
27356	819.18	Excision or curettage of bone cyst or benign tumor of femur; with allograft
27357	857.36	Excision or curettage of bone cyst or benign tumor of femur; with autograft (includes obtaining graft)
27358	857.36	Excision or curettage of bone cyst or benign tumor of femur; with internal fixation (List in addition to code for primary procedure)
27360	857.36	Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (e.g., osteomyelitis or bone abscess)
27372	833.34	Removal of foreign body, deep, thigh region or knee area
27380	541.73	Suture of infrapatellar tendon; primary
27381	619.40	Suture of infrapatellar tendon; secondary reconstruction, including fascial or tendon graft
27385	619.40	Suture of quadriceps or hamstring muscle rupture; primary
27386	619.40	Suture of quadriceps or hamstring muscle rupture; secondary reconstruction, including fascial or tendon graft
27390	541.73	Tenotomy, open, hamstring, knee to hip; single tendon
27391	591.31	Tenotomy, open, hamstring, knee to hip; multiple tendons, one leg
27392	619.40	Tenotomy, open, hamstring, knee to hip; multiple tendons, bilateral
27393	738.44	Lengthening of hamstring tendon; single tendon
27394	766.53	Lengthening of hamstring tendon; multiple tendons, one leg
27395	1,047.54	Lengthening of hamstring tendon; multiple tendons, bilateral
27396	766.53	Transplant, hamstring tendon to patella; single tendon
27397	1,047.54	Transplant, hamstring tendon to patella; multiple tendons
27400	1,047.54	Transfer, tendon or muscle, hamstrings to femur (e.g., Eggers type procedure)
27403	819.18	Arthrotomy with meniscus repair, knee
27405	1,100.20	Repair, primary, torn ligament and/or capsule, knee; collateral
27407	1,849.28	Repair, primary, torn ligament and/or capsule, knee; cruciate

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
27409	1,100.20	Repair, primary, torn ligament and/or capsule, knee; collateral and cruciate ligaments
27416	1,647.51	Osteochondral autograft(s), knee, open (e.g., mosaicplasty) (includes harvesting of autograft[s])
27418	1,047.54	Anterior tibial tubercleplasty (e.g., Maquet type procedure)
27420	1,047.54	Reconstruction of dislocating patella; (e.g., Hauser type procedure)
27422	1,260.35	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (e.g., Campbell, Goldwaite type procedure)
27424	1,047.54	Reconstruction of dislocating patella; with patellectomy
27425	979.34	Lateral retinacular release, open
27427	1,047.54	Ligamentous reconstruction (augmentation), knee; extra-articular
27428	1,849.28	Ligamentous reconstruction (augmentation), knee; intra-articular (open)
27429	1,849.28	Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular
27430	1,100.20	Quadricepsplasty (e.g., Bennett or Thompson type)
27435	1,100.20	Capsulotomy, posterior capsular release, knee
27437	963.57	Arthroplasty, patella; without prosthesis
27438	1,280.22	Arthroplasty, patella; with prosthesis
27440	1,374.26	Arthroplasty, knee, tibial plateau;
27441	1,001.75	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy
27442	1,001.75	Arthroplasty, femoral condyles or tibial plateau(s), knee;
27443	1,001.75	Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy
27446	9,829.05	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
27496	710.23	Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor);
27497	619.40	Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor); with debridement of nonviable muscle and/or nerve
27498	619.40	Decompression fasciotomy, thigh and/or knee, multiple compartments;
27499	619.40	Decompression fasciotomy, thigh and/or knee, multiple compartments; with debridement of nonviable muscle and/or nerve
27500	157.13	Closed treatment of femoral shaft fracture, without manipulation

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
27501	74.48	Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, without manipulation
27502	406.41	Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction
27503	74.48	Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, with manipulation, with or without skin or skeletal traction
27508	74.48	Closed treatment of femoral fracture, distal end, medial or lateral condyle, without manipulation
27509	685.94	Percutaneous skeletal fixation of femoral fracture, distal end, medial or lateral condyle, or supracondylar or transcondylar, with or without intercondylar extension, or distal femoral epiphyseal separation
27510	157.13	Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation
27516	74.48	Closed treatment of distal femoral epiphyseal separation; without manipulation
27517	74.48	Closed treatment of distal femoral epiphyseal separation; with manipulation, with or without skin or skeletal traction
27520	74.48	Closed treatment of patellar fracture, without manipulation
27530	74.48	Closed treatment of tibial fracture, proximal (plateau); without manipulation
27532	406.41	Closed treatment of tibial fracture, proximal (plateau); with or without manipulation, with skeletal traction
27538	74.48	Closed treatment of intercondylar spine(s) and/or tuberosity fracture(s) of knee, with or without manipulation
27550	74.48	Closed treatment of knee dislocation; without anesthesia
27552	428.87	Closed treatment of knee dislocation; requiring anesthesia
27560	74.48	Closed treatment of patellar dislocation; without anesthesia
27562	428.87	Closed treatment of patellar dislocation; requiring anesthesia
27566	974.28	Open treatment of patellar dislocation, with or without partial or total patellectomy
27570	428.87	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)
27594	619.40	Amputation, thigh, through femur, any level; secondary closure or scar revision
27600	619.40	Decompression fasciotomy, leg; anterior and/or lateral compartments

Code	Fee	Description
		only
27601	619.40	Decompression fasciotomy, leg; posterior compartment(s) only
27602	619.40	Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s)
27603	547.84	Incision and drainage, leg or ankle; deep abscess or hematoma
27604	591.31	Incision and drainage, leg or ankle; infected bursa
27605	538.82	Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia
27606	541.73	Tenotomy, percutaneous, Achilles tendon (separate procedure); general anesthesia
27607	591.31	Incision (e.g., osteomyelitis or bone abscess), leg or ankle
27610	738.44	Arthrotomy, ankle, including exploration, drainage, or removal of foreign body
27612	766.53	Arthrotomy, posterior capsular release, ankle, with or without Achilles tendon lengthening
27613	121.73	Biopsy, soft tissue of leg or ankle area; superficial
27614	592.43	Biopsy, soft tissue of leg or ankle area; deep (subfascial or intramuscular)
27615	766.53	Radical resection of tumor (e.g., malignant neoplasm), soft tissue of leg or ankle area
27618	484.44	Excision, tumor, leg or ankle area; subcutaneous tissue
27619	620.52	Excision, tumor, leg or ankle area; deep (subfascial or intramuscular)
27620	819.18	Arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of loose or foreign body
27625	819.18	Arthrotomy, with synovectomy, ankle;
27626	819.18	Arthrotomy, with synovectomy, ankle; including tenosynovectomy
27630	619.40	Excision of lesion of tendon sheath or capsule (e.g., cyst or ganglion), leg and/or ankle
27635	766.53	Excision or curettage of bone cyst or benign tumor, tibia or fibula;
27637	766.53	Excision or curettage of bone cyst or benign tumor, tibia or fibula; with autograft (includes obtaining graft)
27638	766.53	Excision or curettage of bone cyst or benign tumor, tibia or fibula; with allograft
27640	1,019.46	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis or exostosis); tibia

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
27641	738.44	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis or exostosis); fibula
27647	1,047.54	Radical resection of tumor, bone; talus or calcaneus
27650	1,047.54	Repair, primary, open or percutaneous, ruptured Achilles tendon;
27652	1,796.63	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)
27654	1,047.54	Repair, secondary, Achilles tendon, with or without graft
27656	591.31	Repair, fascial defect of leg
27658	541.73	Repair, flexor tendon, leg; primary, without graft, each tendon
27659	591.31	Repair, flexor tendon, leg; secondary, with or without graft, each tendon
27664	591.31	Repair, extensor tendon, leg; primary, without graft, each tendon
27665	738.44	Repair, extensor tendon, leg; secondary, with or without graft, each tendon
27675	591.31	Repair, dislocating peroneal tendons; without fibular osteotomy
27676	766.53	Repair, dislocating peroneal tendons; with fibular osteotomy
27680	766.53	Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon
27681	738.44	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision(s))
27685	766.53	Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)
27686	766.53	Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each
27687	766.53	Gastrocnemius recession (e.g., Strayer procedure)
27690	1,100.20	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (e.g., anterior tibial extensors into midfoot)
27691	1,100.20	Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (e.g., anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)
27692	1,047.54	Transfer or transplant of single tendon (with muscle redirection or rerouting); each additional tendon (List separately in addition to code for primary procedure)
27695	738.44	Repair, primary, disrupted ligament, ankle; collateral
27696	738.44	Repair, primary, disrupted ligament, ankle; both collateral ligaments
27698	738.44	Repair, secondary, disrupted ligament, ankle, collateral (e.g., Watson-

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
		Jones procedure)
27700	1,001.75	Arthroplasty, ankle;
27704	591.31	Removal of ankle implant
27705	1,019.46	Osteotomy; tibia
27707	591.31	Osteotomy; fibula
27709	738.44	Osteotomy; tibia and fibula
27726	924.29	Repair of fibula nonunion and/or malunion with internal fixation
27730	738.44	Arrest, epiphyseal (epiphysiodesis), open; distal tibia
27732	738.44	Arrest, epiphyseal (epiphysiodesis), open; distal fibula
27734	738.44	Arrest, epiphyseal (epiphysiodesis), open; distal tibia and fibula
27740	738.44	Arrest, epiphyseal (epiphysiodesis), any method, combined, proximal and distal tibia and fibula;
27742	1,019.46	Arrest, epiphyseal (epiphysiodesis), any method, combined, proximal and distal tibia and fibula; and distal femur
27745	1,796.63	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, tibia
27750	74.48	Closed treatment of tibial shaft fracture (with or without fibular fracture); without manipulation
27752	406.41	Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation, with or without skeletal traction
27756	685.94	Percutaneous skeletal fixation of tibial shaft fracture (with or without fibular fracture) (e.g., pins or screws)
27758	1,055.02	Open treatment of tibial shaft fracture, (with or without fibular fracture) with plate/screws, with or without cerclage
27759	1,412.88	Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage
27760	74.48	Closed treatment of medial malleolus fracture; without manipulation
27762	406.41	Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction
27766	1,002.36	Open treatment of medial malleolus fracture, with or without internal or external fixation
27767	58.04	Closed treatment of posterior malleolus fracture; without manipulation
27768	58.04	Closed treatment of posterior malleolus fracture; with manipulation

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
27769	1,557.14	Open treatment of posterior malleolus fracture, includes internal fixation, when performed
27780	74.48	Closed treatment of proximal fibula or shaft fracture; without manipulation
27781	406.41	Closed treatment of proximal fibula or shaft fracture; with manipulation
27784	1,002.36	Open treatment of proximal fibula or shaft fracture, with or without internal or external fixation
27786	74.48	Closed treatment of distal fibular fracture (lateral malleolus); without manipulation
27788	74.48	Closed treatment of distal fibular fracture (lateral malleolus); with manipulation
27792	1,002.36	Open treatment of distal fibular fracture (lateral malleolus), with or without internal or external fixation
27808	74.48	Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation
27810	157.13	Closed treatment of bimalleolar ankle fracture, (including Potts); with manipulation
27814	1,002.36	Open treatment of bimalleolar ankle fracture, with or without internal or external fixation
27816	74.48	Closed treatment of trimalleolar ankle fracture; without manipulation
27818	157.13	Closed treatment of trimalleolar ankle fracture; with manipulation
27822	1,002.36	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; without fixation of posterior lip
27823	1,360.23	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip
27824	74.48	Closed treatment of fracture of weight bearing articular portion of distal tibia (e.g., pilon or tibial plafond), with or without anesthesia; without manipulation
27825	406.41	Closed treatment of fracture of weight bearing articular portion of distal tibia (e.g., pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation
27826	1,002.36	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (e.g., pilon or tibial plafond), with internal or external fixation; of fibula only
27827	1,360.23	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (e.g., pilon or tibial plafond), with internal or external fixation; of tibia only

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
27828	1,412.88	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (e.g., pilon or tibial plafond), with internal or external fixation; of both tibia and fibula
27829	974.28	Open treatment of distal tibiofibular joint (syndesmosis) disruption, with or without internal or external fixation
27830	74.48	Closed treatment of proximal tibiofibular joint dislocation; without anesthesia
27831	406.41	Closed treatment of proximal tibiofibular joint dislocation; requiring anesthesia
27832	974.28	Open treatment of proximal tibiofibular joint dislocation, with or without internal or external fixation, or with excision of proximal fibula
27840	157.13	Closed treatment of ankle dislocation; without anesthesia
27842	428.87	Closed treatment of ankle dislocation; requiring anesthesia, with or without percutaneous skeletal fixation
27846	1,002.36	Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; without repair or internal fixation
27848	1,002.36	Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; with repair or internal or external fixation
27860	428.87	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)
27870	1,849.28	Arthrodesis, ankle, open
27871	1,849.28	Arthrodesis, tibiofibular joint, proximal or distal
27884	619.40	Amputation, le.g., through tibia and fibula; secondary closure or scar revision
27889	766.53	Ankle disarticulation
27892	619.40	Decompression fasciotomy, leg; anterior and/or lateral compartments only, with debridement of nonviable muscle and/or nerve
27893	619.40	Decompression fasciotomy, leg; posterior compartment(s) only, with debridement of nonviable muscle and/or nerve
27894	619.40	Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s), with debridement of nonviable muscle and/or nerve
28001	118.80	Incision and drainage, bursa, foot
28002	619.40	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
28003	619.40	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas
28005	616.49	Incision, bone cortex (e.g., osteomyelitis or bone abscess), foot
28008	616.49	Fasciotomy, foot and/or toe
28010	87.32	Tenotomy, percutaneous, toe; single tendon
28011	616.49	Tenotomy, percutaneous, toe; multiple tendons
28020	588.40	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; intertarsal or tarsometatarsal joint
28022	588.40	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; metatarsophalangeal joint
28024	588.40	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; interphalangeal joint
28035	612.66	Release, tarsal tunnel (posterior tibial nerve decompression)
28043	592.43	Excision, tumor, foot; subcutaneous tissue
28045	616.49	Excision, tumor, foot; deep, subfascial, intramuscular
28046	616.49	Radical resection of tumor (e.g., malignant neoplasm), soft tissue of foot
28050	588.40	Arthrotomy with biopsy; intertarsal or tarsometatarsal joint
28052	588.40	Arthrotomy with biopsy; metatarsophalangeal joint
28054	588.40	Arthrotomy with biopsy; interphalangeal joint
28055	612.66	Neurectomy, intrinsic musculature of foot
28060	588.40	Fasciectomy, plantar fascia; partial (separate procedure)
28062	616.49	Fasciectomy, plantar fascia; radical (separate procedure)
28070	616.49	Synovectomy; intertarsal or tarsometatarsal joint, each
28072	616.49	Synovectomy; metatarsophalangeal joint, each
28080	616.49	Excision, interdigital (Morton) neuroma, single, each
28086	588.40	Synovectomy, tendon sheath, foot; flexor
28088	588.40	Synovectomy, tendon sheath, foot; extensor
28090	616.49	Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (e.g., cyst or ganglion); foot
28092	616.49	Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (e.g., cyst or ganglion); toe(s), each
28100	588.40	Excision or curettage of bone cyst or benign tumor, talus or calcaneus;

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
28102	1,082.75	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with iliac or other autograft (includes obtaining graft)
28103	1,082.75	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with allograft
28104	588.40	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus;
28106	1,082.75	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with iliac or other autograft (includes obtaining graft)
28107	1,082.75	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with allograft
28108	588.40	Excision or curettage of bone cyst or benign tumor, phalanges of foot
28110	616.49	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)
28111	616.49	Ostectomy, complete excision; first metatarsal head
28112	616.49	Ostectomy, complete excision; other metatarsal head (second, third or fourth)
28113	616.49	Ostectomy, complete excision; fifth metatarsal head
28114	616.49	Ostectomy, complete excision; all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (e.g., Clayton type procedure)
28116	616.49	Ostectomy, excision of tarsal coalition
28118	669.14	Ostectomy, calcaneus;
28119	669.14	Ostectomy, calcaneus; for spur, with or without plantar fascial release
28120	829.31	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (e.g., osteomyelitis or bossing); talus or calcaneus
28122	616.49	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (e.g., osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus
28124	200.93	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (e.g., osteomyelitis or bossing); phalanx of toe
28126	616.49	Resection, partial or complete, phalangeal base, each toe
28130	616.49	Talectomy (astragalectomy)
28140	616.49	Metatarsectomy
28150	616.49	Phalangectomy, toe, each toe
28153	616.49	Resection, condyle(s), distal end of phalanx, each toe

