

OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

MEDICAL FEE SCHEDULE

Effective TBD



**Workers'
Compensation
Board**

COPYRIGHT

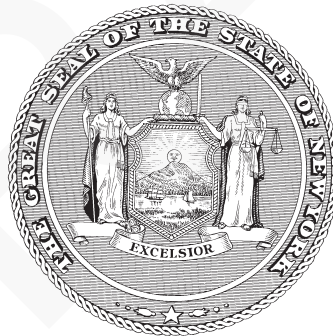
© 2025 State of New York

CPT codes, descriptions, and two-digit numeric modifiers only, © 2023 American Medical Association

Anesthesia base units only, © 2023 American Society of Anesthesiologists

All rights reserved. Printed in the United States of America. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or storage in a database retrieval system, without the prior written permission of the publisher.

Made in the USA



863.222.4071

REFMED NOTICE

The *Official New York State Workers' Compensation Medical Fee Schedule* is designed to be an accurate and authoritative source of information about medical coding and reimbursement. Every reasonable effort has been made to verify its accuracy, and all information is believed reliable at the time of publication. Absolute accuracy, however, cannot be guaranteed.

RefMed worked closely with the New York Workers' Compensation Board in the development, formatting, and production of this fee schedule. However, all decisions resulting in the final content of this schedule were made solely by the New York State Workers' Compensation Board.

This publication is made available with the understanding that the publisher is not engaged in rendering legal and other services that require a professional license.

For additional copies of this publication or other fee schedules, please call 863.222.4071.

AMERICAN MEDICAL ASSOCIATION NOTICE

CPT © 2023 American Medical Association. All rights reserved.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CPT is a registered trademark of the American Medical Association.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS' NOTICE

Relative Value Guide © 2023 American Society of Anesthesiologists. All Rights Reserved.

Relative Value Guide® is a relative value study and not a fee schedule. It is intended only as a guide. ASA does not directly or indirectly practice medicine or dispense medical services. ASA assumes no liability for data contained or not contained herein.

Relative Value Guide® is a registered trademark of the American Society of Anesthesiologists.

NEW YORK WORKERS' COMPENSATION BOARD FILING NOTICE

The Medical Fee Schedule was duly filed in the Office of the Department of State, and constitutes Sections 329-1.1 and 329-1.3 of Title 12 of the Official Compilation of Codes, Rules, and Regulations of the State of New York.

OUR COMMITMENT TO ACCURACY

RefMed is committed to producing accurate and reliable materials. To report corrections, please visit marketplace.refmed.com or call 863.222.4071.

FOREWORD

The Workers' Compensation Board is pleased to present the updated version of the *Official New York State Workers' Compensation Medical Fee Schedule*.

The revised fee schedule is an essential tool for health care providers and those paying the cost of health care services under the New York State Workers' Compensation system. This schedule provides comprehensive billing guides, which will allow health care providers to appropriately describe their services and minimize disputes over reimbursement. Also, this schedule includes many new procedures and coding changes that have taken place since the previously published fee schedule.

This fee schedule could not have been produced without the assistance of many individuals. The spirit of cooperation between the provider and payer communities is very much appreciated. The excellence of this schedule is due, in large part, to the commitment of many people in the workers' compensation community. We are grateful for their efforts.

Except where noted, this fee schedule is effective for medical services rendered on or after [Insert Date], regardless of the date of accident. The fees established herein are payable to health care providers authorized or permitted to render care under the Workers' Compensation Law, Volunteer Firefighters' Benefit Law, and Volunteer Ambulance Workers' Benefit Law.

New York State Workers' Compensation Board

Contents

The Official New York State Workers' Compensation Medical Fee Schedule

1 Introduction and General Guidelines.....	7	5 Radiology.....	292
Format.....	7	Radiology Ground Rules	292
How To Interpret Fee Schedule Data.....	8	6 Pathology and Laboratory	324
Calculating Fees Using Relative Values And		Pathology and Laboratory Ground Rules	324
Conversion Factors	9	7 Medicine	394
General Ground Rules	10	Medicine Ground Rules	394
2 Evaluation and Management (E/M)	22	8 Physical Medicine.....	450
Evaluation and Management Ground Rules	22	Physical Medicine Ground Rules.....	450
3 Anesthesia	36	9 Category III Codes	462
Anesthesia Ground Rules.....	36	Category III Ground Rules.....	462
4 Surgery	50	Appendix.....	494
Surgery Ground Rules.....	50		

1 Introduction and General Guidelines

The *Official New York State Workers' Compensation Medical Fee Schedule* shows physician, nurse practitioner, and physician assistant services and their relative value units. The services are listed by *Current Procedural Terminology* (CPT®) codes. The relative value set for each CPT service is based on comparative magnitude among various services and procedures. The relative values within each section apply only to that section. CPT is a registered trademark of the American Medical Association (AMA).

The accompanying instructions and ground rules explain the application of these procedure descriptors and relative value units in medical practice. All sections of the book may be used within the scope of practice as established by New York State Law by any or all appropriately trained physicians, nurse practitioners, and physician assistants. Appropriate surgery codes are not confined to use by surgeons, nor is the medicine section confined to use by internists, etc.

Because the Medical Fee Schedule is applicable to all of New York State, a large and diverse geographical area, the relative value units contained herein do not necessarily reflect the charges of any individual physician or the pattern of charges in any specific area of New York State.

A primary purpose of the schedule is to provide a precise description and coding of the services provided by New York State physicians, nurse practitioners, physician assistants in the care of workers' compensation covered patients and to ensure the proper payment for such services by assuring that they are specifically identifiable.