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
28160	616.49	Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each
28171	616.49	Radical resection of tumor, bone; tarsal (except talus or calcaneus)
28173	616.49	Radical resection of tumor, bone; metatarsal
28175	616.49	Radical resection of tumor, bone; phalanx of toe
28190	122.70	Removal of foreign body, foot; subcutaneous
28192	484.44	Removal of foreign body, foot; deep
28193	333.59	Removal of foreign body, foot; complicated
28200	616.49	Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon
28202	616.49	Repair, tendon, flexor, foot; secondary with free graft, each tendon (includes obtaining graft)
28208	616.49	Repair, tendon, extensor, foot; primary or secondary, each tendon
28210	1,082.75	Repair, tendon, extensor, foot; secondary with free graft, each tendon (includes obtaining graft)
28220	189.24	Tenolysis, flexor, foot; single tendon
28222	538.82	Tenolysis, flexor, foot; multiple tendons
28225	538.82	Tenolysis, extensor, foot; single tendon
28226	538.82	Tenolysis, extensor, foot; multiple tendons
28230	185.67	Tenotomy, open, tendon flexor; foot, single or multiple tendon(s) (separate procedure)
28232	177.55	Tenotomy, open, tendon flexor; toe, single tendon (separate procedure)
28234	588.40	Tenotomy, open, extensor, foot or toe, each tendon
28238	1,082.75	Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (e.g., Kidner type procedure)
28240	588.40	Tenotomy, lengthening, or release, abductor hallucis muscle
28250	616.49	Division of plantar fascia and muscle (e.g., Steindler stripping) (separate procedure)
28260	616.49	Capsulotomy, midfoot; medial release only (separate procedure)
28261	616.49	Capsulotomy, midfoot; with tendon lengthening
28262	669.14	Capsulotomy, midfoot; extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (e.g., resistant clubfoot deformity)
28264	1,005.08	Capsulotomy, midtarsal (e.g., Heyman type procedure)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
28270	616.49	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)
28272	171.39	Capsulotomy; interphalangeal joint, each joint (separate procedure)
28280	588.40	Syndactylization, toes (e.g., webbing or Kelikian type procedure)
28285	616.49	Correction, hammertoe (e.g., interphalangeal fusion, partial or total phalangectomy)
28286	669.14	Correction, cock-up fifth toe, with plastic skin closure (e.g., Ruiz-Mora type procedure)
28288	616.49	Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head
28289	616.49	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint
28290	759.91	Correction, hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (e.g., Silver type procedure)
28292	759.91	Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride, or Mayo type procedure
28293	787.99	Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant
28294	787.99	Correction, hallux valgus (bunion), with or without sesamoidectomy; with tendon transplants (e.g., Joplin type procedure)
28296	787.99	Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (e.g., Mitchell, Chevron, or concentric type procedures)
28297	787.99	Correction, hallux valgus (bunion), with or without sesamoidectomy; Lapidus type procedure
28298	787.99	Correction, hallux valgus (bunion), with or without sesamoidectomy; by phalanx osteotomy
28299	878.81	Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy
28300	1,054.67	Osteotomy; calcaneus (e.g., Dwyer or Chambers type procedure), with or without internal fixation
28302	588.40	Osteotomy; talus
28304	1,054.67	Osteotomy, tarsal bones, other than calcaneus or talus;
28305	1,082.75	Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (e.g., Fowler type)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
28306	669.14	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal
28307	669.14	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)
28308	588.40	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each
28309	1,135.40	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (e.g., Swanson type cavus foot procedure)
28310	616.49	Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)
28312	616.49	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe
28313	588.40	Reconstruction, angular deformity of toe, soft tissue procedures only (e.g., overlapping second toe, fifth toe, curly toes)
28315	669.14	Sesamoidectomy, first toe (separate procedure)
28320	1,135.40	Repair, nonunion or malunion; tarsal bones
28322	1,135.40	Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)
28340	669.14	Reconstruction, toe, macrodactyly; soft tissue resection
28341	669.14	Reconstruction, toe, macrodactyly; requiring bone resection
28344	669.14	Reconstruction, toe(s); polydactyly
28345	669.14	Reconstruction, toe(s); syndactyly, with or without skin graft(s), each web
28400	74.48	Closed treatment of calcaneal fracture; without manipulation
28405	406.41	Closed treatment of calcaneal fracture; with manipulation
28406	657.85	Percutaneous skeletal fixation of calcaneal fracture, with manipulation
28415	1,360.23	Open treatment of calcaneal fracture, with or without internal or external fixation;
28420	1,055.02	Open treatment of calcaneal fracture, with or without internal or external fixation; with primary iliac or other autogenous bone graft (includes obtaining graft)
28430	58.04	Closed treatment of talus fracture; without manipulation
28435	74.48	Closed treatment of talus fracture; with manipulation
28436	657.85	Percutaneous skeletal fixation of talus fracture, with manipulation

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
28445	1,002.36	Open treatment of talus fracture, with or without internal or external fixation
28446	1,717.92	Open osteochondral autograft, talus (includes obtaining graft[s])
28450	58.04	Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each
28455	58.04	Treatment of tarsal bone fracture (except talus and calcaneus); with manipulation, each
28456	657.85	Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus), with manipulation, each
28465	1,002.36	Open treatment of tarsal bone fracture (except talus and calcaneus), with or without internal or external fixation, each
28470	58.04	Closed treatment of metatarsal fracture; without manipulation, each
28475	58.04	Closed treatment of metatarsal fracture; with manipulation, each
28476	657.85	Percutaneous skeletal fixation of metatarsal fracture, with manipulation, each
28485	1,055.02	Open treatment of metatarsal fracture, with or without internal or external fixation, each
28490	58.04	Closed treatment of fracture great toe, phalanx or phalanges; without manipulation
28495	58.04	Closed treatment of fracture great toe, phalanx or phalanges; with manipulation
28496	657.85	Percutaneous skeletal fixation of fracture great toe, phalanx or phalanges, with manipulation
28505	685.94	Open treatment of fracture great toe, phalanx or phalanges, with or without internal or external fixation
28510	52.26	Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each
28515	58.04	Closed treatment of fracture, phalanx or phalanges, other than great toe; with manipulation, each
28525	685.94	Open treatment of fracture, phalanx or phalanges, other than great toe, with or without internal or external fixation, each
28530	50.31	Closed treatment of sesamoid fracture
28531	685.94	Open treatment of sesamoid fracture, with or without internal fixation
28540	58.04	Closed treatment of tarsal bone dislocation, other than talotarsal; without anesthesia
28545	608.27	Closed treatment of tarsal bone dislocation, other than talotarsal;

Code	Fee	Description
		requiring anesthesia
28546	657.85	Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation
28555	974.28	Open treatment of tarsal bone dislocation, with or without internal or external fixation
28570	75.30	Closed treatment of talotarsal joint dislocation; without anesthesia
28575	406.41	Closed treatment of talotarsal joint dislocation; requiring anesthesia
28576	685.94	Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation
28585	685.94	Open treatment of talotarsal joint dislocation, with or without internal or external fixation
28600	58.04	Closed treatment of tarsometatarsal joint dislocation; without anesthesia
28605	74.48	Closed treatment of tarsometatarsal joint dislocation; requiring anesthesia
28606	657.85	Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation
28615	1,002.36	Open treatment of tarsometatarsal joint dislocation, with or without internal or external fixation
28630	58.04	Closed treatment of metatarsophalangeal joint dislocation; without anesthesia
28635	428.87	Closed treatment of metatarsophalangeal joint dislocation; requiring anesthesia
28636	685.94	Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation
28645	685.94	Open treatment of metatarsophalangeal joint dislocation, with or without internal or external fixation
28660	41.55	Closed treatment of interphalangeal joint dislocation; without anesthesia
28665	428.87	Closed treatment of interphalangeal joint dislocation; requiring anesthesia
28666	685.94	Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation
28675	685.94	Open treatment of interphalangeal joint dislocation, with or without internal or external fixation
28705	1,135.40	Arthrodesis; pantalar
28715	1,849.28	Arthrodesis; triple
28725	1,135.40	Arthrodesis; subtalar
28730	1,135.40	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
28735	1,135.40	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (e.g., flatfoot correction)
28737	1,173.57	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (e.g., Miller type procedure)
28740	1,135.40	Arthrodesis, midtarsal or tarsometatarsal, single joint
28750	1,135.40	Arthrodesis, great toe; metatarsophalangeal joint
28755	669.14	Arthrodesis, great toe; interphalangeal joint
28760	1,135.40	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (e.g., Jones type procedure)
28810	588.40	Amputation, metatarsal, with toe, single
28820	588.40	Amputation, toe; metatarsophalangeal joint
28825	588.40	Amputation, toe; interphalangeal joint
28890	155.48	Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia
29000	39.39	Application of halo type body cast (see 20661-20663 for insertion)
29010	88.29	Application of Risser jacket, localizer, body; only
29015	88.29	Application of Risser jacket, localizer, body; including head
29020	39.39	Application of turnbuckle jacket, body; only
29025	39.39	Application of turnbuckle jacket, body; including head
29035	88.29	Application of body cast, shoulder to hips;
29040	39.39	Application of body cast, shoulder to hips; including head, Minerva type
29044	88.29	Application of body cast, shoulder to hips; including one thigh
29046	88.29	Application of body cast, shoulder to hips; including both thighs
29049	35.70	Application, cast; figure-of-eight
29055	88.29	Application, cast; shoulder spica
29058	39.39	Application, cast; plaster Velpeau
29065	41.88	Application, cast; shoulder to hand (long arm)
29075	40.25	Application, cast; elbow to finger (short arm)
29085	39.39	Application, cast; hand and lower forearm (gauntlet)
29086	33.76	Application, cast; finger (e.g., contracture)
29105	36.35	Application of long arm splint (shoulder to hand)
29125	31.48	Application of short arm splint (forearm to hand); static

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
29126	33.44	Application of short arm splint (forearm to hand); dynamic
29130	14.28	Application of finger splint; static
29131	20.77	Application of finger splint; dynamic
29200	20.12	Strapping; thorax
29220	21.74	Strapping; low back
29240	22.73	Strapping; shoulder (e.g., Velpeau)
29260	21.74	Strapping; elbow or wrist
29280	22.08	Strapping; hand or finger
29305	88.29	Application of hip spica cast; one leg
29325	88.29	Application of hip spica cast; one and one-half spica or both legs
29345	54.86	Application of long leg cast (thigh to toes);
29355	53.88	Application of long leg cast (thigh to toes); walker or ambulatory type
29358	66.87	Application of long leg cast brace
29365	51.94	Application of cylinder cast (thigh to ankle)
29405	38.63	Application of short leg cast (below knee to toes);
29425	39.28	Application of short leg cast (below knee to toes); walking or ambulatory type
29435	49.66	Application of patellar tendon bearing (PTB) cast
29440	21.10	Adding walker to previously applied cast
29445	52.26	Application of rigid total contact leg cast
29450	39.39	Application of clubfoot cast with molding or manipulation, long or short leg
29505	35.06	Application of long leg splint (thigh to ankle or toes)
29515	29.86	Application of short leg splint (calf to foot)
29520	21.42	Strapping; hip
29530	21.74	Strapping; knee
29540	16.23	Strapping; ankle and/or foot
29550	16.55	Strapping; toes
29580	22.40	Strapping; Unna boot
29590	18.18	Denis-Browne splint strapping
29700	30.19	Removal or bivalving; gauntlet, boot or body cast
29705	25.64	Removal or bivalving; full arm or full leg cast
29710	45.12	Removal or bivalving; shoulder or hip spica, Minerva, or Risser jacket, etc.

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
29715	39.39	Removal or bivalving; turnbuckle jacket
29720	37.66	Repair of spica, body cast or jacket
29730	24.67	Windowing of cast
29740	33.76	Wedging of cast (except clubfoot casts)
29750	35.38	Wedging of clubfoot cast
29800	758.05	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)
29804	758.05	Arthroscopy, temporomandibular joint, surgical
29805	758.05	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
29806	1,117.68	Arthroscopy, shoulder, surgical; capsulorrhaphy
29807	1,117.68	Arthroscopy, shoulder, surgical; repair of SLAP lesion
29819	1,117.68	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
29820	1,117.68	Arthroscopy, shoulder, surgical; synovectomy, partial
29821	1,117.68	Arthroscopy, shoulder, surgical; synovectomy, complete
29822	758.05	Arthroscopy, shoulder, surgical; debridement, limited
29823	1,117.68	Arthroscopy, shoulder, surgical; debridement, extensive
29824	848.88	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)
29825	1,117.68	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation
29826	1,117.68	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release
29827	1,208.51	Arthroscopy, shoulder, surgical; with rotator cuff repair
29828	1,787.80	Arthroscopy, shoulder, surgical; biceps tenodesis
29830	758.05	Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)
29834	758.05	Arthroscopy, elbow, surgical; with removal of loose body or foreign body
29835	758.05	Arthroscopy, elbow, surgical; synovectomy, partial
29836	758.05	Arthroscopy, elbow, surgical; synovectomy, complete
29837	758.05	Arthroscopy, elbow, surgical; debridement, limited
29838	758.05	Arthroscopy, elbow, surgical; debridement, extensive
29840	758.05	Arthroscopy, wrist, diagnostic, with or without synovial biopsy

Code	Fee	Description
		(separate procedure)
29843	758.05	Arthroscopy, wrist, surgical; for infection, lavage and drainage
29844	758.05	Arthroscopy, wrist, surgical; synovectomy, partial
29845	758.05	Arthroscopy, wrist, surgical; synovectomy, complete
29846	758.05	Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement
29847	1,117.68	Arthroscopy, wrist, surgical; internal fixation for fracture or instability
29848	1,121.81	Endoscopy, wrist, surgical, with release of transverse carpal ligament
29850	810.70	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)
29851	1,170.34	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; with internal or external fixation (includes arthroscopy)
29855	1,170.34	Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar, with or without internal or external fixation (includes arthroscopy)
29856	1,170.34	Arthroscopically aided treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal or external fixation (includes arthroscopy)
29860	1,170.34	Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)
29861	1,170.34	Arthroscopy, hip, surgical; with removal of loose body or foreign body
29862	1,481.45	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
29863	1,170.34	Arthroscopy, hip, surgical; with synovectomy
29866	1,787.80	Arthroscopy, knee, surgical; osteochondral autograft(s) (e.g., mosaicplasty) (includes harvesting of the autograft)
29870	758.05	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
29871	758.05	Arthroscopy, knee, surgical; for infection, lavage and drainage
29873	758.05	Arthroscopy, knee, surgical; with lateral release
29874	758.05	Arthroscopy, knee, surgical; for removal of loose body or foreign body (e.g., osteochondritis dissecans fragmentation, chondral fragmentation)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
29875	810.70	Arthroscopy, knee, surgical; synovectomy, limited (e.g., plica or shelf resection) (separate procedure)
29876	810.70	Arthroscopy, knee, surgical; synovectomy, major, two or more compartments (e.g., medial or lateral)
29877	810.70	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)
29879	758.05	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture
29880	810.70	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving)
29881	810.70	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving)
29882	758.05	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)
29883	758.05	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)
29884	758.05	Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)
29885	1,117.68	Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)
29886	758.05	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion
29887	758.05	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation
29888	1,117.68	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29889	1,117.68	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction
29891	1,117.68	Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect
29892	1,117.68	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)
29893	943.63	Endoscopic plantar fasciotomy
29894	758.05	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body
29895	758.05	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; synovectomy, partial

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
29897	758.05	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, limited
29898	758.05	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive
29899	1,117.68	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis
29900	758.05	Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy
29901	758.05	Arthroscopy, metacarpophalangeal joint, surgical; with debridement
29902	758.05	Arthroscopy, metacarpophalangeal joint, surgical; with reduction of displaced ulnar collateral ligament (e.g., Stenar lesion)
29904	1,068.53	Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body
29905	1,068.53	Arthroscopy, subtalar joint, surgical; with synovectomy
29906	1,068.53	Arthroscopy, subtalar joint, surgical; with debridement
29907	1,787.80	Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis
30000	120.13	Drainage abscess or hematoma, nasal, internal approach
30020	120.13	Drainage abscess or hematoma, nasal septum
30100	77.90	Biopsy, intranasal
30110	120.43	Excision, nasal polyp(s), simple
30115	508.83	Excision, nasal polyp(s), extensive
30117	536.92	Excision or destruction (e.g., laser), intranasal lesion; internal approach
30118	673.43	Excision or destruction (e.g., laser), intranasal lesion; external approach (lateral rhinotomy)
30120	459.25	Excision or surgical planing of skin of nose for rhinophyma
30124	273.65	Excision dermoid cyst, nose; simple, skin, subcutaneous
30125	956.26	Excision dermoid cyst, nose; complex, under bone or cartilage
30130	536.92	Excision inferior turbinate, partial or complete, any method
30140	645.34	Submucous resection inferior turbinate, partial or complete, any method
30150	984.35	Rhinectomy; partial
30160	1,037.00	Rhinectomy; total
30200	61.35	Injection into turbinate(s), therapeutic
30210	77.90	Displacement therapy (Proetz type)
30220	340.49	Insertion, nasal septal prosthesis (button)
30300	23.47	Removal foreign body, intranasal; office type procedure

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
30310	459.25	Removal foreign body, intranasal; requiring general anesthesia
30320	508.83	Removal foreign body, intranasal; by lateral rhinotomy
30400	1,037.00	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	1,075.18	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	1,075.18	Rhinoplasty, primary; including major septal repair
30430	673.43	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	1,075.18	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	1,197.16	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460	1,197.16	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	1,348.10	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30465	1,348.10	Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction)
30520	726.08	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30540	1,075.18	Repair choanal atresia; intranasal
30545	1,075.18	Repair choanal atresia; transpalatine
30560	126.20	Lysis intranasal synechia
30580	1,037.00	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)
30600	1,037.00	Repair fistula; oronasal
30620	1,197.16	Septal or other intranasal dermatoplasty (does not include obtaining graft)
30630	886.24	Repair nasal septal perforations
30801	282.94	Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method; superficial
30802	282.94	Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method; intramural
30901	40.36	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
30903	51.98	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method
30905	51.98	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial
30906	51.98	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent
30915	692.67	Ligation arteries; ethmoidal
30920	720.76	Ligation arteries; internal maxillary artery, transantral
30930	589.57	Fracture nasal inferior turbinate(s), therapeutic
31000	100.31	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)
31002	273.65	Lavage by cannulation; sphenoid sinus
31020	645.34	Sinusotomy, maxillary (antrotomy); intranasal
31030	984.35	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyps
31032	1,037.00	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) with removal of antrochoanal polyps
31040	899.28	Pterygomaxillary fossa surgery, any approach
31050	956.26	Sinusotomy, sphenoid, with or without biopsy;
31051	1,037.00	Sinusotomy, sphenoid, with or without biopsy; with mucosal stripping or removal of polyp(s)
31070	645.34	Sinusotomy frontal; external, simple (trephine operation)
31075	1,037.00	Sinusotomy frontal; transorbital, unilateral (for mucocele or osteoma, Lynch type)
31080	1,037.00	Sinusotomy frontal; obliterative without osteoplastic flap, brow incision (includes ablation)
31081	1,037.00	Sinusotomy frontal; obliterative, without osteoplastic flap, coronal incision (includes ablation)
31084	1,037.00	Sinusotomy frontal; obliterative, with osteoplastic flap, brow incision
31085	1,037.00	Sinusotomy frontal; obliterative, with osteoplastic flap, coronal incision
31086	1,037.00	Sinusotomy frontal; nonobliterative, with osteoplastic flap, brow incision
31087	1,037.00	Sinusotomy frontal; nonobliterative, with osteoplastic flap, coronal incision

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
31090	1,075.18	Sinusotomy, unilateral, three or more paranasal sinuses (frontal, maxillary, ethmoid, sphenoid)
31200	956.26	Ethmoidectomy; intranasal, anterior
31201	1,075.18	Ethmoidectomy; intranasal, total
31205	984.35	Ethmoidectomy; extranasal, total
31231	65.67	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
31233	70.74	Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)
31235	480.61	Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)
31237	530.19	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)
31238	480.61	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage
31239	701.54	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy
31240	530.19	Nasal/sinus endoscopy, surgical; with concha bullosa resection
31254	648.88	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)
31255	739.71	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)
31256	648.88	Nasal/sinus endoscopy, surgical, with maxillary antrostomy;
31267	648.88	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus
31276	648.88	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus
31287	648.88	Nasal/sinus endoscopy, surgical, with sphenoidotomy;
31288	648.88	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus
31300	764.25	Laryngotomy (thyrotomy, laryngofissure); with removal of tumor or laryngocele, cordectomy
31320	956.26	Laryngotomy (thyrotomy, laryngofissure); diagnostic
31400	956.26	Arytenoidectomy or arytenoidopexy, external approach
31420	956.26	Epiglottidectomy
31500	87.84	Intubation, endotracheal, emergency procedure
31502	50.51	Tracheotomy tube change prior to establishment of fistula tract
31505	29.84	Laryngoscopy, indirect; diagnostic (separate procedure)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
31510	530.19	Laryngoscopy, indirect; with biopsy
31511	70.74	Laryngoscopy, indirect; with removal of foreign body
31512	530.19	Laryngoscopy, indirect; with removal of lesion
31513	70.74	Laryngoscopy, indirect; with vocal cord injection
31515	480.61	Laryngoscopy direct, with or without tracheoscopy; for aspiration
31520	65.67	Laryngoscopy direct, with or without tracheoscopy; diagnostic, newborn
31525	480.61	Laryngoscopy direct, with or without tracheoscopy; diagnostic, except newborn
31526	620.80	Laryngoscopy direct, with or without tracheoscopy; diagnostic, with operating microscope or telescope
31527	571.21	Laryngoscopy direct, with or without tracheoscopy; with insertion of obturator
31528	530.19	Laryngoscopy direct, with or without tracheoscopy; with dilation, initial
31529	530.19	Laryngoscopy direct, with or without tracheoscopy; with dilation, subsequent
31530	620.80	Laryngoscopy, direct, operative, with foreign body removal;
31531	648.88	Laryngoscopy, direct, operative, with foreign body removal; with operating microscope or telescope
31535	620.80	Laryngoscopy, direct, operative, with biopsy;
31536	648.88	Laryngoscopy, direct, operative, with biopsy; with operating microscope or telescope
31540	648.88	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis;
31541	701.54	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope or telescope
31545	701.54	Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with local tissue flap(s)
31546	701.54	Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with graft(s) (includes obtaining autograft)
31560	739.71	Laryngoscopy, direct, operative, with arytenoidectomy;
31561	739.71	Laryngoscopy, direct, operative, with arytenoidectomy; with operating microscope or telescope

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
31570	530.19	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic;
31571	620.80	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope
31575	56.48	Laryngoscopy, flexible fiberoptic; diagnostic
31576	620.80	Laryngoscopy, flexible fiberoptic; with biopsy
31577	183.38	Laryngoscopy, flexible fiberoptic; with removal of foreign body
31578	620.80	Laryngoscopy, flexible fiberoptic; with removal of lesion
31579	100.63	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy
31580	1,075.18	Laryngoplasty; for laryngeal web, two stage, with keel insertion and removal
31582	1,075.18	Laryngoplasty; for laryngeal stenosis, with graft or core mold, including tracheotomy
31588	1,075.18	Laryngoplasty, not otherwise specified (e.g., for burns, reconstruction after partial laryngectomy)
31590	1,075.18	Laryngeal reinnervation by neuromuscular pedicle
31595	956.26	Section recurrent laryngeal nerve, therapeutic (separate procedure), unilateral
31603	282.94	Tracheostomy, emergency procedure; transtracheal
31605	273.65	Tracheostomy, emergency procedure; cricothyroid membrane
31611	673.43	Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (e.g., voice button, Blom-Singer prosthesis)
31612	595.76	Tracheal puncture, percutaneous with transtracheal aspiration and/or injection
31613	645.34	Tracheostoma revision; simple, without flap rotation
31614	956.26	Tracheostoma revision; complex, with flap rotation
31615	282.94	Tracheobronchoscopy through established tracheostomy incision
31622	331.37	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)
31623	380.95	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with brushing or protected brushings
31624	380.95	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with bronchial alveolar lavage
31625	380.95	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with bronchial or endobronchial biopsy(s), single or multiple sites

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
31628	380.95	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), single lobe
31629	380.95	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)
31630	652.80	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with tracheal/bronchial dilation or closed reduction of fracture
31631	652.80	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)
31632	370.50	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)
31633	370.50	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)
31635	380.95	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with removal of foreign body
31636	652.80	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus
31637	331.37	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; each additional major bronchus stented (List separately in addition to code for primary procedure)
31638	652.80	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)
31640	652.80	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with excision of tumor
31641	652.80	Bronchoscopy, (rigid or flexible); with destruction of tumor or relief of stenosis by any method other than excision (e.g., laser therapy, cryotherapy)
31643	380.95	Bronchoscopy, (rigid or flexible); with placement of catheter(s) for intracavitary radioelement application
31645	331.37	Bronchoscopy, (rigid or flexible); with therapeutic aspiration of tracheobronchial tree, initial (e.g., drainage of lung abscess)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
31646	331.37	Bronchoscopy, (rigid or flexible); with therapeutic aspiration of tracheobronchial tree, subsequent
31656	331.37	Bronchoscopy, (rigid or flexible); with injection of contrast material for segmental bronchography (fiberscope only)
31717	183.38	Catheterization with bronchial brush biopsy
31720	28.08	Catheter aspiration (separate procedure); nasotracheal
31730	183.38	Transtracheal (percutaneous) introduction of needle wire dilator/stent or indwelling tube for oxygen therapy
31750	1,075.18	Tracheoplasty; cervical
31755	956.26	Tracheoplasty; tracheopharyngeal fistulization, each stage
31820	459.25	Surgical closure tracheostomy or fistula; without plastic repair
31825	645.34	Surgical closure tracheostomy or fistula; with plastic repair
31830	645.34	Revision of tracheostomy scar
32400	320.09	Biopsy, pleura; percutaneous needle
32405	320.09	Biopsy, lung or mediastinum, percutaneous needle
32420	194.64	Pneumocentesis, puncture of lung for aspiration
32421	194.64	Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent
32422	193.78	Thoracentesis with insertion of tube, includes water seal (e.g., for pneumothorax), when performed (separate procedure)
32550	1,084.95	Insertion of indwelling tunneled pleural catheter with cuff
32960	193.78	Pneumothorax, therapeutic, intrapleural injection of air
32998	1,689.21	Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral
33010	194.64	Pericardiocentesis; initial
33011	194.64	Pericardiocentesis; subsequent
33206	6,244.88	Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial
33207	6,244.88	Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular
33208	7,745.43	Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
33210	1,833.83	Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter (separate procedure)
33211	1,833.83	Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)
33212	4,904.46	Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular
33213	5,660.80	Insertion or replacement of pacemaker pulse generator only; dual chamber
33214	7,745.43	Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator)
33215	803.79	Repositioning of previously implanted transvenous pacemaker or pacing cardioverter-defibrillator (right atrial or right ventricular) electrode
33216	1,833.83	Insertion of a transvenous electrode; single chamber (one electrode) permanent pacemaker or single chamber pacing cardioverter-defibrillator
33217	1,833.83	Insertion of a transvenous electrode; dual chamber (two electrodes) permanent pacemaker or dual chamber pacing cardioverter-defibrillator
33218	803.79	Repair of single transvenous electrode for a single chamber, permanent pacemaker or single chamber pacing cardioverter-defibrillator
33220	803.79	Repair of two transvenous electrodes for a dual chamber permanent pacemaker or dual chamber pacing cardioverter-defibrillator
33222	485.86	Revision or relocation of skin pocket for pacemaker
33223	485.86	Revision of skin pocket for single or dual chamber pacing cardioverter-defibrillator
33224	7,310.96	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or pacing cardioverter-defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of generator)
33225	7,310.96	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system) (List separately in addition to code for primary procedure)
33226	803.79	Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement

Code	Fee	Description
		of generator)
33233	597.60	Removal of permanent pacemaker pulse generator
33234	803.79	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular
33235	803.79	Removal of transvenous pacemaker electrode(s); dual lead system
33240	18,224.36	Insertion of single or dual chamber pacing cardioverter defibrillator pulse generator
33241	803.79	Subcutaneous removal of single or dual chamber pacing cardioverter-defibrillator pulse generator
33249	24,321.80	Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter defibrillator and insertion of pulse generator
33282	3,845.43	Implantation of patient activated cardiac event recorder
33284	299.93	Removal of an implantable, patient activated cardiac event recorder
34490	1,464.36	Thrombectomy, direct or with catheter; axillary and subclavian vein, by arm incision
35188	1,008.62	Repair, acquired or traumatic arteriovenous fistula; head and neck
35207	1,008.62	Repair blood vessel, direct; hand, finger
35473	1,756.67	Transluminal balloon angioplasty, percutaneous; iliac
35476	1,756.67	Transluminal balloon angioplasty, percutaneous; venous
35492	3,278.66	Transluminal peripheral atherectomy, percutaneous; iliac
35761	1,054.70	Exploration (not followed by surgical repair), with or without lysis of artery; other vessels
35875	1,319.72	Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula);
35876	1,319.72	Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula); with revision of arterial or venous graft
36002	84.23	Injection procedures (e.g., thrombin) for percutaneous treatment of extremity pseudoaneurysm
36260	764.09	Insertion of implantable intra-arterial infusion pump (e.g., for chemotherapy of liver)
36261	597.60	Revision of implanted intra-arterial infusion pump
36262	548.01	Removal of implanted intra-arterial infusion pump
36420	7.94	Venipuncture, cutdown; younger than age 1 year
36425	7.94	Venipuncture, cutdown; age 1 or over

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
36430	30.51	Transfusion, blood or blood components
36440	121.85	Push transfusion, blood, 2 years or younger
36450	121.85	Exchange transfusion, blood; newborn
36455	121.85	Exchange transfusion, blood; other than newborn
36468	30.08	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk
36469	30.08	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face
36470	30.08	Injection of sclerosing solution; single vein
36471	30.08	Injection of sclerosing solution; multiple veins, same leg
36475	1,382.94	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
36476	1,084.51	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
36478	1,084.51	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated
36479	1,084.51	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
36511	417.76	Therapeutic apheresis; for white blood cells
36512	417.76	Therapeutic apheresis; for red blood cells
36513	417.76	Therapeutic apheresis; for platelets
36514	417.76	Therapeutic apheresis; for plasma pheresis
36515	1,118.35	Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion
36516	1,118.35	Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion
36522	1,118.35	Photopheresis, extracorporeal
36555	347.10	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
36556	347.10	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older
36557	648.24	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; younger than 5 years of age
36558	648.24	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older
36560	764.09	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age
36561	764.09	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older
36563	764.09	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump
36565	764.09	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; without subcutaneous port or pump (e.g., Tesio type catheter)
36566	764.09	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; with subcutaneous port(s)
36568	347.10	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; younger than 5 years of age
36569	347.10	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older
36570	676.32	Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age
36571	676.32	Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older
36575	279.17	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site
36576	396.68	Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site
36578	648.24	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site
36580	347.10	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
36581	648.24	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36582	764.09	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access
36583	764.09	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access
36584	347.10	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access
36585	676.32	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access
36589	229.59	Removal of tunneled central venous catheter, without subcutaneous port or pump
36590	347.10	Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion
36593	23.05	Declotting by thrombolytic agent of implanted vascular access device or catheter
36595	905.08	Mechanical removal of pericatheter obstructive material (e.g., fibrin sheath) from central venous device via separate venous access
36596	401.96	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen
36597	401.96	Repositioning of previously placed central venous catheter under fluoroscopic guidance
36598	74.33	Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report
36640	686.42	Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown
36680	52.03	Placement of needle for intraosseous infusion
36800	822.55	Insertion of cannula for hemodialysis, other purpose (separate procedure); vein to vein
36810	822.55	Insertion of cannula for hemodialysis, other purpose (separate procedure); arteriovenous, external (Scribner type)
36815	822.55	Insertion of cannula for hemodialysis, other purpose (separate procedure); arteriovenous, external revision, or closure
36818	955.97	Arteriovenous anastomosis, open; by upper arm cephalic vein transposition

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
36819	955.97	Arteriovenous anastomosis, open; by upper arm basilic vein transposition
36820	955.97	Arteriovenous anastomosis, open; by forearm vein transposition
36821	955.97	Arteriovenous anastomosis, open; direct, any site (e.g., Cimino type) (separate procedure)
36825	1,008.62	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft
36830	1,008.62	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (e.g., biological collagen, thermoplastic graft)
36831	1,319.72	Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)
36832	1,008.62	Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)
36833	1,008.62	Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)
36834	955.97	Plastic repair of arteriovenous aneurysm (separate procedure)
36835	875.21	Insertion of Thomas shunt (separate procedure)
36860	100.45	External cannula declotting (separate procedure); without balloon catheter
36861	822.55	External cannula declotting (separate procedure); with balloon catheter
36870	1,438.51	Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)
37184	1,464.36	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel
37185	1,464.36	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
37186	1,464.36	Secondary percutaneous transluminal thrombectomy (e.g., nonprimary mechanical, snare basket, suction technique), noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)
37187	1,464.36	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance
37188	1,464.36	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy
37200	1,080.61	Transcatheter biopsy
37203	1,080.61	Transcatheter retrieval, percutaneous, of intravascular foreign body (e.g., fractured venous or arterial catheter)
37500	1,019.19	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)
37607	720.76	Ligation or banding of angioaccess arteriovenous fistula
37609	484.44	Ligation or biopsy, temporal artery
37650	692.67	Ligation of femoral vein
37700	692.67	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions
37718	720.76	Ligation, division, and stripping, short saphenous vein
37722	1,019.19	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below
37735	1,019.19	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower le.g., with excision of deep fascia
37760	720.76	Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open
37765	993.93	Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions
37766	993.93	Stab phlebectomy of varicose veins, one extremity; more than 20 incisions
37780	720.76	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
37785	720.76	Ligation, division, and/or excision of varicose vein cluster(s), one leg
37790	869.73	Penile venous occlusive procedure
38205	417.76	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic
38206	417.76	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous
38220	95.76	Bone marrow; aspiration only
38221	100.31	Bone marrow; biopsy, needle or trocar
38230	1,118.35	Bone marrow harvesting for transplantation
38241	1,118.35	Bone marrow or blood-derived peripheral stem cell transplantation; autologous
38242	417.76	Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions
38300	374.89	Drainage of lymph node abscess or lymphadenitis; simple
38305	547.84	Drainage of lymph node abscess or lymphadenitis; extensive
38308	625.98	Lymphangiotomy or other operations on lymphatic channels
38500	625.98	Biopsy or excision of lymph node(s); open, superficial
38505	239.50	Biopsy or excision of lymph node(s); by needle, superficial (e.g., cervical, inguinal, axillary)
38510	625.98	Biopsy or excision of lymph node(s); open, deep cervical node(s)
38520	625.98	Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad
38525	625.98	Biopsy or excision of lymph node(s); open, deep axillary node(s)
38530	625.98	Biopsy or excision of lymph node(s); open, internal mammary node(s)
38542	1,053.12	Dissection, deep jugular node(s)
38550	654.07	Excision of cystic hygroma, axillary or cervical; without deep neurovascular dissection
38555	706.72	Excision of cystic hygroma, axillary or cervical; with deep neurovascular dissection
38570	1,428.92	Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple
38571	1,857.56	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy
38572	1,428.92	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple
38700	860.55	Suprahyoid lymphadenectomy

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
38740	1,053.12	Axillary lymphadenectomy; superficial
38745	1,133.86	Axillary lymphadenectomy; complete
38760	625.98	Inguinofemoral lymphadenectomy, superficial, including Cloquets node (separate procedure)
40490	63.95	Biopsy of lip
40500	508.83	Vermilionectomy (lip shave), with mucosal advancement
40510	645.34	Excision of lip; transverse wedge excision with primary closure
40520	508.83	Excision of lip; V-excision with primary direct linear closure
40525	645.34	Excision of lip; full thickness, reconstruction with local flap (e.g., Estlander or fan)
40527	645.34	Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)
40530	645.34	Resection of lip, more than one-fourth, without reconstruction
40650	340.49	Repair lip, full thickness; vermilion only
40652	340.49	Repair lip, full thickness; up to half vertical height
40654	340.49	Repair lip, full thickness; over one-half vertical height, or complex
40700	1,197.16	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral
40701	1,197.16	Plastic repair of cleft lip/nasal deformity; primary bilateral, one stage procedure
40702	1,521.12	Plastic repair of cleft lip/nasal deformity; primary bilateral, one of two stages
40720	1,197.16	Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure
40761	984.35	Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle
40800	51.32	Drainage of abscess, cyst, hematoma, vestibule of mouth; simple
40801	332.52	Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated
40804	23.47	Removal of embedded foreign body, vestibule of mouth; simple
40805	158.73	Removal of embedded foreign body, vestibule of mouth; complicated
40806	73.04	Incision of labial frenum (frenotomy)
40808	108.41	Biopsy, vestibule of mouth
40810	112.31	Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair
40812	140.88	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
40814	508.83	Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair
40816	645.34	Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle
40818	126.20	Excision of mucosa of vestibule of mouth as donor graft
40819	282.94	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)
40820	161.97	Destruction of lesion or scar of vestibule of mouth by physical methods (e.g., laser, thermal, cryo, chemical)
40830	120.13	Closure of laceration, vestibule of mouth; 2.5 cm or less
40831	282.94	Closure of laceration, vestibule of mouth; over 2.5 cm or complex
40840	645.34	Vestibuloplasty; anterior
40842	673.43	Vestibuloplasty; posterior, unilateral
40843	673.43	Vestibuloplasty; posterior, bilateral
40844	1,075.18	Vestibuloplasty; entire arch
40845	1,075.18	Vestibuloplasty; complex (including ridge extension, muscle repositioning)
41000	80.51	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual
41005	126.20	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, superficial
41006	595.76	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, deep, supramylohyoid
41007	459.25	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submental space
41008	459.25	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space
41009	126.20	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; masticator space
41010	282.94	Incision of lingual frenum (frenotomy)
41015	126.20	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual
41016	282.94	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submental