Inclusion of a code in this Fee Schedule does not guarantee reimbursement. All codes billed should be based on medical necessity and be in alignment with all applicable Medical Treatment Guidelines and Fee Schedule Ground Rules, as further discussed herein. Reimbursement may be dependent on multiple factors, including but not necessarily limited to, causal relationship, clinical necessity and appropriateness of the fees submitted.

This edition of the *Official New York State Workers' Compensation Medical Fee Schedule* uses CPT procedure codes, modifiers, and descriptions and, where appropriate, the American Society of Anesthesiologists' *Relative Value Guide*®. Please refer to the CPT book for an explanation of coding rules and regulations not listed in this schedule.

FORMAT

The *Official New York State Workers' Compensation Medical Fee Schedule* consists of eight sections. Each section has instructions that precede the codes, descriptions, and values. The schedule is divided into sections for structural purposes only. Physicians, nurse practitioners, and physician assistants are to use the sections that contain the procedures they perform, or the services they render. The sections in this schedule are:

Section	CPT/State-Specific Codes
Evaluation Management	99202–99499
Anesthesia	00100–01999, 99100–99140
Surgery	10004–69990
Radiology (including Nuclear Medicine and Diagnostic Ultrasound)	70010–79999
Pathology and Laboratory	80047–89398
Medicine	90281–95836, 95857–96999, 97XXX–97546, 97597–97610, 97802–99091, 99151–99243, 99499–99607
Physical Medicine	95851–95852, 97010–97124, 97139–97530, 97535–97546, 97750–97799, ∞97800
Category III Codes	0042T–0866T

Note: The ∞ symbol indicates that the code is state-specific.

The sections are organized according to the type of service and variations of overhead expense ratios for providing the services. Therefore, each section uses a single conversion factor.

Category II codes are not reimbursable services and are not included in this schedule.

INTRODUCTORY INFORMATION

The introductory ground rules that precede the data in each section include definitions, references, prohibitions, and directions for proper use. It cannot be emphasized too strongly that the introductory ground rules be read and understood before using the data in this schedule.

REGIONS

The Board has established four regions within New York State based on the difference in the cost of maintaining a practice in different localities of the state. The Board has defined each such region by use of the U.S. Postal Service ZIP codes for the state of New York, based upon the relative cost factors which are compatible to that region.

The fees payable for services shall be determined by the region in which the services were rendered.

ADDITIONAL SCHEDULES

The Acupuncture, Physical & Occupational Therapy schedules, Behavioral Health schedule, Chiropractic schedule, and Podiatry schedule have also been published as separate schedules. Contact RefMed by calling (863) 222-4071 or online at <https://marketplace.refmed.com/>, keyword New York.

HOW TO INTERPRET FEE SCHEDULE DATA

There are six columns used in the *Official New York State Workers' Compensation Medical Fee Schedule*. The columns vary by section throughout the schedule.

ICONS

The following icons are included in the *Official New York State Workers' Compensation Medical Fee Schedule*:

- New and changed codes—Codes that are new, changed description, or changed value since the 2018/2020 Fee Schedules.
- ⊕ Add-on service—Add-on codes have been designated in the CPT book as being additional or supplemental procedures that are carried out in addition to the primary procedure.
- ⊖ Modifier 51 exempt service—Modifier 51 exempt codes have not been identified as add-on services but are exempt from modifier 51 when performed in conjunction with other services.
- Ⓜ Optum identified modifier 51 exempt service—Additional modifier 51 exempt codes identified by Optum based upon CPT language are exempt from modifier 51 when performed in conjunction with other services.

- ® Altered CPT codes and modifiers—Services listed have been altered from the official CPT code description.
- ∞ State-specific codes or modifiers—Where a CPT code or modifier does not currently exist to describe a service there may be a state-specific code number assigned to describe the service. Relative value units (RVUs) are state assigned or gap filled.

CODE

The Code column lists the American Medical Association's CPT code. *CPT 2024* codes are used by arrangement with the AMA. Any altered CPT codes and modifiers are identified with the registered trademark symbol (®). State-specific codes and modifiers are identified with the infinity symbol (∞).

DESCRIPTION

This manual lists full 2024 CPT code descriptions.

RELATIVE VALUE

The Relative Value column lists the relative value used to calculate the fee amount for a service. Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value by the applicable conversion factor. Conversion factors are listed later in this chapter.

Relative values are used to calculate fees using the following formula:

Relative value x applicable conversion factor = fee.

For example, the fee for code 93000, performed in Region I or Region II, would be calculated as follows:

	6.59	(Relative Value)
x	\$8.91	(Medicine Section Conversion Factor for Region I or Region II)
=	\$58.72	(Subject to PC/TC Split)

BR

Some services do not have a relative value because they are too variable or new. These “by report” services are identified with “BR.”

NC

NC represents services that are not covered by the State of New York. These services have no reimbursement allowance and are not covered under workers' compensation guidelines.

FUD

The FUD column lists the follow-up days included in a surgical procedure's global charge. In counting follow-up days, day one is the day of surgery, not the discharge day. The State of New York has determined the number of follow-up days in this schedule and these follow-up days are consistent with those found in the Medicare Physician Fee Schedule. Follow-up days will be designated as 000 (0 follow-up days), 010 (10 follow-up days), or 090 (90 follow-up days). Medicare also uses letter designations to identify four circumstances where the usual follow-up days concept does not apply. These four circumstances are as follows:

MMM	Describes services in uncomplicated maternity care. This includes antepartum, delivery, and postpartum care. The usual global surgery concept does not apply.
XXX	Indicates that the global surgery concept does not apply.
YYY	Indicates that the global period is to be established by report.
ZZZ	Indicates that the service is an add-on service and, therefore, is treated in the global period of the primary procedure that is billed in conjunction with the ZZZ service. Do not bill these codes with modifier 51. Reimbursement should not be reduced.