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
41017	282.94	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submandibular
41018	282.94	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space
41019	899.28	Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application
41100	84.72	Biopsy of tongue; anterior two-thirds
41105	83.75	Biopsy of tongue; posterior one-third
41108	77.58	Biopsy of floor of mouth
41110	112.31	Excision of lesion of tongue without closure
41112	508.83	Excision of lesion of tongue with closure; anterior two-thirds
41113	508.83	Excision of lesion of tongue with closure; posterior one-third
41114	645.34	Excision of lesion of tongue with closure; with local tongue flap
41115	130.82	Excision of lingual frenum (frenectomy)
41116	459.25	Excision, lesion of floor of mouth
41120	764.25	Glossectomy; less than one-half tongue
41250	86.31	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue
41251	126.20	Repair of laceration 2.5 cm or less; posterior one-third of tongue
41252	332.52	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex
41500	595.76	Fixation of tongue, mechanical, other than suture (e.g., K-wire)
41510	459.25	Suture of tongue to lip for micrognathia (Douglas type procedure)
41520	332.52	Frenoplasty (surgical revision of frenum, e.g., with Z-plasty)
41530	626.27	Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session
41800	64.48	Drainage of abscess, cyst, hematoma from dentoalveolar structures
41805	139.58	Removal of embedded foreign body from dentoalveolar structures; soft tissues
41806	172.04	Removal of embedded foreign body from dentoalveolar structures; bone
41820	273.65	Gingivectomy, excision gingiva, each quadrant
41821	273.65	Operculectomy, excision pericoronal tissues
41822	142.50	Excision of fibrous tuberosities, dentoalveolar structures
41823	207.75	Excision of osseous tuberosities, dentoalveolar structures

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
41825	114.26	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair
41826	143.80	Excision of lesion or tumor (except listed above), dentoalveolar structures; with simple repair
41827	645.34	Excision of lesion or tumor (except listed above), dentoalveolar structures; with complex repair
41828	129.84	Excision of hyperplastic alveolar mucosa, each quadrant (specify)
41830	184.37	Alveolectomy, including curettage of osteitis or sequestrectomy
41850	626.27	Destruction of lesion (except excision), dentoalveolar structures
41870	899.28	Periodontal mucosal grafting
41872	184.37	Gingivoplasty, each quadrant (specify)
41874	177.88	Alveoloplasty, each quadrant (specify)
42000	126.20	Drainage of abscess of palate, uvula
42100	72.06	Biopsy of palate, uvula
42104	107.12	Excision, lesion of palate, uvula; without closure
42106	134.39	Excision, lesion of palate, uvula; with simple primary closure
42107	645.34	Excision, lesion of palate, uvula; with local flap closure
42120	1,037.00	Resection of palate or extensive resection of lesion
42140	332.52	Uvulectomy, excision of uvula
42145	764.25	Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty)
42160	127.24	Destruction of lesion, palate or uvula (thermal, cryo or chemical)
42180	126.20	Repair, laceration of palate; up to 2 cm
42182	956.26	Repair, laceration of palate; over 2 cm or complex
42200	1,075.18	Palatoplasty for cleft palate, soft and/or hard palate only
42205	1,075.18	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only
42210	1,075.18	Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)
42215	1,197.16	Palatoplasty for cleft palate; major revision
42220	1,075.18	Palatoplasty for cleft palate; secondary lengthening procedure
42226	1,075.18	Lengthening of palate, and pharyngeal flap
42235	627.75	Repair of anterior palate, including vomer flap
42260	726.08	Repair of nasolabial fistula

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
42280	70.11	Maxillary impression for palatal prosthesis
42281	626.27	Insertion of pin-retained palatal prosthesis
42300	459.25	Drainage of abscess; parotid, simple
42305	508.83	Drainage of abscess; parotid, complicated
42310	126.20	Drainage of abscess; submaxillary or sublingual, intraoral
42320	126.20	Drainage of abscess; submaxillary, external
42330	108.41	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral
42335	179.83	Sialolithotomy; submandibular (submaxillary), complicated, intraoral
42340	508.83	Sialolithotomy; parotid, extraoral or complicated intraoral
42400	61.03	Biopsy of salivary gland; needle
42405	508.83	Biopsy of salivary gland; incisional
42408	536.92	Excision of sublingual salivary cyst (ranula)
42409	536.92	Marsupialization of sublingual salivary cyst (ranula)
42410	984.35	Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection
42415	1,197.16	Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve
42420	1,197.16	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve
42425	1,197.16	Excision of parotid tumor or parotid gland; total, en bloc removal with sacrifice of facial nerve
42440	984.35	Excision of submandibular (submaxillary) gland
42450	645.34	Excision of sublingual gland
42500	673.43	Plastic repair of salivary duct, sialodochoplasty; primary or simple
42505	1,037.00	Plastic repair of salivary duct, sialodochoplasty; secondary or complicated
42507	984.35	Parotid duct diversion, bilateral (Wilke type procedure);
42508	1,037.00	Parotid duct diversion, bilateral (Wilke type procedure); with excision of one submandibular gland
42509	1,037.00	Parotid duct diversion, bilateral (Wilke type procedure); with excision of both submandibular glands
42510	1,037.00	Parotid duct diversion, bilateral (Wilke type procedure); with ligation of both submandibular (Whartons) ducts

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
42600	459.25	Closure salivary fistula
42650	39.92	Dilation salivary duct
42660	46.75	Dilation and catheterization of salivary duct, with or without injection
42665	886.24	Ligation salivary duct, intraoral
42700	126.20	Incision and drainage abscess; peritonsillar
42720	459.25	Incision and drainage abscess; retropharyngeal or parapharyngeal, intraoral approach
42725	956.26	Incision and drainage abscess; retropharyngeal or parapharyngeal, external approach
42800	77.26	Biopsy; oropharynx
42802	459.25	Biopsy; hypopharynx
42804	459.25	Biopsy; nasopharynx, visible lesion, simple
42806	645.34	Biopsy; nasopharynx, survey for unknown primary lesion
42808	508.83	Excision or destruction of lesion of pharynx, any method
42809	23.47	Removal of foreign body from pharynx
42810	673.43	Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues
42815	1,075.18	Excision branchial cleft cyst, vestige, or fistula, extending beneath subcutaneous tissues and/or into pharynx
42820	673.43	Tonsillectomy and adenoidectomy; younger than age 12
42821	764.25	Tonsillectomy and adenoidectomy; age 12 or over
42825	726.08	Tonsillectomy, primary or secondary; younger than age 12
42826	726.08	Tonsillectomy, primary or secondary; age 12 or over
42830	726.08	Adenoidectomy, primary; younger than age 12
42831	726.08	Adenoidectomy, primary; age 12 or over
42835	726.08	Adenoidectomy, secondary; younger than age 12
42836	726.08	Adenoidectomy, secondary; age 12 or over
42860	673.43	Excision of tonsil tags
42870	673.43	Excision or destruction lingual tonsil, any method (separate procedure)
42890	1,197.16	Limited pharyngectomy
42892	1,197.16	Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and posterior pharyngeal walls
42900	282.94	Suture pharynx for wound or injury
42950	645.34	Pharyngoplasty (plastic or reconstructive operation on pharynx)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
42955	645.34	Pharyngostomy (fistulization of pharynx, external for feeding)
42960	51.98	Control oropharyngeal hemorrhage, primary or secondary (e.g., post-tonsillectomy); simple
42962	956.26	Control oropharyngeal hemorrhage, primary or secondary (e.g., post-tonsillectomy); with secondary surgical intervention
42970	40.36	Control of nasopharyngeal hemorrhage, primary or secondary (e.g., postadenoidectomy); simple, with posterior nasal packs, with or without anterior packs and/or cautery
42972	536.92	Control of nasopharyngeal hemorrhage, primary or secondary (e.g., postadenoidectomy); with secondary surgical intervention
43030	626.27	Cricopharyngeal myotomy
43200	303.27	Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
43201	303.27	Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance
43202	303.27	Esophagoscopy, rigid or flexible; with biopsy, single or multiple
43204	303.27	Esophagoscopy, rigid or flexible; with injection sclerosis of esophageal varices
43205	303.27	Esophagoscopy, rigid or flexible; with band ligation of esophageal varices
43215	303.27	Esophagoscopy, rigid or flexible; with removal of foreign body
43216	303.27	Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
43217	303.27	Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43219	612.92	Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent
43220	303.27	Esophagoscopy, rigid or flexible; with balloon dilation (less than 30 mm diameter)
43226	303.27	Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire
43227	352.86	Esophagoscopy, rigid or flexible; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
43228	656.65	Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
43231	352.86	Esophagoscopy, rigid or flexible; with endoscopic ultrasound

Code	Fee	Description
		examination
43232	352.86	Esophagoscopy, rigid or flexible; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)
43234	303.27	Upper gastrointestinal endoscopy, simple primary examination (e.g., with small diameter flexible endoscope) (separate procedure)
43235	303.27	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
43236	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance
43237	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus
43238	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)
43239	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple
43240	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transmural drainage of pseudocyst
43241	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic intraluminal tube or catheter placement
43242	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum as appropriate)
43243	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with injection sclerosis of esophageal and/or gastric varices

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
43244	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of esophageal and/or gastric varices
43245	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation of gastric outlet for obstruction (e.g., balloon, guide wire, bougie)
43246	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube
43247	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body
43248	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire
43249	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)
43250	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
43251	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43255	352.86	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method
43256	690.59	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation)
43257	684.74	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
43258	380.94	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
43259	380.94	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate
43260	594.05	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
43261	594.05	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple
43262	594.05	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy
43263	594.05	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct)
43264	594.05	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts
43265	594.05	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method
43267	594.05	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube
43268	662.51	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct
43269	662.51	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent
43271	594.05	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
43272	594.05	Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
43273	796.69	Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure)
43450	265.23	Dilation of esophagus, by unguided sound or bougie, single or multiple passes
43453	265.23	Dilation of esophagus, over guide wire
43456	266.28	Dilation of esophagus, by balloon or dilator, retrograde
43458	304.34	Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia
43600	303.27	Biopsy of stomach; by capsule, tube, peroral (one or more specimens)
43653	1,428.92	Laparoscopy, surgical; gastrostomy, without construction of gastric tube (e.g., Stamm procedure) (separate procedure)
43760	147.09	Change of gastrostomy tube
43761	303.27	Repositioning of the gastric feeding tube, any method, through the duodenum for enteric nutrition
43870	303.27	Closure of gastrostomy, surgical
43886	765.23	Gastric restrictive procedure, open; revision of subcutaneous port component only
43887	160.95	Gastric restrictive procedure, open; removal of subcutaneous port component only
43888	765.23	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only
44100	303.27	Biopsy of intestine by capsule, tube, peroral (one or more specimens)
44312	528.73	Revision of ileostomy; simple (release of superficial scar) (separate procedure)
44340	606.40	Revision of colostomy; simple (release of superficial scar) (separate procedure)
44360	369.57	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44361	369.57	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
44363	369.57	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body
44364	369.57	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
44365	369.57	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
44366	369.57	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44369	369.57	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
44370	1,054.35	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with transendoscopic stent placement (includes predilation)
44372	369.57	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with placement of percutaneous jejunostomy tube
44373	369.57	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube
44376	369.57	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44377	369.57	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with biopsy, single or multiple
44378	369.57	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44379	1,054.35	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with transendoscopic stent placement (includes predilation)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
44380	319.98	Ileoscopy, through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44382	319.98	Ileoscopy, through stoma; with biopsy, single or multiple
44383	1,054.35	Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)
44385	309.38	Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44386	309.38	Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; with biopsy, single or multiple
44388	309.38	Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44389	309.38	Colonoscopy through stoma; with biopsy, single or multiple
44390	309.38	Colonoscopy through stoma; with removal of foreign body
44391	309.38	Colonoscopy through stoma; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44392	309.38	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
44393	309.38	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
44394	309.38	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
44397	612.92	Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)
44500	166.95	Introduction of long gastrointestinal tube (e.g., Miller-Abbott) (separate procedure)
45000	358.78	Transrectal drainage of pelvic abscess
45005	417.55	Incision and drainage of submucosal abscess, rectum
45020	417.55	Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess
45100	567.28	Biopsy of anorectal wall, anal approach (e.g., congenital megacolon)
45108	616.86	Anorectal myomectomy
45150	616.86	Division of stricture of rectum
45160	616.86	Excision of rectal tumor by proctotomy, transsacral or transcoccygeal approach

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
45170	616.86	Excision of rectal tumor, transanal approach
45190	1,008.70	Destruction of rectal tumor (e.g., electrodessication, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach
45300	59.72	Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45303	331.75	Proctosigmoidoscopy, rigid; with dilation (e.g., balloon, guide wire, bougie)
45305	311.99	Proctosigmoidoscopy, rigid; with biopsy, single or multiple
45307	576.27	Proctosigmoidoscopy, rigid; with removal of foreign body
45308	311.99	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
45309	311.99	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique
45315	311.99	Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique
45317	311.99	Proctosigmoidoscopy, rigid; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45320	576.27	Proctosigmoidoscopy, rigid; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (e.g., laser)
45321	576.27	Proctosigmoidoscopy, rigid; with decompression of volvulus
45327	612.92	Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation)
45330	78.88	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45331	233.25	Sigmoidoscopy, flexible; with biopsy, single or multiple
45332	233.25	Sigmoidoscopy, flexible; with removal of foreign body
45333	311.99	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45334	311.99	Sigmoidoscopy, flexible; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45335	233.25	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance
45337	233.25	Sigmoidoscopy, flexible; with decompression of volvulus, any method

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
45338	311.99	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45339	311.99	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45340	311.99	Sigmoidoscopy, flexible; with dilation by balloon, 1 or more strictures
45341	311.99	Sigmoidoscopy, flexible; with endoscopic ultrasound examination
45342	311.99	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45345	612.92	Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)
45355	309.38	Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple
45378	358.97	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45379	358.97	Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body
45380	358.97	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
45381	358.97	Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance
45382	358.97	Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45383	358.97	Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45384	358.97	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	358.97	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45386	358.97	Colonoscopy, flexible, proximal to splenic flexure; with dilation by balloon, 1 or more strictures
45387	612.92	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
45391	358.97	Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examination
45392	358.97	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45500	616.86	Proctoplasty; for stenosis
45505	759.48	Proctoplasty; for prolapse of mucous membrane
45520	30.08	Perirectal injection of sclerosing solution for prolapse
45560	759.48	Repair of rectocele (separate procedure)
45900	243.23	Reduction of procidentia (separate procedure) under anesthesia
45905	567.28	Dilation of anal sphincter (separate procedure) under anesthesia other than local
45910	567.28	Dilation of rectal stricture (separate procedure) under anesthesia other than local
45915	358.78	Removal of fecal impaction or foreign body (separate procedure) under anesthesia
45990	558.09	Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic
46020	644.95	Placement of seton
46030	243.23	Removal of anal seton, other marker
46040	644.95	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)
46045	616.86	Incision and drainage of intramural, intramuscular, or submucosal abscess, transanal, under anesthesia
46050	358.78	Incision and drainage, perianal abscess, superficial
46060	616.86	Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton
46070	443.68	Incision, anal septum (infant)
46080	644.95	Sphincterotomy, anal, division of sphincter (separate procedure)
46083	67.91	Incision of thrombosed hemorrhoid, external
46200	616.86	Fissurectomy, with or without sphincterotomy
46210	616.86	Cryptectomy; single
46211	616.86	Cryptectomy; multiple (separate procedure)
46220	567.28	Papillectomy or excision of single tag, anus (separate procedure)
46221	111.66	Hemorrhoidectomy, by simple ligature (e.g., rubber band)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
46230	567.28	Excision of external hemorrhoid tags and/or multiple papillae
46250	644.95	Hemorrhoidectomy, external, complete
46255	644.95	Hemorrhoidectomy, internal and external, simple;
46257	644.95	Hemorrhoidectomy, internal and external, simple; with fissurectomy
46258	644.95	Hemorrhoidectomy, internal and external, simple; with fistulectomy, with or without fissurectomy
46260	644.95	Hemorrhoidectomy, internal and external, complex or extensive;
46261	697.60	Hemorrhoidectomy, internal and external, complex or extensive; with fissurectomy
46262	697.60	Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy
46270	644.95	Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous
46275	644.95	Surgical treatment of anal fistula (fistulectomy/fistulotomy); submuscular
46280	697.60	Surgical treatment of anal fistula (fistulectomy/fistulotomy); complex or multiple, with or without placement of seton
46285	567.28	Surgical treatment of anal fistula (fistulectomy/fistulotomy); second stage
46288	697.60	Closure of anal fistula with rectal advancement flap
46320	75.64	Enucleation or excision of external thrombotic hemorrhoid
46500	104.19	Injection of sclerosing solution, hemorrhoids
46505	443.68	Chemodenervation of internal anal sphincter
46600	23.47	Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
46604	331.75	Anoscopy; with dilation (e.g., balloon, guide wire, bougie)
46606	124.65	Anoscopy; with biopsy, single or multiple
46608	311.99	Anoscopy; with removal of foreign body
46610	576.27	Anoscopy; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
46611	311.99	Anoscopy; with removal of single tumor, polyp, or other lesion by snare technique
46612	576.27	Anoscopy; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
46614	65.57	Anoscopy; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
46615	625.85	Anoscopy; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
46700	644.95	Anoplasty, plastic operation for stricture; adult
46706	709.89	Repair of anal fistula with fibrin glue
46750	787.56	Sphincteroplasty, anal, for incontinence or prolapse; adult
46753	644.95	Graft (Thiersch operation) for rectal incontinence and/or prolapse
46754	616.86	Removal of Thiersch wire or suture, anal canal
46760	759.48	Sphincteroplasty, anal, for incontinence, adult; muscle transplant
46761	787.56	Sphincteroplasty, anal, for incontinence, adult; levator muscle imbrication (Park posterior anal repair)
46762	1,000.38	Sphincteroplasty, anal, for incontinence, adult; implantation artificial sphincter
46900	99.13	Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical
46910	118.48	Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation
46916	55.11	Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery
46917	514.06	Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery
46922	514.06	Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision
46924	514.06	Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)
46930	114.91	Destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency)
46937	616.86	Cryosurgery of rectal tumor; benign
46938	759.48	Cryosurgery of rectal tumor; malignant
46940	85.04	Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); initial