PC/TC SPLIT

The PC/TC Split column shows the percentage of the procedure that is professional or technical. A procedure with a relative value unit of 3.0 and a 40/60 in the PC/TC Split column would be calculated as follows: 40 percent of the value (3.0 x conversion factor x .40 = PC) is for the professional component of the service, and 60 percent of the value (3.0 x conversion factor x .60 = TC) represents the technical component of the service. The total component reimbursed should never be more than the professional and technical components combined.

Codes billed with modifier 26 for the PC split, cannot be billed by two providers during the same procedure.

POSTAL ZIP CODES BY REGION

See Appendix.

CONVERSION FACTORS

Regional conversion factors for services rendered on or after TBD.

Section	Region I	Region II	Region III	Region IV
E/M - Codes* 99202-99215	\$15.93	\$15.93	\$16.07	\$16.07
E/M - Codes 99221-99499	\$12.11	\$12.11	\$13.85	\$15.06
Medicine	\$8.91	\$8.91	\$10.19	\$11.07
Physical Medicine	\$8.43	\$8.43	\$9.65	\$10.48
Anesthesia	\$23.88	\$23.88	\$27.34	\$29.71
Surgery	\$202.53	\$202.53	\$231.78	\$251.94
Radiology	\$46.77	\$46.77	\$53.53	\$58.19
Pathology and Laboratory	\$1.06	\$1.06	\$1.21	\$1.31

*** Relative value units for E/M codes 99202-99215 for the Medical Fee Schedule are different than other fee schedules that contain the same codes. See Ground Rule 2.**

CALCULATING FEES USING RELATIVE VALUES AND CONVERSION FACTORS

Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value by the applicable conversion factor. For example, the total fee for code 99213, performed in Region I or Region II, would be calculated as follows:

$$\begin{array}{rcl}
 & 9.74 & \text{(Relative Value)} \\
 \times & \$15.93 & \text{(E/M - Codes 99202-99215 Section} \\
 & & \text{Conversion Factor for Region I or Region II)} \\
 \hline
 = & \$155.16 &
 \end{array}$$

NEW, CHANGED, AND DELETED CPT CODES

See Appendix.

GENERAL GROUND RULES

1A. NYS Medical Treatment Guidelines

Treatment of work-related injuries should be in accordance with any applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.

1B. Multiple Procedures

In extremely limited circumstances, if an acute problem arises during a routine visit, additional procedures may be reported on the same bill. For example, if in the course of a level three established patient office visit (99213) an acute situation requires an ECG (93000), it is appropriate to designate both the established patient office visit and the ECG. In this instance, both 99213 and 93000 would be reported.

2. Enhanced Reimbursement for Office Visits

Specific Evaluation and Management (E/M) visit codes are now eligible for increased reimbursement only when billed by physicians (MD, DO), nurse practitioners (NP) and physician assistants (PA).

Codes included are: 99202, 99203, 99204, 99205, and 99211, 99212, 99213, 99214, and 99215.

See the adjusted Conversion Factors per region in the chart for these particular codes.

The RVUs assigned to these codes have also increased. The codes' values can be found in the Evaluation and Management section.

Modifier 1B cannot be added to these E/M codes.

3. Miscellaneous and By Report Codes

- Providers should only use codes listed in the Fee Schedule. When billing a service or procedure, select the CPT code from the WCB Fee schedule that accurately identifies the service or procedure performed. If no such code is available, report the service or procedure using the closest appropriate **Miscellaneous** code in the Fee Schedule (often ending in -99). These codes may also be titled "Unlisted," "Unspecified," or "Not Otherwise Specified".

- By Report (BR) in the Relative Value (RVU) column represents services that too variable to permit assignment of RVUs. Fees for such procedures need to be justified with additional information.

- The inclusion of a miscellaneous or by report code in this Fee Schedule does not guarantee reimbursement. All codes billed should be based on medical necessity and be in alignment with all applicable Medical Treatment Guidelines and Fee Schedule Ground Rules. Reimbursement may be dependent on multiple factors, including but not necessarily limited to, causal relationship, clinical necessity and appropriateness of the fees submitted.
- It is the responsibility of the provider to ensure all information required to process a miscellaneous or by report procedure is included with the bill. If required information is missing, or if there is a valid code that describes the procedure, then the code may not be reimbursed.
- Nearly all miscellaneous and by report codes, require prior authorization (PAR). If a procedure or item is not recommended or not addressed in an applicable WCB Medical Treatment Guideline (MTG), then prior authorization is always required. If the procedure or item involves a body part or condition for which there is no MTG and costs over \$1,000 then prior authorization must be obtained.
- While emergency procedures/items do not require prior authorization, the circumstances must be identified and explained in the procedure record. The codes billed may be subject to review and non-payment.
- When a miscellaneous or by report code is used, the actual service/item should be identified on the bill, narrative note, and in an additional attached report.
- The price billed must be substantiated by indicating the closest comparable code found in the current fee schedule and/or with a manufacturer's invoice.
- Documentation should include: any decision making, medical necessity and explanation why an existing fee schedule code could not be used.
- Any PARs including identification numbers should also be submitted with bills.
- Miscellaneous and by report codes should not be billed merely to describe a proprietary product or procedure, when an existing fee schedule code adequately describes the procedure or item.
- Surgical miscellaneous or by report codes may require additional documentation including: time, skill, equipment necessary, diagnosis, pertinent history, and physical findings, size/ location/number of lesions or procedures.

4. Materials Supplied by Provider: Pharmaceuticals and Durable Medical Equipment

A. Pharmacy

A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of:

- i. Persons practicing in hospitals as defined in section 2801 of the public health law;
- ii. The dispensing of drugs at no charge to their patients;
- iii. Persons whose practices are situated ten miles or more from a registered pharmacy;
- iv. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution;
- v. The dispensing of drugs in a medical emergency as defined in subdivision 6 of section 6810 of the State Education Law.

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070. Identify the product being given with the NDC number and amount of product being used. Except in emergencies, any medications must follow all WCB Formulary and applicable Medical Treatment Guidelines. Any variations require Prior Authorization (PAR).

B. Durable Medical Equipment

All durable medical equipment (DME) supplied shall be billed and paid using the current published WCB Durable Medical Equipment (DME) Fee Schedule. The WCB DME Fee Schedule is available on the Board's website. Any item identified as requiring prior authorization in the WCB Durable Medical Equipment Fee Schedule or not listed in the WCB Durable Medical Equipment Fee Schedule may not be billed without such prior authorization.

Medical necessity should be documented for all prescribed DME. Prescription or order form must be completed by the provider and accurately describe the item needed.

Appropriate HCPCS codes should be billed for items. All miscellaneous/unspecified codes, or codes without a listed price- require Prior Authorization (PAR) and manufacturer's invoice.

Also see Surgery Ground Rules regarding post procedure casting/splinting DME.

Do not bill for/or report supplies that are customarily included in surgical packages, such as gauze, sponges, Steri-strips, and dressings; drug screening supplies;

and hot and cold packs. These items are included in the fee for the medical services in which such supplies are used.

5. Separate Procedures

Certain procedures are an inherent portion of a procedure or service and, as such, do not warrant a separate charge. For example: multiple muscle strains, such as cervical and lumbar areas, extremity, etc., when treated by other than a specific descriptor listed in the Surgery section will be considered as an entity and not carry cumulative and/or additional charges; that is, the appropriate level of service for office, hospital, or home visits will apply. When such a procedure is carried out as a separate entity not immediately related to other services, the indicated value for "separate procedure" is applicable. See also Surgery Ground Rule 7 "Separate or Independent Procedures".

If a CPT code description includes the term "separate procedure," the CPT code may not be used with a related procedure in an anatomically related region—often through the same skin incision, or surgical approach.

See also information in Surgery section and under other Ground Rules for "Modifiers". Also refer to any currently published WCB policies and/or guidance.

6. Concurrent Care

When more than one physician treats a patient for the same condition during the same period of time, payment is made only to one physician, the one whose specialty is most relevant to the diagnosis. For example, if claims are received from both a cardiologist and a general practitioner for the treatment of a heart condition, or from both an orthopedist and a surgeon for the treatment of a back disorder, payment is due only to the cardiologist and orthopedist, respectively. Where the concurrent care involves overlapping or common services, the fees payable shall not be increased but prorated. Each physician shall submit separate bills but indicate if agreement has been reached on the proration.

When the condition of the patient requires the disparate skills of two or more physicians to treat different conditions which do not fall within the scope of other physicians treating the patient at the same time (e.g., management of diabetes mellitus in a surgical case), payment is due each physician who plays an active role in the treatment program. The services rendered by each physician shall be distinct, in different disciplines, identifiable, and adequately documented in the records and reports.

6A. Multiple Case Numbers

If a claimant has more than one WCB claim/number, it is permissible to bill services for both claims on the same date of service. Separate bills should be submitted for each claim/visit. However the total time billed for each claim number should not exceed the actual face-to-face time spent with the patient. The visits need to be scheduled and

documented as two distinct and sequential office visits, with two distinct and separate office visit notes. Each billing physician/provider must be WCB authorized, as applicable.

7. Alternating Physicians

When physicians of similar skills alternate in the care of a patient (e.g., partners, groups, or same facility covering for another physician on weekends or vacation periods), each physician shall bill individually for the services each personally rendered and in accordance with the Medical Fee Schedule. Each billing physician/provider must be WCB authorized, as applicable.

If a provider wishes to perform a procedure for which a Prior Authorization (PAR) was granted to a different provider, the subsequent provider should seek express written authorization from the payer, ideally as a new PAR, or as otherwise approved in writing by the payer.

8. Proration of Scheduled Relative Value Unit Fee

When the schedule specifies a relative value unit fee for a definite treatment with an inclusive period of aftercare (follow-up days), and the patient is transferred from one physician to another physician, the employer (or Payer) is only responsible for the total amount listed in the schedule. Such amount is to be apportioned between the physicians. If the concerned physicians agree to the amounts to be prorated to each, they shall render separate bills accordingly. When treatment is terminated by the departure of the patient from New York State before the expiration of the stated period of follow-up days, the fee shall be the portion of the appropriate fee having regard for the fact that usually the greater portion is earned at the time of the original operation or service. When treatment is terminated by the death of the patient before the expiration of follow-up days, the full fee is payable, subject to proration where applicable.

9. Home Visits

The necessity for such visits is infrequent in cases covered by the Workers' Compensation Law. When necessary, a statement setting forth the medical indications justifying such visits shall be submitted. Please refer to the Evaluation and Management section for coding of these services.

10. Medical Testimony

Attendance fees for depositions are handled in accordance with Part 301 of Title 12 NYCRR of the NYS Workers' Compensation regulations and information may also be found on the Board's website at wcb.ny.gov.