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
46942	82.77	Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); subsequent
46945	140.88	Ligation of internal hemorrhoids; single procedure
46946	367.96	Ligation of internal hemorrhoids; multiple procedures
46947	1,000.38	Hemorrhoidopexy (e.g., for prolapsing internal hemorrhoids) by stapling
47000	320.09	Biopsy of liver, needle; percutaneous
47382	1,689.21	Ablation, one or more liver tumor(s), percutaneous, radiofrequency
47510	748.08	Introduction of percutaneous transhepatic catheter for biliary drainage
47511	1,099.04	Introduction of percutaneous transhepatic stent for internal and external biliary drainage
47525	429.45	Change of percutaneous biliary drainage catheter
47530	429.45	Revision and/or reinsertion of transhepatic tube
47552	748.08	Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic, with or without collection of specimen(s) by brushing and/or washing (separate procedure)
47553	776.16	Biliary endoscopy, percutaneous via T-tube or other tract; with biopsy, single or multiple
47554	776.16	Biliary endoscopy, percutaneous via T-tube or other tract; with removal of calculus/calculi
47555	776.16	Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) without stent
47556	1,099.04	Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) with stent
47560	911.96	Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy
47561	911.96	Laparoscopy, surgical; with guided transhepatic cholangiography with biopsy
47562	1,682.76	Laparoscopy, surgical; cholecystectomy
47563	1,682.76	Laparoscopy, surgical; cholecystectomy with cholangiography
47564	1,682.76	Laparoscopy, surgical; cholecystectomy with exploration of common duct
47630	776.16	Biliary duct stone extraction, percutaneous via T-tube tract, basket, or snare (e.g., Burhenne technique)
48102	320.09	Biopsy of pancreas, percutaneous needle

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
49080	194.64	Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial
49081	194.64	Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); subsequent
49180	320.09	Biopsy, abdominal or retroperitoneal mass, percutaneous needle
49250	701.66	Umbilectomy, omphalectomy, excision of umbilicus (separate procedure)
49320	911.96	Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
49321	964.62	Laparoscopy, surgical; with biopsy (single or multiple)
49322	964.62	Laparoscopy, surgical; with aspiration of cavity or cyst (e.g., ovarian cyst) (single or multiple)
49324	1,376.35	Laparoscopy, surgical; with insertion of intraperitoneal cannula or catheter, permanent
49325	1,376.35	Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed
49326	1,376.35	Laparoscopy, surgical; with omentopexy (omental tacking procedure) (List separately in addition to code for primary procedure)
49402	620.92	Removal of peritoneal foreign body from peritoneal cavity
49419	744.88	Insertion of intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent (ie, totally implantable)
49420	688.59	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary
49421	688.59	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent
49422	548.01	Removal of permanent intraperitoneal cannula or catheter
49423	566.67	Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)
49426	620.92	Revision of peritoneal-venous shunt
49429	803.79	Removal of peritoneal-venous shunt
49440	314.32	Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
49441	314.32	Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image

Code	Fee	Description
		documentation and report
49446	314.32	Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
49450	166.95	Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
49451	166.95	Replacement of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
49452	166.95	Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
49460	166.95	Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s), if performed, image documentation and report
49495	851.54	Repair, initial inguinal hernia, full term infant younger than age 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; reducible
49496	851.54	Repair, initial inguinal hernia, full term infant younger than age 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; incarcerated or strangulated
49500	851.54	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducible
49501	1,162.64	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; incarcerated or strangulated
49505	851.54	Repair initial inguinal hernia, age 5 years or older; reducible
49507	1,162.64	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated
49520	1,011.70	Repair recurrent inguinal hernia, any age; reducible
49521	1,162.64	Repair recurrent inguinal hernia, any age; incarcerated or strangulated
49525	851.54	Repair inguinal hernia, sliding, any age
49540	770.80	Repair lumbar hernia

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
49550	889.71	Repair initial femoral hernia, any age; reducible
49553	1,162.64	Repair initial femoral hernia, any age; incarcerated or strangulated
49555	889.71	Repair recurrent femoral hernia; reducible
49557	1,162.64	Repair recurrent femoral hernia; incarcerated or strangulated
49560	851.54	Repair initial incisional or ventral hernia; reducible
49561	1,162.64	Repair initial incisional or ventral hernia; incarcerated or strangulated
49565	851.54	Repair recurrent incisional or ventral hernia; reducible
49566	1,162.64	Repair recurrent incisional or ventral hernia; incarcerated or strangulated
49568	1,011.70	Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to code for the incisional or ventral hernia repair)
49570	851.54	Repair epigastric hernia (e.g., preperitoneal fat); reducible (separate procedure)
49572	1,162.64	Repair epigastric hernia (e.g., preperitoneal fat); incarcerated or strangulated
49580	851.54	Repair umbilical hernia, younger than age 5 years; reducible
49582	1,162.64	Repair umbilical hernia, younger than age 5 years; incarcerated or strangulated
49585	851.54	Repair umbilical hernia, age 5 years or older; reducible
49587	1,162.64	Repair umbilical hernia, age 5 years or older; incarcerated or strangulated
49590	798.89	Repair spigelian hernia
49600	851.54	Repair of small omphalocele, with primary closure
49650	1,117.82	Laparoscopy, surgical; repair initial inguinal hernia
49651	1,277.98	Laparoscopy, surgical; repair recurrent inguinal hernia
49652	1,376.35	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible
49653	1,376.35	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated
49654	1,376.35	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible
49655	1,376.35	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
49656	1,376.35	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible
49657	1,376.35	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated
50200	320.09	Renal biopsy; percutaneous, by trocar or needle
50382	929.48	Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation
50384	682.69	Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation
50385	682.69	Removal (via snare/capture) and replacement of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation
50386	261.93	Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation
50387	566.67	Removal and replacement of externally accessible transnephric ureteral stent (e.g., external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation
50389	261.93	Removal of nephrostomy tube, requiring fluoroscopic guidance (e.g., with concurrent indwelling ureteral stent)
50390	320.09	Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous
50391	37.91	Instillation(s) of therapeutic agent into renal pelvis and/or ureter through established nephrostomy, pyelostomy or ureterostomy tube (e.g., anticarcinogenic or antifungal agent)
50392	487.46	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous
50393	610.86	Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous
50395	487.46	Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous
50396	91.66	Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral catheter

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
50398	429.45	Change of nephrostomy or pyelostomy tube
50551	277.08	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
50553	610.86	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter
50555	277.08	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
50557	610.86	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
50561	610.86	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50562	261.93	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with resection of tumor
50570	261.93	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
50572	261.93	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter
50574	261.93	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
50575	1,302.88	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with endopyelotomy (includes cystoscopy, ureteroscopy, dilation of ureter and ureteral pelvic junction, incision of ureteral pelvic junction and insertion of endopyelotomy stent)
50576	682.69	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
50580	682.69	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50590	1,522.06	Lithotripsy, extracorporeal shock wave
50592	1,689.21	Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency
50686	37.91	Manometric studies through ureterostomy or indwelling ureteral catheter
50688	429.45	Change of ureterostomy tube or externally accessible ureteral stent via ileal conduit
50947	1,428.92	Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placement
50948	1,428.92	Laparoscopy, surgical; ureteroneocystostomy without cystoscopy and ureteral stent placement
50951	277.08	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
50953	277.08	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter
50955	610.86	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
50957	610.86	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
50961	610.86	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50970	277.08	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
50972	277.08	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter
50974	487.46	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with

Code	Fee	Description
		biopsy
50976	487.46	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
50980	610.86	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
51020	741.19	Cystotomy or cystostomy; with fulguration and/or insertion of radioactive material
51030	741.19	Cystotomy or cystostomy; with cryosurgical destruction of intravesical lesion
51040	741.19	Cystostomy, cystotomy with drainage
51045	306.14	Cystotomy, with insertion of ureteral catheter or stent (separate procedure)
51050	741.19	Cystolithotomy, cystotomy with removal of calculus, without vesical neck resection
51065	741.19	Cystotomy, with calculus basket extraction and/or ultrasonic or electrohydraulic fragmentation of ureteral calculus
51080	498.25	Drainage of perivesical or prevesical space abscess
51100	28.89	Aspiration of bladder; by needle
51101	37.91	Aspiration of bladder; by trocar or intracatheter
51102	510.00	Aspiration of bladder; with insertion of suprapubic catheter
51500	851.54	Excision of urachal cyst or sinus, with or without umbilical hernia repair
51520	741.19	Cystotomy; for simple excision of vesical neck (separate procedure)
51700	49.34	Bladder irrigation, simple, lavage and/or instillation
51701	23.47	Insertion of non-indwelling bladder catheter (e.g., straight catheterization for residual urine)
51702	23.47	Insertion of temporary indwelling bladder catheter; simple (e.g., Foley)
51703	37.91	Insertion of temporary indwelling bladder catheter; complicated (e.g., altered anatomy, fractured catheter/balloon)
51705	67.91	Change of cystostomy tube; simple
51710	429.45	Change of cystostomy tube; complicated

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
51715	779.76	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck
51720	54.53	Bladder instillation of anticarcinogenic agent (including retention time)
51725	104.76	Simple cystometrogram (CMG) (e.g., spinal manometer)
51726	144.30	Complex cystometrogram (e.g., calibrated electronic equipment)
51736	19.80	Simple uroflowmetry (UFR) (e.g., stop-watch flow rate, mechanical uroflowmeter)
51741	23.05	Complex uroflowmetry (e.g., calibrated electronic equipment)
51772	91.66	Urethral pressure profile studies (UPP) (urethral closure pressure profile), any technique
51784	37.91	Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique
51785	63.32	Needle electromyography studies (EMG) of anal or urethral sphincter, any technique
51792	37.91	Stimulus evoked response (e.g., measurement of bulbocavernosus reflex latency time)
51795	67.91	Voiding pressure studies (VP); bladder voiding pressure, any technique
51797	67.91	Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal)
51798	16.88	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging
51880	610.86	Closure of cystostomy (separate procedure)
51992	1,156.00	Laparoscopy, surgical; sling operation for stress incontinence (e.g., fascia or synthetic)
52000	277.08	Cystourethroscopy (separate procedure)
52001	516.52	Cystourethroscopy with irrigation and evacuation of multiple obstructing clots
52005	537.04	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
52007	660.45	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis
52010	306.14	Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
52204	537.04	Cystourethroscopy, with biopsy(s)
52214	660.45	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands
52224	660.45	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy
52234	660.45	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)
52235	688.53	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
52240	688.53	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)
52250	741.19	Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration
52260	537.04	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia
52265	261.93	Cystourethroscopy, with dilation of bladder for interstitial cystitis; local anesthesia
52270	537.04	Cystourethroscopy, with internal urethrotomy; female
52275	660.45	Cystourethroscopy, with internal urethrotomy; male
52276	688.53	Cystourethroscopy with direct vision internal urethrotomy
52277	660.45	Cystourethroscopy, with resection of external sphincter (sphincterotomy)
52281	537.04	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female
52282	1,238.99	Cystourethroscopy, with insertion of urethral stent
52283	660.45	Cystourethroscopy, with steroid injection into stricture
52285	537.04	Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone
52290	537.04	Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
52300	660.45	Cystourethroscopy; with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral
52301	688.53	Cystourethroscopy; with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral
52305	660.45	Cystourethroscopy; with incision or resection of orifice of bladder diverticulum, single or multiple
52310	516.52	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple
52315	660.45	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated
52317	610.86	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)
52318	660.45	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; complicated or large (over 2.5 cm)
52320	779.36	Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus
52325	741.19	Cystourethroscopy (including ureteral catheterization); with fragmentation of ureteral calculus (e.g., ultrasonic or electro-hydraulic technique)
52327	847.14	Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material
52330	660.45	Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus
52332	660.45	Cystourethroscopy, with insertion of indwelling ureteral stent (e.g., Gibbons or double J type)
52334	688.53	Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde
52341	688.53	Cystourethroscopy; with treatment of ureteral stricture (e.g., balloon dilation, laser, electrocautery, and incision)
52342	688.53	Cystourethroscopy; with treatment of ureteropelvic junction stricture (e.g., balloon dilation, laser, electrocautery, and incision)
52343	688.53	Cystourethroscopy; with treatment of intra-renal stricture (e.g., balloon dilation, laser, electrocautery, and incision)
52344	688.53	Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (e.g., balloon dilation, laser, electrocautery, and incision)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
52345	688.53	Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (e.g., balloon dilation, laser, electrocautery, and incision)
52346	688.53	Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (e.g., balloon dilation, laser, electrocautery, and incision)
52351	688.53	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic
52352	741.19	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)
52353	927.88	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)
52354	741.19	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion
52355	741.19	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor
52400	688.53	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds
52402	688.53	Cystourethroscopy with transurethral resection or incision of ejaculatory ducts
52450	688.53	Transurethral incision of prostate
52500	688.53	Transurethral resection of bladder neck (separate procedure)
52601	927.88	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
52630	847.14	Transurethral resection; of regrowth of obstructive tissue longer than one year postoperative
52640	660.45	Transurethral resection; of postoperative bladder neck contracture
52647	1,419.57	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)
52648	1,419.57	Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)
52700	660.45	Transurethral drainage of prostatic abscess

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
53000	506.89	Urethrotomy or urethrostomy, external (separate procedure); pendulous urethra
53010	506.89	Urethrotomy or urethrostomy, external (separate procedure); perineal urethra, external
53020	506.89	Meatotomy, cutting of meatus (separate procedure); except infant
53025	721.54	Meatotomy, cutting of meatus (separate procedure); infant
53040	556.48	Drainage of deep periurethral abscess
53060	65.90	Drainage of Skenes gland abscess or cyst
53080	584.56	Drainage of perineal urinary extravasation; uncomplicated (separate procedure)
53085	721.54	Drainage of perineal urinary extravasation; complicated
53200	506.89	Biopsy of urethra
53210	870.59	Urethrectomy, total, including cystostomy; female
53215	675.39	Urethrectomy, total, including cystostomy; male
53220	751.67	Excision or fulguration of carcinoma of urethra
53230	751.67	Excision of urethral diverticulum (separate procedure); female
53235	584.56	Excision of urethral diverticulum (separate procedure); male
53240	751.67	Marsupialization of urethral diverticulum, male or female
53250	556.48	Excision of bulbourethral gland (Cowpers gland)
53260	556.48	Excision or fulguration; urethral polyp(s), distal urethra
53265	556.48	Excision or fulguration; urethral caruncle
53270	556.48	Excision or fulguration; Skenes glands
53275	556.48	Excision or fulguration; urethral prolapse
53400	779.76	Urethroplasty; first stage, for fistula, diverticulum, or stricture (e.g., Johannsen type)
53405	751.67	Urethroplasty; second stage (formation of urethra), including urinary diversion
53410	751.67	Urethroplasty, one-stage reconstruction of male anterior urethra
53420	779.76	Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	751.67	Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	751.67	Urethroplasty, reconstruction of female urethra
53431	751.67	Urethroplasty with tubularization of posterior urethra and/or lower bladder for incontinence (e.g., Tenago, Leadbetter procedure)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
53440	4,329.93	Sling operation for correction of male urinary incontinence (e.g., fascia or synthetic)
53442	702.09	Removal or revision of sling for male urinary incontinence (e.g., fascia or synthetic)
53444	4,329.93	Insertion of tandem cuff (dual cuff)
53445	7,273.18	Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff
53446	702.09	Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
53447	7,273.18	Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff at the same operative session
53449	702.09	Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
53450	702.09	Urethromeatoplasty, with mucosal advancement
53460	506.89	Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)
53502	556.48	Urethrorrhaphy, suture of urethral wound or injury, female
53505	751.67	Urethrorrhaphy, suture of urethral wound or injury; penile
53510	556.48	Urethrorrhaphy, suture of urethral wound or injury; perineal
53515	751.67	Urethrorrhaphy, suture of urethral wound or injury; prostatomembranous
53520	751.67	Closure of urethrostomy or urethrocutaneous fistula, male (separate procedure)
53600	37.98	Dilation of urethral stricture by passage of sound or urethral dilator, male; initial
53601	37.91	Dilation of urethral stricture by passage of sound or urethral dilator, male; subsequent
53605	537.04	Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia
53620	58.43	Dilation of urethral stricture by passage of filiform and follower, male; initial
53621	61.35	Dilation of urethral stricture by passage of filiform and follower, male; subsequent
53660	37.91	Dilation of female urethra including suppository and/or instillation; initial
53661	37.91	Dilation of female urethra including suppository and/or instillation; subsequent

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
53665	506.89	Dilation of female urethra, general or conduction (spinal) anesthesia
53850	1,664.06	Transurethral destruction of prostate tissue; by microwave thermotherapy
53852	1,664.06	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy
54000	556.48	Slitting of prepuce, dorsal or lateral (separate procedure); newborn
54001	556.48	Slitting of prepuce, dorsal or lateral (separate procedure); except newborn
54015	628.58	Incision and drainage of penis, deep
54050	30.08	Destruction of lesion(s), penis (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical
54055	61.35	Destruction of lesion(s), penis (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation
54056	30.08	Destruction of lesion(s), penis (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery
54057	514.06	Destruction of lesion(s), penis (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery
54060	514.06	Destruction of lesion(s), penis (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision
54065	514.06	Destruction of lesion(s), penis (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)
54100	434.86	Biopsy of penis; (separate procedure)
54105	542.85	Biopsy of penis; deep structures
54110	841.65	Excision of penile plaque (Peyronie disease);
54111	841.65	Excision of penile plaque (Peyronie disease); with graft to 5 cm in length
54112	841.65	Excision of penile plaque (Peyronie disease); with graft greater than 5 cm in length
54115	498.25	Removal foreign body from deep penile tissue (e.g., plastic implant)
54120	841.65	Amputation of penis; partial
54150	560.92	Circumcision, using clamp or other device with regional dorsal penile or ring block
54160	610.51	Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days of age or less)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
54161	610.51	Circumcision, surgical excision other than clamp, device, or dorsal slit; older than 28 days of age
54162	610.51	Lysis or excision of penile post-circumcision adhesions
54163	610.51	Repair incomplete circumcision
54164	610.51	Frenulotomy of penis
54200	63.95	Injection procedure for Peyronie disease;
54205	922.39	Injection procedure for Peyronie disease; with surgical exposure of plaque
54220	91.66	Irrigation of corpora cavernosa for priapism
54231	60.05	Dynamic cavernosometry, including intracavernosal injection of vasoactive drugs (e.g., papaverine, phentolamine)
54235	42.53	Injection of corpora cavernosa with pharmacologic agent(s) (e.g., papaverine, phentolamine)
54240	30.19	Penile plethysmography
54250	10.71	Nocturnal penile tumescence and/or rigidity test
54300	869.73	Plastic operation of penis for straightening of chordee (e.g., hypospadias), with or without mobilization of urethra
54304	869.73	Plastic operation on penis for correction of chordee or for first stage hypospadias repair with or without transplantation of prepuce and/or skin flaps
54308	869.73	Urethroplasty for second stage hypospadias repair (including urinary diversion); less than 3 cm
54312	869.73	Urethroplasty for second stage hypospadias repair (including urinary diversion); greater than 3 cm
54316	869.73	Urethroplasty for second stage hypospadias repair (including urinary diversion) with free skin graft obtained from site other than genitalia
54318	869.73	Urethroplasty for third stage hypospadias repair to release penis from scrotum (e.g., third stage Cecil repair)
54322	869.73	One stage distal hypospadias repair (with or without chordee or circumcision); with simple meatal advancement (e.g., Magpi, V-flap)
54324	869.73	One stage distal hypospadias repair (with or without chordee or circumcision); with urethroplasty by local skin flaps (e.g., flip-flap, prepucial flap)
54326	869.73	One stage distal hypospadias repair (with or without chordee or circumcision); with urethroplasty by local skin flaps and mobilization of urethra

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
54328	869.73	One stage distal hypospadias repair (with or without chordee or circumcision); with extensive dissection to correct chordee and urethroplasty with local skin flaps, skin graft patch, and/or island flap
54340	869.73	Repair of hypospadias complications (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple
54344	869.73	Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring mobilization of skin flaps and urethroplasty with flap or patch graft
54348	869.73	Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring extensive dissection and urethroplasty with flap, patch or tubed graft (includes urinary diversion)
54352	869.73	Repair of hypospadias cripple requiring extensive dissection and excision of previously constructed structures including re-release of chordee and reconstruction of urethra and penis by use of local skin as grafts and island flaps and skin brought in as flaps or grafts
54360	869.73	Plastic operation on penis to correct angulation
54380	869.73	Plastic operation on penis for epispadias distal to external sphincter;
54385	869.73	Plastic operation on penis for epispadias distal to external sphincter; with incontinence
54400	4,358.02	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	7,350.85	Insertion of penile prosthesis; inflatable (self-contained)
54405	7,350.85	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54406	869.73	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408	869.73	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	7,350.85	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54415	869.73	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	7,350.85	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54420	922.39	Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
54435	922.39	Corpora cavernosa-glans penis fistulization (e.g., biopsy needle, Winter procedure, rongeur, or punch) for priapism
54440	922.39	Plastic operation of penis for injury
54450	144.30	Foreskin manipulation including lysis of preputial adhesions and stretching
54500	391.64	Biopsy of testis, needle (separate procedure)
54505	560.92	Biopsy of testis, incisional (separate procedure)
54512	610.51	Excision of extraparenchymal lesion of testis
54520	638.59	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54522	638.59	Orchiectomy, partial
54530	851.54	Orchiectomy, radical, for tumor; inguinal approach
54550	851.54	Exploration for undescended testis (inguinal or scrotal area)
54560	829.60	Exploration for undescended testis with abdominal exploration
54600	691.25	Reduction of torsion of testis, surgical, with or without fixation of contralateral testis
54620	638.59	Fixation of contralateral testis (separate procedure)
54640	851.54	Orchiopexy, inguinal approach, with or without hernia repair
54660	610.51	Insertion of testicular prosthesis (separate procedure)
54670	638.59	Suture or repair of testicular injury
54680	638.59	Transplantation of testis(es) to thigh (because of scrotal destruction)
54690	1,428.92	Laparoscopy, surgical; orchiectomy
54692	2,540.04	Laparoscopy, surgical; orchiopexy for intra-abdominal testis
54700	610.51	Incision and drainage of epididymis, testis and/or scrotal space (e.g., abscess or hematoma)
54800	137.03	Biopsy of epididymis, needle
54830	638.59	Excision of local lesion of epididymis
54840	691.25	Excision of spermatocele, with or without epididymectomy
54860	638.59	Epididymectomy; unilateral
54861	691.25	Epididymectomy; bilateral
54865	560.92	Exploration of epididymis, with or without biopsy
54900	691.25	Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral
54901	691.25	Epididymovasostomy, anastomosis of epididymis to vas deferens; bilateral

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
55000	62.33	Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication
55040	798.89	Excision of hydrocele; unilateral
55041	889.71	Excision of hydrocele; bilateral
55060	691.25	Repair of tunica vaginalis hydrocele (Bottle type)
55100	374.89	Drainage of scrotal wall abscess
55110	610.51	Scrotal exploration
55120	610.51	Removal of foreign body in scrotum
55150	560.92	Resection of scrotum
55175	560.92	Scrotoplasty; simple
55180	610.51	Scrotoplasty; complicated
55200	610.51	Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)
55250	610.51	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
55400	560.92	Vasovasostomy, vasovasorrhaphy
55450	200.60	Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)
55500	638.59	Excision of hydrocele of spermatic cord, unilateral (separate procedure)
55520	691.25	Excision of lesion of spermatic cord (separate procedure)
55530	691.25	Excision of varicocele or ligation of spermatic veins for varicocele; (separate procedure)
55535	851.54	Excision of varicocele or ligation of spermatic veins for varicocele; abdominal approach
55540	889.71	Excision of varicocele or ligation of spermatic veins for varicocele; with hernia repair
55550	1,428.92	Laparoscopy, surgical, with ligation of spermatic veins for varicocele
55600	829.60	Vesiculotomy;
55680	560.92	Excision of Mullerian duct cyst
55700	361.49	Biopsy, prostate; needle or punch, single or multiple, any approach
55705	361.49	Biopsy, prostate; incisional, any approach
55706	419.48	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance
55720	610.86	Prostatotomy, external drainage of prostatic abscess, any approach; simple
55725	660.45	Prostatotomy, external drainage of prostatic abscess, any approach;

Code	Fee	Description
		complicated
55860	727.78	Exposure of prostate, any approach, for insertion of radioactive substance;
55870	74.01	Electroejaculation
55873	5,758.44	Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)
55875	1,238.99	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy
55876	67.84	Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple
55920	850.45	Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application
56405	39.60	Incision and drainage of vulva or perineal abscess
56420	51.69	Incision and drainage of Bartholins gland abscess
56440	555.04	Marsupialization of Bartholins gland cyst
56441	505.45	Lysis of labial adhesions
56442	505.45	Hymenotomy, simple incision
56501	54.53	Destruction of lesion(s), vulva; simple (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)
56515	591.73	Destruction of lesion(s), vulva; extensive (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)
56605	31.48	Biopsy of vulva or perineum (separate procedure); one lesion
56606	12.99	Biopsy of vulva or perineum (separate procedure); each separate additional lesion (List separately in addition to code for primary procedure)
56620	673.95	Vulvectomy simple; partial
56625	795.93	Vulvectomy simple; complete
56700	505.45	Partial hymenectomy or revision of hymenal ring
56740	583.12	Excision of Bartholins gland or cyst
56800	583.12	Plastic repair of introitus
56805	718.67	Clitoroplasty for intersex state
56810	673.95	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
56820	40.25	Colposcopy of the vulva;
56821	51.69	Colposcopy of the vulva; with biopsy(s)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
57000	505.45	Colpotomy; with exploration
57010	555.04	Colpotomy; with drainage of pelvic abscess
57020	291.09	Colpocentesis (separate procedure)
57022	457.54	Incision and drainage of vaginal hematoma; obstetrical/postpartum
57023	498.25	Incision and drainage of vaginal hematoma; non-obstetrical (e.g., post-trauma, spontaneous bleeding)
57061	50.31	Destruction of vaginal lesion(s); simple (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)
57065	505.45	Destruction of vaginal lesion(s); extensive (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)
57100	32.14	Biopsy of vaginal mucosa; simple (separate procedure)
57105	555.04	Biopsy of vaginal mucosa; extensive, requiring suture (including cysts)
57130	555.04	Excision of vaginal septum
57135	555.04	Excision of vaginal cyst or tumor
57150	23.37	Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease
57155	291.09	Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy
57160	33.76	Fitting and insertion of pessary or other intravaginal support device
57170	5.54	Diaphragm or cervical cap fitting with instructions
57180	103.97	Introduction of any hemostatic agent or pack for spontaneous or traumatic nonobstetrical vaginal hemorrhage (separate procedure)
57200	505.45	Colporrhaphy, suture of injury of vagina (nonobstetrical)
57210	555.04	Colpoperineorrhaphy, suture of injury of vagina and/or perineum (nonobstetrical)
57220	1,017.86	Plastic operation on urethral sphincter, vaginal approach (e.g., Kelly urethral plication)
57230	835.76	Plastic repair of urethrocele
57240	926.59	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele
57250	926.59	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy
57260	926.59	Combined anteroposterior colporrhaphy;
57265	1,230.68	Combined anteroposterior colporrhaphy; with enterocele repair

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
57267	1,048.57	Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)
57268	835.76	Repair of enterocele, vaginal approach (separate procedure)
57287	1,223.95	Removal or revision of sling for stress incontinence (e.g., fascia or synthetic)
57288	1,108.69	Sling operation for stress incontinence (e.g., fascia or synthetic)
57289	926.59	Pereyra procedure, including anterior colporrhaphy
57291	926.59	Construction of artificial vagina; without graft
57300	835.76	Closure of rectovaginal fistula; vaginal or transanal approach
57320	1,223.95	Closure of vesicovaginal fistula; vaginal approach
57400	555.04	Dilation of vagina under anesthesia
57410	555.04	Pelvic examination under anesthesia
57415	555.04	Removal of impacted vaginal foreign body (separate procedure) under anesthesia
57420	41.55	Colposcopy of the entire vagina, with cervix if present;
57421	54.21	Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix
57452	39.28	Colposcopy of the cervix including upper/adjacent vagina;
57454	48.04	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage
57455	50.96	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix
57456	49.34	Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage
57460	151.59	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix
57461	161.00	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix
57500	69.46	Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)
57505	44.15	Endocervical curettage (not done as part of a dilation and curettage)
57510	44.79	Cautery of cervix; electro or thermal
57511	51.69	Cautery of cervix; cryocautery, initial or repeat
57513	555.04	Cautery of cervix; laser ablation

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
57520	555.04	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser
57522	555.04	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision
57530	835.76	Trachelectomy (cervicectomy), amputation of cervix (separate procedure)
57550	835.76	Excision of cervical stump, vaginal approach;
57556	1,108.69	Excision of cervical stump, vaginal approach; with repair of enterocele
57558	583.12	Dilation and curettage of cervical stump
57700	505.45	Cerclage of uterine cervix, nonobstetrical
57720	583.12	Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach
57800	23.70	Dilation of cervical canal, instrumental (separate procedure)
58100	38.95	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
58120	555.04	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
58145	926.59	Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; vaginal approach
58301	36.35	Removal of intrauterine device (IUD)
58321	34.08	Artificial insemination; intra-cervical
58322	35.06	Artificial insemination; intra-uterine
58323	8.12	Sperm washing for artificial insemination
58345	718.67	Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography
58346	555.04	Insertion of Heyman capsules for clinical brachytherapy
58350	835.76	Chromotubation of oviduct, including materials
58353	1,048.57	Endometrial ablation, thermal, without hysteroscopic guidance
58356	1,588.16	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed
58545	1,275.72	Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 g or less and/or removal of surface myomas
58546	1,428.92	Laparoscopy, surgical, myomectomy, excision; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g
58550	1,857.56	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or

Code	Fee	Description
		less;
58552	1,682.76	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58555	546.11	Hysteroscopy, diagnostic (separate procedure)
58558	623.78	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C
58559	595.70	Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)
58560	889.43	Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)
58561	889.43	Hysteroscopy, surgical; with removal of leiomyomata
58562	623.78	Hysteroscopy, surgical; with removal of impacted foreign body
58563	1,253.18	Hysteroscopy, surgical; with endometrial ablation (e.g., endometrial resection, electrosurgical ablation, thermoablation)
58565	1,381.63	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
58600	1,223.95	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58615	718.67	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58660	1,156.00	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)
58661	1,156.00	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58662	1,156.00	Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method
58670	1,065.17	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671	1,065.17	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
58672	1,156.00	Laparoscopy, surgical; with fimbrioplasty
58673	1,156.00	Laparoscopy, surgical; with salpingostomy (salpingoneostomy)
58800	583.12	Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); vaginal approach

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
58805	1,223.95	Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); abdominal approach
58820	835.76	Drainage of ovarian abscess; vaginal approach, open
58900	583.12	Biopsy of ovary, unilateral or bilateral (separate procedure)
58970	162.42	Follicle puncture for oocyte retrieval, any method
58974	162.42	Embryo transfer, intrauterine
58976	162.42	Gamete, zygote, or embryo intrafallopian transfer, any method
59000	59.40	Amniocentesis; diagnostic
59001	222.97	Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)
59012	109.03	Cordocentesis (intrauterine), any method
59015	48.04	Chorionic villus sampling, any method
59020	25.32	Fetal contraction stress test
59025	13.31	Fetal non-stress test
59070	109.03	Transabdominal amnioinfusion, including ultrasound guidance
59072	109.03	Fetal umbilical cord occlusion, including ultrasound guidance
59076	109.03	Fetal shunt placement, including ultrasound guidance
59100	1,223.95	Hysterotomy, abdominal (e.g., for hydatidiform mole, abortion)
59150	1,682.76	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy
59151	1,682.76	Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy
59160	583.12	Curettage, postpartum
59200	32.46	Insertion of cervical dilator (e.g., laminaria, prostaglandin) (separate procedure)
59300	70.11	Episiotomy or vaginal repair, by other than attending physician
59320	505.45	Cerclage of cervix, during pregnancy; vaginal
59412	718.67	External cephalic version, with or without tocolysis
59414	718.67	Delivery of placenta (separate procedure)
59812	673.95	Treatment of incomplete abortion, any trimester, completed surgically
59820	673.95	Treatment of missed abortion, completed surgically; first trimester
59821	673.95	Treatment of missed abortion, completed surgically; second trimester
59840	673.95	Induced abortion, by dilation and curettage
59841	673.95	Induced abortion, by dilation and evacuation

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
59866	109.03	Multifetal pregnancy reduction(s) (MPR)
59870	673.95	Uterine evacuation and curettage for hydatidiform mole
59871	673.95	Removal of cerclage suture under anesthesia (other than local)
60000	282.94	Incision and drainage of thyroglossal duct cyst, infected
60100	44.47	Biopsy thyroid, percutaneous core needle
60200	1,053.12	Excision of cyst or adenoma of thyroid, or transection of isthmus
60280	1,133.86	Excision of thyroglossal duct cyst or sinus;
60281	1,133.86	Excision of thyroglossal duct cyst or sinus; recurrent
60300	58.43	Aspiration and/or injection, thyroid cyst
61000	260.53	Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; initial
61001	260.53	Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; subsequent taps
61020	210.93	Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; without injection
61026	210.93	Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; with injection of medication or other substance for diagnosis or treatment
61050	210.93	Cisternal or lateral cervical (C1-C2) puncture; without injection (separate procedure)
61055	210.93	Cisternal or lateral cervical (C1-C2) puncture; with injection of medication or other substance for diagnosis or treatment (e.g., C1-C2)
61070	164.13	Puncture of shunt tubing or reservoir for aspiration or injection procedure
61215	987.38	Insertion of subcutaneous reservoir, pump or continuous infusion system for connection to ventricular catheter
61330	1,521.12	Decompression of orbit only, transcranial approach
61334	1,521.12	Exploration of orbit (transcranial approach); with removal of foreign body
61790	560.00	Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (e.g., alcohol, thermal, electrical, radiofrequency); gasserian ganglion
61791	415.46	Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (e.g., alcohol, thermal, electrical, radiofrequency); trigeminal medullary tract
61880	713.37	Revision or removal of intracranial neurostimulator electrodes

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
61885	10,265.47	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
61886	15,328.85	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays
61888	682.77	Revision or removal of cranial neurostimulator pulse generator or receiver
62194	276.38	Replacement or irrigation, subarachnoid/subdural catheter
62225	429.45	Replacement or irrigation, ventricular catheter
62230	959.29	Replacement or revision of cerebrospinal fluid shunt, obstructed valve, or distal catheter in shunt system
62252	43.50	Reprogramming of programmable cerebrospinal shunt
62263	276.38	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
62264	407.15	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
62267	162.48	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming
62268	210.93	Percutaneous aspiration, spinal cord cyst or syrinx
62269	320.09	Biopsy of spinal cord, percutaneous needle
62270	127.29	Spinal puncture, lumbar, diagnostic
62272	127.29	Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter)
62273	212.41	Injection, epidural, of blood or clot patch
62280	276.38	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid
62281	276.38	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic
62282	276.38	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
62287	1,240.70	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method, single or multiple levels, lumbar (e.g., manual or automated percutaneous discectomy, percutaneous laser discectomy)
62292	260.53	Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar
62294	210.93	Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal
62310	276.38	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic
62311	276.38	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)
62318	276.38	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic
62319	276.38	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)
62350	959.29	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy
62355	456.74	Removal of previously implanted intrathecal or epidural catheter
62360	959.29	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
62361	9,847.26	Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
62362	9,847.26	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming
62365	848.85	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion
62367	15.58	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming
62368	19.80	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming
63600	531.92	Creation of lesion of spinal cord by stereotactic method, percutaneous, any modality (including stimulation and/or recording)
63610	482.33	Stereotactic stimulation of spinal cord, percutaneous, separate procedure not followed by other surgery
63615	672.43	Stereotactic biopsy, aspiration, or excision of lesion, spinal cord
63650	2,863.04	Percutaneous implantation of neurostimulator electrode array, epidural
63655	4,193.65	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63660	502.80	Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)
63685	12,728.69	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
63688	682.77	Revision or removal of implanted spinal neurostimulator pulse generator or receiver
63744	987.38	Replacement, irrigation or revision of lumbosubarachnoid shunt
63746	456.74	Removal of entire lumbosubarachnoid shunt system without replacement
64400	49.99	Injection, anesthetic agent; trigeminal nerve, any division or branch
64402	47.07	Injection, anesthetic agent; facial nerve
64405	39.92	Injection, anesthetic agent; greater occipital nerve
64408	49.66	Injection, anesthetic agent; vagus nerve
64410	276.38	Injection, anesthetic agent; phrenic nerve
64412	73.04	Injection, anesthetic agent; spinal accessory nerve
64413	46.75	Injection, anesthetic agent; cervical plexus