11. Ground Rules for Physician Assistants (PA) and Nurse Practitioners (NP)

WCB Authorized Nurse Practitioners (NP) and Physician Assistants (PA) who render care within their scope of practice under NYS Education Law, and in accordance with their delineation of activities in Workers' Compensation Law, shall bill and be reimbursed for their services at 80 percent of the corresponding physician fee schedule rate. See currently published information on Expanded Provider Legislation available on the WCB webpage. This Ground Rule does not apply to bills for assistance during surgeries. Also see Surgery Ground Rule for Concurrent Services. See Ground Rule 12 F in Surgery section, and also modifier 83 information. State-specific modifier 83 is used to identify assistant at surgery services provided by a physician assistant or nurse practitioner.

12. Moderate (Conscious) Sedation

Sedation with or without analgesia is used to achieve a state of depressed consciousness while maintaining the patient's ability to control their own breathing as well as respond to stimulation. The use of these codes requires the presence of an independent trained observer to assist the physician in monitoring the patient's level of consciousness and physiological status.

Conscious sedation includes pre- and post-sedation evaluations, administration of the sedation, and monitoring of cardiorespiratory function.

Procedures that are integral to the moderate (conscious) sedation service and that should not be reported separately include:

- Assessment of the patient
- Establishment of IV access and provision of fluids to maintain patency
- Administration of sedation agents
- Maintenance of sedation
- Monitoring of oxygen saturation, heart rate, and blood pressure
- Recovery

Do not report minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care with moderate (conscious) sedation codes.

Codes 99151–99153 identify moderate (conscious) sedation services provided by the same physician performing the diagnostic or therapeutic service that the sedation supports. CPT codes 99155–99157 identify moderate (conscious) sedation services provided by a second physician other than the health care professional performing the diagnostic or therapeutic service. When moderate (conscious) sedation services are provided by a second physician in a facility or non-facility setting, the conscious sedation service may be billed separately.

13. Add-on Procedures

CPT identifies procedures that are always performed in addition to the primary procedure and designates them with a + in the CPT book. Add-on codes are never reported for stand-alone services but are reported secondarily in addition to the primary procedure. CPT uses specific language to identify add-on procedures such as “each additional” or “(List separately in addition to primary procedure).”

The same physician that performed the primary procedures/services must perform the add-on procedures. Add-on codes describe additional intra-service work associated with the primary procedure/service (e.g., additional digits, lesion, neurotomy, vertebral segment, tendon, joint).

Add-on procedures are not subject to multiple procedure rules and, as such, modifier 51 does not apply. Fee schedule amounts for add-on codes are not subject to reduction and should be reimbursed at the lesser of 100 percent of the listed value or the billed amount. Do not append modifier 51 to a code identified as an add-on procedure.

The CPT codes currently designated as add-on codes are listed in Appendix D of *CPT 2024*.

14. Exempt From Modifier 51 Codes

As the description implies, modifier 51 exempt procedures are not subject to multiple procedure rules and, as such, modifier 51 does not apply. Fee schedule amounts for modifier 51 exempt codes are not subject to reduction and should be reimbursed at the lesser of 100 percent of the listed value or the billed amount.

The CPT book identifies these services with the Ⓢ symbol.

Modifier 51 exempt services and procedures can be found in current CPT books.

In addition to the codes noted in CPT book, Optum has identified codes that are modifier 51 exempt according to CPT guidelines. The additional Optum modifier 51 exempt codes are identified in the data with the icon Ⓢ. See Appendix.

15. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers may be restricted by provider type. See any applicable Ground Rules listed in separate sections/fee schedules. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book.

1B∞ Behavioral Health Provider Enhanced Reimbursement

- Provides a 20 percent reimbursement increase for certain E/M and psychotherapy services.
- The following types of codes may not be appended with modifier 1B: diagnostic testing codes, procedural codes, and E/M visit codes 99202-99205, and 99211-99215.
- Behavioral Health consultation codes may use modifier 1B.
- ** Modifier 1B may be used by psychologists and LCSWs with the appropriate telehealth codes.
- May only be used by the following WCB authorized Behavioral Health providers:
 - a. Licensed psychiatrist
 - b. Licensed physician with a specialty rating code from American Board of Psychiatry & Neurology as published on the WCB webpage
 - c. Board certified psychiatric nurse practitioner (NP)
 - d. Appropriately certified physician assistant (PA) with eligible supervising physician
 - e. Licensed psychologist
 - f. Licensed clinical social worker

See **Appendix** for Behavioral Health Provider Enhanced Rating Codes.

** See current Telehealth Ground Rule and webpage: <https://www.wcb.ny.gov/telehealth/>

1R∞ Non-surgical services provided by residents and fellows

Billed and payable at the same applicable rate as the WCB authorized, supervising physician. 1R can be used for E/M codes, such as office visits, as well as for stand-alone procedures not performed during a surgery i.e., injections. This modifier is not used for assistance at surgery. See modifier 84.

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

23 Unusual Anesthesia

Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

24 Unrelated Evaluation and Management Services by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other | Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number. For intra-operative imaging, this modifier should not be used on the same code by two providers during the same procedure.

TC Technical Component

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

27 Multiple Outpatient Hospital E/M Encounters on the Same Date (This CPT modifier is for use by Ambulatory Surgery Center (ASC) and Hospital Outpatient Settings Only.)

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

32 Mandated Services

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

47 Anesthesia by Surgeon

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

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5 digit code. **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

51 Multiple Procedures

When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

52 Reduced Services

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

53 Discontinued Procedure

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

54 Surgical Care Only

When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only

When 1 physician or other qualified health care professional performs the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only

When 1 physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery

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

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures or services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

62 Two Surgeons

When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure[s]) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of an additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

66 Surgical Team

Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professional, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating individual with the addition of modifier 66 to the basic procedure number used for reporting services.

76 Repeat Procedure or Service by the Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure/service. **Note:** This modifier should not be appended to an E/M service.