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
64415	127.29	Injection, anesthetic agent; brachial plexus, single
64416	260.53	Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration
64417	127.29	Injection, anesthetic agent; axillary nerve
64418	65.57	Injection, anesthetic agent; suprascapular nerve
64420	127.29	Injection, anesthetic agent; intercostal nerve, single
64421	276.38	Injection, anesthetic agent; intercostal nerves, multiple, regional block
64425	45.44	Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves
64430	191.26	Injection, anesthetic agent; pudendal nerve
64435	68.49	Injection, anesthetic agent; paracervical (uterine) nerve
64445	60.70	Injection, anesthetic agent; sciatic nerve, single
64446	522.07	Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter, (including catheter placement) including daily management for anesthetic agent administration
64447	132.59	Injection, anesthetic agent; femoral nerve, single
64448	132.59	Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration
64449	260.53	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration
64450	40.57	Injection, anesthetic agent; other peripheral nerve or branch
64455	16.88	Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (e.g., Morton's neuroma)
64470	276.38	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level
64472	212.41	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64475	276.38	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level
64476	191.30	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
64479	276.38	Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, single level
64480	212.41	Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64483	276.38	Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level
64484	212.41	Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
64505	37.01	Injection, anesthetic agent; sphenopalatine ganglion
64508	78.55	Injection, anesthetic agent; carotid sinus (separate procedure)
64510	276.38	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)
64517	191.26	Injection, anesthetic agent; superior hypogastric plexus
64520	276.38	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)
64530	276.38	Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring
64553	2,813.45	Percutaneous implantation of neurostimulator electrodes; cranial nerve
64555	3,159.33	Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve)
64560	3,159.33	Percutaneous implantation of neurostimulator electrodes; autonomic nerve
64561	2,891.12	Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)
64565	3,159.33	Percutaneous implantation of neurostimulator electrodes; neuromuscular
64573	4,921.77	Incision for implantation of neurostimulator electrodes; cranial nerve
64575	3,762.29	Incision for implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve)
64577	3,762.29	Incision for implantation of neurostimulator electrodes; autonomic nerve
64580	3,762.29	Incision for implantation of neurostimulator electrodes; neuromuscular
64581	3,839.96	Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)
64585	502.80	Revision or removal of peripheral neurostimulator electrodes

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
64590	10,265.47	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
64595	682.77	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver
64600	407.15	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch
64605	407.15	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale
64610	407.15	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring
64612	59.40	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)
64613	57.46	Chemodenervation of muscle(s); neck muscle(s) (e.g., for spasmodic torticollis, spasmodic dysphonia)
64614	65.57	Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (e.g., for dystonia, cerebral palsy, multiple sclerosis)
64620	276.38	Destruction by neurolytic agent, intercostal nerve
64622	407.15	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level
64623	276.38	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
64626	407.15	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level
64627	191.30	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64630	284.69	Destruction by neurolytic agent; pudendal nerve
64632	30.83	Destruction by neurolytic agent; plantar common digital nerve
64640	91.86	Destruction by neurolytic agent; other peripheral nerve or branch
64650	30.83	Chemodenervation of eccrine glands; both axillae
64653	33.44	Chemodenervation of eccrine glands; other area(s) (e.g., scalp, face, neck), per day
64680	432.59	Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
64681	456.74	Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus
64702	482.33	Neuroplasty; digital, one or both, same digit
64704	482.33	Neuroplasty; nerve of hand or foot
64708	531.92	Neuroplasty, major peripheral nerve, arm or leg; other than specified
64712	531.92	Neuroplasty, major peripheral nerve, arm or leg; sciatic nerve
64713	531.92	Neuroplasty, major peripheral nerve, arm or leg; brachial plexus
64714	531.92	Neuroplasty, major peripheral nerve, arm or leg; lumbar plexus
64716	560.00	Neuroplasty and/or transposition; cranial nerve (specify)
64718	531.92	Neuroplasty and/or transposition; ulnar nerve at elbow
64719	531.92	Neuroplasty and/or transposition; ulnar nerve at wrist
64721	531.92	Neuroplasty and/or transposition; median nerve at carpal tunnel
64722	482.33	Decompression; unspecified nerve(s) (specify)
64726	482.33	Decompression; plantar digital nerve
64727	482.33	Internal neurolysis, requiring use of operating microscope (List separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis)
64732	531.92	Transection or avulsion of; supraorbital nerve
64734	531.92	Transection or avulsion of; infraorbital nerve
64736	531.92	Transection or avulsion of; mental nerve
64738	531.92	Transection or avulsion of; inferior alveolar nerve by osteotomy
64740	531.92	Transection or avulsion of; lingual nerve
64742	531.92	Transection or avulsion of; facial nerve, differential or complete
64744	531.92	Transection or avulsion of; greater occipital nerve
64746	531.92	Transection or avulsion of; phrenic nerve
64761	672.43	Transection or avulsion of; pudendal nerve
64763	672.43	Transection or avulsion of obturator nerve, extrapelvic, with or without adductor tenotomy
64766	1,306.30	Transection or avulsion of obturator nerve, intrapelvic, with or without adductor tenotomy
64771	531.92	Transection or avulsion of other cranial nerve, extradural
64772	531.92	Transection or avulsion of other spinal nerve, extradural
64774	531.92	Excision of neuroma; cutaneous nerve, surgically identifiable
64776	560.00	Excision of neuroma; digital nerve, one or both, same digit

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
64778	531.92	Excision of neuroma; digital nerve, each additional digit (List separately in addition to code for primary procedure)
64782	560.00	Excision of neuroma; hand or foot, except digital nerve
64783	531.92	Excision of neuroma; hand or foot, each additional nerve, except same digit (List separately in addition to code for primary procedure)
64784	560.00	Excision of neuroma; major peripheral nerve, except sciatic
64786	876.93	Excision of neuroma; sciatic nerve
64787	531.92	Implantation of nerve end into bone or muscle (List separately in addition to neuroma excision)
64788	560.00	Excision of neurofibroma or neurolemmoma; cutaneous nerve
64790	560.00	Excision of neurofibroma or neurolemmoma; major peripheral nerve
64792	876.93	Excision of neurofibroma or neurolemmoma; extensive (including malignant type)
64795	531.92	Biopsy of nerve
64802	531.92	Sympathectomy, cervical
64820	672.43	Sympathectomy; digital arteries, each digit
64821	785.00	Sympathectomy; radial artery
64822	1,017.11	Sympathectomy; ulnar artery
64823	1,017.11	Sympathectomy; superficial palmar arch
64831	929.59	Suture of digital nerve, hand or foot; one nerve
64832	799.26	Suture of digital nerve, hand or foot; each additional digital nerve (List separately in addition to code for primary procedure)
64834	848.85	Suture of one nerve, hand or foot; common sensory nerve
64835	876.93	Suture of one nerve, hand or foot; median motor thenar
64836	876.93	Suture of one nerve, hand or foot; ulnar motor
64837	799.26	Suture of each additional nerve, hand or foot (List separately in addition to code for primary procedure)
64840	848.85	Suture of posterior tibial nerve
64856	848.85	Suture of major peripheral nerve, arm or le.g., except sciatic; including transposition
64857	848.85	Suture of major peripheral nerve, arm or le.g., except sciatic; without transposition
64858	848.85	Suture of sciatic nerve
64859	799.26	Suture of each additional major peripheral nerve (List separately in addition to code for primary procedure)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
64861	876.93	Suture of; brachial plexus
64862	876.93	Suture of; lumbar plexus
64864	876.93	Suture of facial nerve; extracranial
64865	929.59	Suture of facial nerve; infratemporal, with or without grafting
64870	929.59	Anastomosis; facial-phrenic
64872	848.85	Suture of nerve; requiring secondary or delayed suture (List separately in addition to code for primary neurorrhaphy)
64874	876.93	Suture of nerve; requiring extensive mobilization, or transposition of nerve (List separately in addition to code for nerve suture)
64876	876.93	Suture of nerve; requiring shortening of bone of extremity (List separately in addition to code for nerve suture)
64885	848.85	Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length
64886	848.85	Nerve graft (includes obtaining graft), head or neck; more than 4 cm length
64890	848.85	Nerve graft (includes obtaining graft), single strand, hand or foot; up to 4 cm length
64891	848.85	Nerve graft (includes obtaining graft), single strand, hand or foot; more than 4 cm length
64892	848.85	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length
64893	848.85	Nerve graft (includes obtaining graft), single strand, arm or leg; more than 4 cm length
64895	876.93	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length
64896	876.93	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length
64897	876.93	Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; up to 4 cm length
64898	876.93	Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; more than 4 cm length
64901	848.85	Nerve graft, each additional nerve; single strand (List separately in addition to code for primary procedure)
64902	848.85	Nerve graft, each additional nerve; multiple strands (cable) (List separately in addition to code for primary procedure)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
64905	848.85	Nerve pedicle transfer; first stage
64907	799.26	Nerve pedicle transfer; second stage
64910	1,306.30	Nerve repair; with synthetic conduit or vein allograft (e.g., nerve tube), each nerve
65091	923.36	Evisceration of ocular contents; without implant
65093	923.36	Evisceration of ocular contents; with implant
65101	923.36	Enucleation of eye; without implant
65103	923.36	Enucleation of eye; with implant, muscles not attached to implant
65105	976.02	Enucleation of eye; with implant, muscles attached to implant
65110	1,014.19	Exenteration of orbit (does not include skin graft), removal of orbital contents; only
65112	1,136.18	Exenteration of orbit (does not include skin graft), removal of orbital contents; with therapeutic removal of bone
65114	1,136.18	Exenteration of orbit (does not include skin graft), removal of orbital contents; with muscle or myocutaneous flap
65125	945.58	Modification of ocular implant with placement or replacement of pegs (e.g., drilling receptacle for prosthesis appendage) (separate procedure)
65130	696.57	Insertion of ocular implant secondary; after evisceration, in scleral shell
65135	668.49	Insertion of ocular implant secondary; after enucleation, muscles not attached to implant
65140	923.36	Insertion of ocular implant secondary; after enucleation, muscles attached to implant
65150	668.49	Reinsertion of ocular implant; with or without conjunctival graft
65155	923.36	Reinsertion of ocular implant; with use of foreign material for reinforcement and/or attachment of muscles to implant
65175	496.92	Removal of ocular implant
65205	19.15	Removal of foreign body, external eye; conjunctival superficial
65210	24.35	Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating
65220	33.92	Removal of foreign body, external eye; corneal, without slit lamp
65222	26.61	Removal of foreign body, external eye; corneal, with slit lamp
65235	499.77	Removal of foreign body, intraocular; from anterior chamber of eye or lens
65260	329.63	Removal of foreign body, intraocular; from posterior segment, magnetic extraction, anterior or posterior route

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
65265	681.97	Removal of foreign body, intraocular; from posterior segment, nonmagnetic extraction
65270	546.50	Repair of laceration; conjunctiva, with or without nonperforating laceration sclera, direct closure
65272	629.73	Repair of laceration; conjunctiva, by mobilization and rearrangement, without hospitalization
65275	710.47	Repair of laceration; cornea, nonperforating, with or without removal foreign body
65280	681.97	Repair of laceration; cornea and/or sclera, perforating, not involving uveal tissue
65285	969.81	Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue
65286	169.67	Repair of laceration; application of tissue glue, wounds of cornea and/or sclera
65290	671.61	Repair of wound, extraocular muscle, tendon and/or Tenons capsule
65400	450.19	Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium
65410	499.77	Biopsy of cornea
65420	499.77	Excision or transposition of pterygium; without graft
65426	748.65	Excision or transposition of pterygium; with graft
65430	33.92	Scraping of cornea, diagnostic, for smear and/or culture
65435	29.54	Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)
65436	128.21	Removal of corneal epithelium; with application of chelating agent (e.g., EDTA)
65450	78.27	Destruction of lesion of cornea by cryotherapy, photocoagulation or thermocauterization
65600	151.26	Multiple punctures of anterior cornea (e.g., for corneal erosion, tattoo)
65710	1,126.19	Keratoplasty (corneal transplant); lamellar
65730	1,126.19	Keratoplasty (corneal transplant); penetrating (except in aphakia)
65750	1,126.19	Keratoplasty (corneal transplant); penetrating (in aphakia)
65755	1,126.19	Keratoplasty (corneal transplant); penetrating (in pseudophakia)
65756	1,379.17	Keratoplasty (corneal transplant); endothelial
65770	5,160.46	Keratoprosthesis
65772	580.51	Corneal relaxing incision for correction of surgically induced astigmatism

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
65775	580.51	Corneal wedge resection for correction of surgically induced astigmatism
65780	1,004.20	Ocular surface reconstruction; amniotic membrane transplantation
65781	1,004.20	Ocular surface reconstruction; limbal stem cell allograft (e.g., cadaveric or living donor)
65782	1,004.20	Ocular surface reconstruction; limbal conjunctival autograft (includes obtaining graft)
65800	450.19	Paracentesis of anterior chamber of eye (separate procedure); with diagnostic aspiration of aqueous
65805	450.19	Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous
65810	657.82	Paracentesis of anterior chamber of eye (separate procedure); with removal of vitreous and/or discission of anterior hyaloid membrane, with or without air injection
65815	629.73	Paracentesis of anterior chamber of eye (separate procedure); with removal of blood, with or without irrigation and/or air injection
65820	230.96	Goniotomy
65850	710.47	Trabeculotomy ab externo
65855	122.70	Trabeculoplasty by laser surgery, one or more sessions (defined treatment series)
65860	114.59	Severing adhesions of anterior segment, laser technique (separate procedure)
65865	450.19	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); goniosynechiae
65870	710.47	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); anterior synechiae, except goniosynechiae
65875	710.47	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); posterior synechiae
65880	580.51	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); corneovitreal adhesions
65900	618.69	Removal of epithelial downgrowth, anterior chamber of eye
65920	870.63	Removal of implanted material, anterior segment of eye
65930	748.65	Removal of blood clot, anterior segment of eye
66020	450.19	Injection, anterior chamber of eye (separate procedure); air or liquid

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
66030	230.96	Injection, anterior chamber of eye (separate procedure); medication
66130	870.63	Excision of lesion, sclera
66150	710.47	Fistulization of sclera for glaucoma; trephination with iridectomy
66155	710.47	Fistulization of sclera for glaucoma; thermocauterization with iridectomy
66160	629.73	Fistulization of sclera for glaucoma; sclerectomy with punch or scissors, with iridectomy
66165	710.47	Fistulization of sclera for glaucoma; iridencleisis or iridotasis
66170	710.47	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery
66172	710.47	Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)
66180	1,058.45	Aqueous shunt to extraocular reservoir (e.g., Molteno, Schocket, Denver-Krupin)
66185	939.55	Revision of aqueous shunt to extraocular reservoir
66220	917.16	Repair of scleral staphyloma; without graft
66225	1,020.29	Repair of scleral staphyloma; with graft
66250	499.77	Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure
66500	230.96	Iridotomy by stab incision (separate procedure); except transfixion
66505	230.96	Iridotomy by stab incision (separate procedure); with transfixion as for iris bombe
66600	657.82	Iridectomy, with corneoscleral or corneal section; for removal of lesion
66605	657.82	Iridectomy, with corneoscleral or corneal section; with cyclectomy
66625	467.71	Iridectomy, with corneoscleral or corneal section; peripheral for glaucoma (separate procedure)
66630	657.82	Iridectomy, with corneoscleral or corneal section; sector for glaucoma (separate procedure)
66635	657.82	Iridectomy, with corneoscleral or corneal section; optical (separate procedure)
66680	657.82	Repair of iris, ciliary body (as for iridodialysis)
66682	629.73	Suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (e.g., McCannel suture)
66700	499.77	Ciliary body destruction; diathermy
66710	499.77	Ciliary body destruction; cyclophotocoagulation, transscleral