78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional following Initial Procedure for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first,

and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 Assistant Surgeon

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

81 Minimum Assistant Surgeon

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

82 Assistant Surgeon (when qualified resident surgeon not available)

The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).

83∞ Services of Physician Assistants (PA) and Nurse Practitioners (NP) assisting during surgical procedures:

The operating physician must bill at 10.7 percent of the total physician fee schedule allowance for the surgical procedures performed by the NP/PA.

Identify the services by adding modifier 83 to the specific procedure codes done by the NP/PA. Payment will be made to the supervising physician performing the surgery. This modifier is valid for surgery only. NPs and PAs cannot bill for surgery independently.

84∞ Assistance at surgery provided by residents and fellows

This modifier should be appended to the individual codes representing work actually performed by the resident/fellow while assisting the WCB authorized, supervising physician.

This modifier should not be used for E/M codes or for procedures not performed during a surgery i.e., injections. See modifier 1R.

90 Reference (Outside) Laboratory

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

91 Repeat Clinical Diagnostic Laboratory Test

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

92 Alternative Laboratory Platform Testing

When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701–86703 and 87389). The test does not require permanent dedicated space, hence by its design it may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System.

Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

95® Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System.

Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and patient during the course of the synchronous

telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

96 Habilitative Services

When a service or procedure that may be either habilitative or rehabilitative in nature is provided for habilitative purposes, the physician or other qualified health care professional may add modifier 96 to the service or procedure code to indicate that the service or procedure provided was a habilitative service. Habilitative services help an individual learn skills and functioning for daily living that the individual has not yet developed, and then keep and/or improve those learned skills. Habilitative services also help an individual keep, learn, or improve skills and functioning for daily living.

97 Rehabilitative Services

When a service or procedure that may be either habilitative or rehabilitative in nature is provided for rehabilitative purposes, the physician or other qualified health care professional may add modifier 97 to the service or procedure code to indicate that the service or procedure provided was a rehabilitative service. Rehabilitative services help an individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt, or disabled.

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

16. Treatment by Out-of-State Providers

Claimant lives outside of New York State—A claimant who lives outside of New York State may treat with a qualified out-of-state medical provider. The medical treatment shall conform to the Medical Treatment Guidelines and the Ground Rules included herein. This includes obtaining any required Prior Authorization (PAR).

Payment for medical treatment shall be at the Fee Schedule amount for work related injuries and illnesses as available in the state where treatment is rendered, or if there is no such fee schedule, then such charges shall be as prevail in the community for similar treatment. Out-of-state providers are required to use only those CPT codes listed in the current applicable New York State WCB fee schedules.

Presence of a CPT code in this fee schedule does not imply medical necessity which is determined by the NYS Medical Treatment Guidelines.

All fees shall be subject to the jurisdiction of the Board.

Claimant lives in New York State but treats outside of New York State—A claimant who lives in New York State may treat with a qualified or Board authorized out-of-state medical provider when such treatment conforms to the Workers' Compensation Law and regulations, the Medical Treatment Guidelines and the Medical Fee Schedule. Payment shall be made to the medical provider as set forth herein and using the regional conversion factor for the ZIP code where the claimant resides.

Out-of-state medical treatment that does not "further the economic and humanitarian objective" of Workers' Compensation Law may be denied by the Board.

A medical provider who has had a NYS WCB authorization suspended, revoked or surrendered shall not be qualified to treat out-of-state.

Permanency—The New York State guidelines on permanent impairment, pertaining to both the schedule loss of use and classification, apply regardless of whether claimant lives in or out of New York State.

17. Narrative Reports

A detailed narrative report must be submitted with all services provided. Physicians & Nurse Practitioners narrative reports must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Physician Assistants must include Work Status & Temporary Impairment Percentages. Providers are strongly encouraged to use the narrative template format found on the WCB webpage [CMS-1500 Requirements](#).

Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/assessment of the patient.

Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed.

Any ordered medications, durable medical equipment, tests, or procedures should be thoroughly explained.

All entries in the medical record must be legible to another reader.

18. Behavioral Health Provider Enhanced Reimbursement

In an effort to increase the number of Board authorized providers in behavioral health available to render care and treatment to injured workers, the WCB has established WCB specific modifier 1B.

- Provides a 20 percent reimbursement increase for certain E/M and psychotherapy services.

- The following types of codes may not be appended with modifier 1B: diagnostic testing codes, procedural codes, and E/M visit codes 99202-99205, and 99211-99215.
- Behavioral Health consultation codes may use modifier 1B.
- ** Modifier 1B may be used by psychologists and LCSWs with the appropriate telehealth codes.
- May only be used by the following WCB authorized Behavioral Health providers:
 - Licensed psychiatrist
 - Licensed physician with a specialty rating code from American Board of Psychiatry & Neurology as published on the WCB webpage
 - Board certified psychiatric nurse practitioner (NP)
 - Appropriately certified physician assistant (PA) with eligible supervising physician
 - Licensed psychologist
 - Licensed clinical social worker

** See current Telehealth Ground Rule and webpage: <https://www.wcb.ny.gov/telehealth/>

See **Appendix** for Behavioral Health Provider Enhanced Rating Codes.

19. Use of Medical Fee Schedule Codes

There are separate and distinct fee schedules for use by Podiatrists (Podiatry Fee Schedule), Chiropractors (Chiropractic Fee Schedule), Psychologists and Licensed Clinical Social Workers (Behavioral Health Fee Schedule), Acupuncture and Physical/Occupational Therapy (Acupuncture and Physical & Occupational Therapy Fee Schedules), Dental, and Durable Medical Equipment.

A Podiatrist, Chiropractor, Psychologist, or Licensed Clinical Social Worker, Acupuncturist, Physical Therapist, or Occupational Therapist may not use the CPT coding guidelines contained in this Medical Fee Schedule. Podiatrists, Chiropractors, Psychologists, and Licensed Clinical Social Workers should consult the applicable fee schedule relevant for his or her scope of practice when submitting bills for treatment.

20. Non-Schedule and Schedule Permanency Evaluations

Please refer to the WCB webpage **CMS1500** guidelines for current billing instructions, and the **Impairment Guidelines** webpage for exam requirements.

Non-schedule: Code 99245 is used for examinations and reports of non-schedule permanency evaluations performed by an authorized physician.

Schedule: Code 99243 is used for examinations and reports of schedule permanency evaluations performed by an authorized physician.

21. Telehealth

Effective July 11, 2023, the NYS Workers' Compensation Board adopted *permanent* regulations for telehealth appointments in certain situations. Telemedicine is not available to all provider types.

Treatment may be rendered by telehealth when medically appropriate and subject to the restrictions contained in the currently published regulations.

1. **Non Behavioral Health** Physicians, Nurse Practitioners, Physician Assistants, and Podiatrists may only bill:
 - E/M code **99212**
2. **Behavioral Health** Psychiatrists, Psych PAs, Psych NPs may bill:
 - E/M codes **99202-99204, 99212**
 - Psychotherapy/Combination/crisis codes: **90832-90834, 90836-90840**
 - Group therapy: **90853**
3. See the **Behavioral Health** Fee Schedule for Psychologist and LCSW telehealth billing guidelines.
4. All eligible provider types should use:
 - Modifier **95** for two-way Audio and Visual communication
 - Modifier **93** for Audio only
 - Place of service (POS) code **10** for patient located in their home
 - POS code **02** for patient located in a healthcare setting that is not their home
5. Modifier **1B** may **not** be used with E/M codes but may be billed with applicable psychotherapy/group therapy telehealth codes.

Updates or modifications to WCB Telemedicine regulations may supersede the content published in this edition of the WCB Fee Schedule.

All current rules and restrictions for telehealth are found on the WCB webpage: <https://www.wcb.ny.gov/telehealth/>

22. Category III Codes

Category III codes are temporary codes identifying emerging technology and should be reported when available. The use of these codes supersedes reporting the service with an unlisted code. Because these codes are temporary, some of them may only be covered on a case-by-case review, and all require Prior Authorization. The temporary codes may be converted to permanent CPT codes or deleted during periodic updates of the code set. The Category III codes will utilize the **Medicine** conversion factor. Any currently published WCB Bulletins may supersede this Ground Rule if necessary.

For a complete explanation of this process refer to the guidelines in CPT 2024.

22A. Extracorporeal Shockwave Therapy

Please see all applicable Medical Treatment Guidelines (MTG). Extracorporeal Shockwave Therapy is only rarely, if ever, recommended in the MTGs. Therefore, use of extracorporeal shockwave therapy will generally require prior authorization. The Category III codes for shockwave treatments will utilize the **Medicine** Conversion factor. Any currently published WCB Bulletins may supersede this Ground Rule if necessary.

23. Electronic Billing

Providers may offset the cost of using an electronic submission partner by using code 99080 as a "By Report" (BR) code, up to a maximum value of one dollar. The code should be placed on the same CMS1500 form for which the billable services payment and the electronic submission costs are being requested. The price listed by the provider for code 99080 should accurately reflect the actual cost incurred by the provider for the electronic submission of the individual bill, up to a maximum of one dollar.

Please see any current guidance on the WCB webpage.

24. Billing for Residents and Fellows

Treatment rendered by residents and fellows can only be billed by the Board authorized supervising physician.

Non-surgical service codes should be appended with modifier 1R. Services with modifier 1R must be billed and reimbursed at the same amount payable to the authorized supervising physician.

Assistant-at-surgery codes should be appended with modifier 84. Surgery codes with modifier 84 must be billed and reimbursed at 16 percent of the applicable physician code fee.

- A. All Fee Schedule Ground Rules for multiple procedures apply.
- B. Physicians cannot additionally bill for supervision of the resident.
- C. If the supervising surgeon bills for a resident/fellow assisting at surgery, only one additional assistant (NP/PA-modifier 83) may be billed, and only if documentation supports the necessity of the additional assistance.
- D. When applicable, modifier 84 should be appended to the individual codes of the surgery. All codes billed should accurately reflect work performed by the resident/fellow. Documentation in the operative/ procedure report should include all details.
- E. Payment may be decided based on review of documentation, as well as the usual and customary standards of CPT/CMS billing guidelines for allowance of assistants at surgery.
- F. Non-authorized out-of-state physicians may not bill for residents/fellows.
- G. Surgeons should not bill for services performed by a resident/fellow that would not normally be billed by another type of assistant at surgery.
- H. Payment shall not be made for observation, or for simple assistance such as closing basic surgical fields or work typically performed by nursing/technical staff.
- I. The name of the resident/fellow does not need to be documented on the CMS1500 form.
- J. All CMS1500 Narrative requirements do apply to any bills submitted. www.wcb.ny.gov/CMS-1500
- K. See WCB webpage for further guidance: <https://www.wcb.ny.gov/content/main/hcpp/residents-fellows.jsp>

2 Evaluation and Management (E/M)

The relative values listed in this section have been determined uniquely for evaluation and management (E/M) services. Use the E/M conversion factor when determining fee amounts. The E/M conversion factor is not applicable to any other section.

The fee for a procedure or service in this section is determined by multiplying the relative value by the E/M conversion factor, subject to the ground rules, instructions, and definitions of the schedule.