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
66711	499.77	Ciliary body destruction; cyclophotocoagulation, endoscopic
66720	499.77	Ciliary body destruction; cryotherapy
66740	629.73	Ciliary body destruction; cyclodialysis
66761	170.74	Iridotomy/iridectomy by laser surgery (e.g., for glaucoma) (one or more sessions)
66762	173.66	Iridoplasty by photocoagulation (one or more sessions) (e.g., for improvement of vision, for widening of anterior chamber angle)
66770	191.25	Destruction of cyst or lesion iris or ciliary body (nonexcisional procedure)
66820	169.67	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler knife)
66821	232.74	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages)
66825	710.47	Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure)
66830	248.48	Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)
66840	534.14	Removal of lens material; aspiration technique, one or more stages
66850	1,005.66	Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (e.g., phacoemulsification), with aspiration
66852	845.50	Removal of lens material; pars plana approach, with or without vitrectomy
66920	845.50	Removal of lens material; intracapsular
66930	883.67	Removal of lens material; intracapsular, for dislocated lens
66940	572.32	Removal of lens material; extracapsular (other than 66840, 66850, 66852)
66982	868.23	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage
66983	868.23	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
66984	868.23	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)
66985	803.73	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
66986	803.73	Exchange of intraocular lens
67005	681.97	Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal
67010	681.97	Removal of vitreous, anterior approach (open sky technique or limbal incision); subtotal removal with mechanical vitrectomy
67015	839.49	Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)
67025	551.65	Injection of vitreous substitute, pars plana or limbal approach, (fluid-gas exchange), with or without aspiration (separate procedure)
67027	969.81	Implantation of intravitreal drug delivery system (e.g., ganciclovir implant), includes concomitant removal of vitreous
67028	76.28	Intravitreal injection of a pharmacologic agent (separate procedure)
67030	551.65	Discission of vitreous strands (without removal), pars plana approach
67031	232.74	Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages)
67036	969.81	Vitrectomy, mechanical, pars plana approach;
67039	1,129.98	Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation
67040	1,129.98	Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation
67041	1,386.75	Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (e.g., macular pucker)
67042	1,386.75	Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (e.g., for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)
67043	1,386.75	Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (e.g., choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
67101	211.70	Repair of retinal detachment, one or more sessions; cryotherapy or diathermy, with or without drainage of subretinal fluid
67105	191.25	Repair of retinal detachment, one or more sessions; photocoagulation, with or without drainage of subretinal fluid
67107	1,007.99	Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation, and drainage of subretinal fluid
67108	1,129.98	Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique
67110	307.72	Repair of retinal detachment; by injection of air or other gas (e.g., pneumatic retinopexy)
67112	1,129.98	Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques
67113	1,386.75	Repair of complex retinal detachment (e.g., proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens
67115	601.23	Release of encircling material (posterior segment)
67120	601.23	Removal of implanted material, posterior segment; extraocular
67121	601.23	Removal of implanted material, posterior segment; intraocular
67141	211.93	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, one or more sessions; cryotherapy, diathermy
67145	180.80	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, one or more sessions; photocoagulation (laser or xenon arc)
67208	192.82	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions; cryotherapy, diathermy
67210	191.25	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions; photocoagulation
67218	720.14	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions; radiation by implantation of source (includes

Code	Fee	Description
		removal of source)
67220	211.70	Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photocoagulation (e.g., laser), one or more sessions
67221	108.74	Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photodynamic therapy (includes intravenous infusion)
67225	7.47	Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)
67227	551.65	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), one or more sessions; cryotherapy, diathermy
67228	191.25	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), one or more sessions; photocoagulation (laser or xenon arc)
67229	191.25	Treatment of extensive or progressive retinopathy, one or more sessions; preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (e.g., retinopathy of prematurity), photocoagulation or cryotherapy
67250	574.59	Scleral reinforcement (separate procedure); without graft
67255	629.32	Scleral reinforcement (separate procedure); with graft
67311	671.61	Strabismus surgery, recession or resection procedure; one horizontal muscle
67312	724.27	Strabismus surgery, recession or resection procedure; two horizontal muscles
67314	724.27	Strabismus surgery, recession or resection procedure; one vertical muscle (excluding superior oblique)
67316	724.27	Strabismus surgery, recession or resection procedure; two or more vertical muscles (excluding superior oblique)
67318	724.27	Strabismus surgery, any procedure, superior oblique muscle
67320	724.27	Transposition procedure (e.g., for paretic extraocular muscle), any extraocular muscle (specify) (List separately in addition to code for primary procedure)
67331	724.27	Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (List separately in addition to code for primary procedure)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
67332	724.27	Strabismus surgery on patient with scarring of extraocular muscles (e.g., prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (e.g., dysthyroid ophthalmopathy) (List separately in addition to code for primary procedure)
67334	724.27	Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)
67335	724.27	Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)
67340	724.27	Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to code for primary procedure)
67343	884.42	Release of extensive scar tissue without detaching extraocular muscle (separate procedure)
67345	75.64	Chemodenervation of extraocular muscle
67346	409.09	Biopsy of extraocular muscle
67400	574.59	Orbitotomy without bone flap (frontal or transconjunctival approach); for exploration, with or without biopsy
67405	749.23	Orbitotomy without bone flap (frontal or transconjunctival approach); with drainage only
67412	665.42	Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of lesion
67413	787.40	Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of foreign body
67414	1,399.16	Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of bone for decompression
67415	496.92	Fine needle aspiration of orbital contents
67420	1,014.19	Orbitotomy with bone flap or window, lateral approach (e.g., Kroenlein); with removal of lesion
67430	1,014.19	Orbitotomy with bone flap or window, lateral approach (e.g., Kroenlein); with removal of foreign body
67440	1,014.19	Orbitotomy with bone flap or window, lateral approach (e.g., Kroenlein); with drainage
67445	1,014.19	Orbitotomy with bone flap or window, lateral approach (e.g., Kroenlein); with removal of bone for decompression

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
67450	1,014.19	Orbitotomy with bone flap or window, lateral approach (e.g., Kroenlein); for exploration, with or without biopsy
67500	78.27	Retrobulbar injection; medication (separate procedure, does not include supply of medication)
67505	24.35	Retrobulbar injection; alcohol
67515	24.67	Injection of medication or other substance into Tenons capsule
67550	976.02	Orbital implant (implant outside muscle cone); insertion
67560	668.49	Orbital implant (implant outside muscle cone); removal or revision
67570	976.02	Optic nerve decompression (e.g., incision or fenestration of optic nerve sheath)
67700	114.52	Blepharotomy, drainage of abscess, eyelid
67710	133.73	Severing of tarsorrhaphy
67715	496.92	Canthotomy (separate procedure)
67800	48.04	Excision of chalazion; single
67801	58.10	Excision of chalazion; multiple, same lid
67805	75.30	Excision of chalazion; multiple, different lids
67808	546.50	Excision of chalazion; under general anesthesia and/or requiring hospitalization, single or multiple
67810	114.52	Biopsy of eyelid
67820	15.90	Correction of trichiasis; epilation, by forceps only
67825	49.01	Correction of trichiasis; epilation by other than forceps (e.g., by electrosurgery, cryotherapy, laser surgery)
67830	335.51	Correction of trichiasis; incision of lid margin
67835	546.50	Correction of trichiasis; incision of lid margin, with free mucous membrane graft
67840	140.23	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure
67850	111.34	Destruction of lesion of lid margin (up to 1 cm)
67875	279.61	Temporary closure of eyelids by suture (e.g., Frost suture)
67880	527.86	Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy;
67882	574.59	Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy; with transposition of tarsal plate
67900	749.23	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
67901	665.42	Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., banked fascia)
67902	787.40	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	627.24	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	627.24	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	665.42	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	627.24	Repair of blepharoptosis; conjunctivo-tarso-Mullers muscle-levator resection (e.g., Fasanella-Servat type)
67909	627.24	Reduction of overcorrection of ptosis
67911	574.59	Correction of lid retraction
67912	574.59	Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)
67914	574.59	Repair of ectropion; suture
67915	155.16	Repair of ectropion; thermocauterization
67916	627.24	Repair of ectropion; excision tarsal wedge
67917	627.24	Repair of ectropion; extensive (e.g., tarsal strip operations)
67921	574.59	Repair of entropion; suture
67922	150.94	Repair of entropion; thermocauterization
67923	627.24	Repair of entropion; excision tarsal wedge
67924	627.24	Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)
67930	155.16	Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva direct closure; partial thickness
67935	546.50	Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva direct closure; full thickness
67938	78.27	Removal of embedded foreign body, eyelid
67950	546.50	Canthoplasty (reconstruction of canthus)
67961	574.59	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
67966	574.59	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin
67971	574.59	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; up to two-thirds of eyelid, one stage or first stage
67973	696.57	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, lower, one stage or first stage
67974	574.59	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, upper, one stage or first stage
67975	574.59	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; second stage
68020	42.53	Incision of conjunctiva, drainage of cyst
68040	21.10	Expression of conjunctival follicles (e.g., for trachoma)
68100	84.39	Biopsy of conjunctiva
68110	108.74	Excision of lesion, conjunctiva; up to 1 cm
68115	546.50	Excision of lesion, conjunctiva; over 1 cm
68130	499.77	Excision of lesion, conjunctiva; with adjacent sclera
68135	54.53	Destruction of lesion, conjunctiva
68200	15.58	Subconjunctival injection
68320	749.23	Conjunctivoplasty; with conjunctival graft or extensive rearrangement
68325	749.23	Conjunctivoplasty; with buccal mucous membrane graft (includes obtaining graft)
68326	627.24	Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement
68328	749.23	Conjunctivoplasty, reconstruction cul-de-sac; with buccal mucous membrane graft (includes obtaining graft)
68330	710.47	Repair of symblepharon; conjunctivoplasty, without graft
68335	749.23	Repair of symblepharon; with free graft conjunctiva or buccal mucous membrane (includes obtaining graft)
68340	627.24	Repair of symblepharon; division of symblepharon, with or without insertion of conformer or contact lens
68360	629.73	Conjunctival flap; bridge or partial (separate procedure)
68362	629.73	Conjunctival flap; total (such as Gunderson thin flap or purse string flap)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
68371	499.77	Harvesting conjunctival allograft, living donor
68400	114.52	Incision, drainage of lacrimal gland
68420	162.95	Incision, drainage of lacrimal sac (dacryocystotomy or dacryocystostomy)
68440	47.72	Snip incision of lacrimal punctum
68500	696.57	Excision of lacrimal gland (dacryoadenectomy), except for tumor; total
68505	696.57	Excision of lacrimal gland (dacryoadenectomy), except for tumor; partial
68510	496.92	Biopsy of lacrimal gland
68520	696.57	Excision of lacrimal sac (dacryocystectomy)
68525	496.92	Biopsy of lacrimal sac
68530	114.52	Removal of foreign body or dacryolith, lacrimal passages
68540	574.59	Excision of lacrimal gland tumor; frontal approach
68550	696.57	Excision of lacrimal gland tumor; involving osteotomy
68700	546.50	Plastic repair of canaliculi
68705	108.74	Correction of everted punctum, cautery
68720	749.23	Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)
68745	749.23	Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); without tube
68750	749.23	Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); with insertion of tube or stent
68760	92.51	Closure of the lacrimal punctum; by thermocauterization, ligation, or laser surgery
68761	63.95	Closure of the lacrimal punctum; by plug, each
68770	749.23	Closure of lacrimal fistula (separate procedure)
68801	33.92	Dilation of lacrimal punctum, with or without irrigation
68810	97.00	Probing of nasolacrimal duct, with or without irrigation;
68811	546.50	Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia
68815	546.50	Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent
68816	701.60	Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation
68840	50.31	Probing of lacrimal canaliculi, with or without irrigation
69000	51.32	Drainage external ear, abscess or hematoma; simple
69005	97.06	Drainage external ear, abscess or hematoma; complicated

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
69020	51.32	Drainage external auditory canal, abscess
69100	58.43	Biopsy external ear
69105	82.77	Biopsy external auditory canal
69110	434.86	Excision external ear; partial, simple repair
69120	645.34	Excision external ear; complete amputation
69140	645.34	Excision exostosis(es), external auditory canal
69145	484.44	Excision soft tissue lesion, external auditory canal
69150	340.49	Radical excision external auditory canal lesion; without neck dissection
69200	23.47	Removal foreign body from external auditory canal; without general anesthesia
69205	542.85	Removal foreign body from external auditory canal; with general anesthesia
69210	19.15	Removal impacted cerumen (separate procedure), one or both ears
69220	30.08	Debridement, mastoidectomy cavity, simple (e.g., routine cleaning)
69222	126.59	Debridement, mastoidectomy cavity, complex (e.g., with anesthesia or more than routine cleaning)
69300	673.43	Otoplasty, protruding ear, with or without size reduction
69310	984.35	Reconstruction of external auditory canal (meatoplasty) (e.g., for stenosis due to injury, infection) (separate procedure)
69320	1,197.16	Reconstruction external auditory canal for congenital atresia, single stage
69400	85.04	Eustachian tube inflation, transnasal; with catheterization
69401	44.79	Eustachian tube inflation, transnasal; without catheterization
69405	117.50	Eustachian tube catheterization, transtympanic
69420	105.50	Myringotomy including aspiration and/or eustachian tube inflation
69421	536.92	Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia
69424	74.01	Ventilating tube removal requiring general anesthesia
69433	105.17	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia
69436	536.92	Tympanostomy (requiring insertion of ventilating tube), general anesthesia
69440	673.43	Middle ear exploration through postauricular or ear canal incision
69450	906.68	Tympanolysis, transcanal
69501	1,197.16	Transmastoid antrotomy (simple mastoidectomy)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
69502	886.24	Mastoidectomy; complete
69505	1,197.16	Mastoidectomy; modified radical
69511	1,197.16	Mastoidectomy; radical
69530	1,197.16	Petrous apicectomy including radical mastoidectomy
69540	123.67	Excision aural polyp
69550	1,075.18	Excision aural glomus tumor; transcanal
69552	1,197.16	Excision aural glomus tumor; transmastoid
69601	1,197.16	Revision mastoidectomy; resulting in complete mastoidectomy
69602	1,197.16	Revision mastoidectomy; resulting in modified radical mastoidectomy
69603	1,197.16	Revision mastoidectomy; resulting in radical mastoidectomy
69604	1,197.16	Revision mastoidectomy; resulting in tympanoplasty
69605	1,197.16	Revision mastoidectomy; with apicectomy
69610	165.55	Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch
69620	645.34	Myringoplasty (surgery confined to drumhead and donor area)
69631	1,075.18	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction
69632	1,075.18	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (e.g., postfenestration)
69633	1,075.18	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction and synthetic prosthesis (e.g., partial ossicular replacement prosthesis (PORP), total ossicular replacement prosthesis (TORP))
69635	1,197.16	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction
69636	1,197.16	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction
69637	1,197.16	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction and synthetic prosthesis (e.g., partial ossicular replacement prosthesis (PORP), total ossicular replacement prosthesis (TORP))

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
69641	1,197.16	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction
69642	1,197.16	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction
69643	1,197.16	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction
69644	1,197.16	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction
69645	1,197.16	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction
69646	1,197.16	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction
69650	886.24	Stapes mobilization
69660	1,075.18	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material;
69661	1,075.18	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material; with footplate drill out
69662	1,075.18	Revision of stapedectomy or stapedotomy
69666	1,037.00	Repair oval window fistula
69667	1,037.00	Repair round window fistula
69670	984.35	Mastoid obliteration (separate procedure)
69676	984.35	Tympanic neurectomy
69700	984.35	Closure postauricular fistula, mastoid (separate procedure)
69711	906.68	Removal or repair of electromagnetic bone conduction hearing device in temporal bone
69714	5,749.99	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69715	5,749.99	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
69717	5,749.99	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69718	5,749.99	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy
69720	1,075.18	Decompression facial nerve, intratemporal; lateral to geniculate ganglion
69740	1,075.18	Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion
69745	1,075.18	Suture facial nerve, intratemporal, with or without graft or decompression; including medial to geniculate ganglion
69801	1,075.18	Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); transcanal
69802	1,197.16	Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); with mastoidectomy
69805	1,197.16	Endolymphatic sac operation; without shunt
69806	1,197.16	Endolymphatic sac operation; with shunt
69820	1,075.18	Fenestration semicircular canal
69840	1,075.18	Revision fenestration operation
69905	1,197.16	Labyrinthectomy; transcanal
69910	1,197.16	Labyrinthectomy; with mastoidectomy
69915	1,197.16	Vestibular nerve section, translabyrinthine approach
69930	21,643.06	Cochlear device implantation, with or without mastoidectomy
C9716	1,127.56	Creations of thermal anal lesions by radiofrequency energy
C9724	921.91	Endoscopic full-thickness plication in the gastric cardia using endoscopic plication system (EPS); includes endoscopy
C9725	212.59	Placement of endorectal intracavitary applicator for high intensity brachytherapy
C9726	780.47	Placement and removal (if performed) of applicator into breast for radiation therapy
C9727	273.65	Insertion of implants into the soft palate; minimum of 3 implants

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.3 CMR 47.00: FREESTANDING AMBULATORY SURGICAL FACILITIES

Code	Fee	Description
C9728	491.00	Placement of interstitial device(s) for radiation therapy/surgery guidance (e.g., fiducial markers, dosimeter), other than prostate (any approach), single or multiple
G0104	78.88	Colorectal cancer screening; flexible sigmoidoscopy
G0105	340.90	Colorectal cancer screening; colonoscopy on individual at high risk
G0121	340.90	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
G0127	11.03	Trimming of dystrophic nails, any number
G0186	211.70	Destruction of localized lesion of choroid (for example, choroidal neovascularization); photocoagulation, feeder vessel technique (one or more sessions)
G0247	20.12	Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include the local care of superficial wounds (i.e., superficial to muscle and fascia) and at least the following, if present: (1) local
G0260	276.38	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography
G0364	5.19	Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service
G0392	1,465.88	Transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; arterial
G0393	1,465.88	Transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; venous

(d) Modifiers.

50	Bilateral procedure
51	Multiple procedures
73	Discontinued outpt hospital/ambulatory surgery center (ASC) procedure prior to administration of anesthesia
74	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia

47.04: Reporting Requirements

(1) Required Reports. Upon request of the Division, each provider within 90 days following the end of its fiscal year, shall forward to the Division a complete and accurate cost report (FDSF-1)

and certified financial statements. The provider shall also make available within 30 days all records and books relating to said operations, including such data, statistics, and records as the Division may from time to time request.

(2) Extension of Filing Date. The Division may grant an extension of time for the submission of cost reports or other information, data or statistics upon written request from the provider demonstrating that good cause exists for such an extension.

(3) Failure to File Timely Reports. Failure to submit accurate information within the time required by 114.3 CMR 47.04(1) and (2) or to submit within the stated time other acceptable data and statistics requested by the Division, may result in the delay, reduction or non-payment of the provider's rates, as well as application of other sanctions and penalties provided by law subject to the approval of the purchasing Governmental Unit.

47.05: Severability

The provisions of 114.3 CMR 47.00 are severable, and if any provision of 114.3 CMR 47.00 or application of such provision to any freestanding surgical facility or any circumstances shall be held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions to eligible freestanding surgical facilities or circumstances other than those held invalid.

REGULATORY AUTHORITY

114.3 CMR 47.00: M.G.L. c. 118G.