To ensure uniformity of billing when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately. After which, charges for products may be added.

CONVERSION FACTORS

Regional conversion factors for services rendered on or after TBD.

Section	Region I	Region II	Region III	Region IV
E/M - Codes* 99202-99215	\$15.93	\$15.93	\$16.07	\$16.07
E/M - Codes 99221-99499	\$12.11	\$12.11	\$13.85	\$15.06

*** Relative value units for E/M codes 99202-99215 for the Medical Fee Schedule are different than other fee schedules that contain the same codes. See E/M Ground Rule 1C.**

EVALUATION AND MANAGEMENT GROUND RULES

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

Note: Rules used by all physicians in reporting their services are presented in the General Ground Rules in the Introduction and General Guidelines section.

When exact text of the AMA CPT® guidelines is used, the text is either in quotations or is preceded by the phrase “CPT guidelines state.”

1A. NYS Medical Treatment Guidelines

Treatment of work-related injuries should be in accordance with any applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.

1B. Consultations

CPT guidelines define a consultation as “a type of evaluation and management service provided at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem.” In addition, “the consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.” Consultations are reimbursable only to providers with the appropriate specialty for the services provided.

Although not recognized by other payers such as the Centers for Medicare and Medicaid Services (CMS), the *Official New York State Workers' Compensation Medical Fee Schedule* continues to recognize consultation services reported with codes 99242–99255.

1C. Enhanced Reimbursement for Office Visits

Specific Evaluation and Management (E/M) visit codes are now eligible for increased reimbursement only when billed by physicians (MD, DO), nurse practitioners (NP) and physician assistants (PA).

Codes included are: 99202, 99203, 99204, 99205, and 99211, 99212, 99213, 99214, and 99215.

See the adjusted Conversion Factors per region in the chart for these particular codes.

The RVUs assigned to these codes have also increased. The codes' values can be found in the Evaluation and Management section.

Modifier 1B cannot be added to these E/M codes.

2. Referral

A referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. (Initial evaluations and subsequent services are designated as listed in E/M services CPT descriptions.)

3. Clinical Examples

It is important to note that the same problem, when seen by different specialties, may involve different levels and amounts of work. Therefore, the appropriate level of encounter should be reported using the descriptions as outlined for explanation of E/M services in the CPT book and this fee schedule rather than the clinical examples.

For more examples, please refer to CPT guidelines.

4. New and Established Patient Service

Several code subcategories in the Evaluation and Management section are based on the patient's status—new or established. *CPT* guidelines define a new patient as listed below. The established patient definition has been expanded from *CPT* for the New York State Fee Schedule (this text will be in italics).

New Patient

A new patient is one who has not received any professional services from the physician or qualified health care professional, or another physician or qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

Established Patient

An established patient is *a patient who has been treated for the same injury by any physician, regardless of specialty, who belongs to the same group practice. Because initial records such as history and physical are available within the group's facility, an initial new patient visit would not be indicated.*

The new versus established patient guidelines also clarify the situation in which a physician is on call or covering for another physician. In this instance, classify the patient encounter the same as if it were for the physician who is unavailable.

5. E/M Service Components

Level of service should be chosen as defined in the CPT year/version used in the currently published fee schedule effective at the time of the encounter.

6. Contributory Components

See Narrative Report section for details.

7. Narrative Reports

A detailed narrative report must be submitted with all services provided. Physicians & Nurse Practitioners narrative reports must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Physician Assistants must include Work Status & Temporary Impairment Percentages. Providers are strongly encouraged to use the narrative template format found on the WCB webpage [CMS-1500 Requirements](#).

Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/assessment of the patient.

Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed.

Any ordered medications, durable medical equipment, tests, or procedures should be thoroughly explained.

All entries in the medical record must be legible to another reader.

8. Guidelines Summary

This brief overview of the current guidelines should not be the provider's or payer's only experience with this section of the CPT book. Carefully read the complete guidelines in *CPT* version in effect at the time of the encounter.

9. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used with E/M procedures are as follows:

1B∞ Behavioral Health Provider Enhanced Reimbursement

- Provides a 20 percent reimbursement increase for certain E/M and psychotherapy services.

- The following types of codes may not be appended with modifier 1B: diagnostic testing codes, procedural codes, and E/M visit codes 99202-99205, and 99211-99215.
- Behavioral Health consultation codes may use modifier 1B.
- ** Modifier 1B may be used by psychologists and LCSWs with the appropriate telehealth codes.
- May only be used by the following WCB authorized Behavioral Health providers:
 - a. Licensed psychiatrist
 - b. Licensed physician with a specialty rating code from American Board of Psychiatry & Neurology as published on the WCB webpage
 - c. Board certified psychiatric nurse practitioner (NP)
 - d. Appropriately certified physician assistant (PA) with eligible supervising physician
 - e. Licensed psychologist
 - f. Licensed clinical social worker

** See current Telehealth Ground Rule and webpage: <https://www.wcb.ny.gov/telehealth/>

1R∞ Non-surgical services provided by residents and fellows

Billed and payable at the same applicable rate as the WCB authorized, supervising physician.

1R can be used for E/M codes, such as office visits, as well as for standalone procedures not performed during a surgery i.e., injections.

This modifier is not used for assistance at surgery. See Modifier 84 in Surgery section.

24 Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for reasons unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date (This CPT modifier is for use by Ambulatory Surgery Center (ASC) and Hospital Outpatient Settings Only.)

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

32 Mandated Services

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

52 Reduced Services

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

57 Decision for Surgery

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

93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System

Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

95[®] Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System

Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

99 Multiple Modifiers

Under certain circumstances, 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

10. Behavioral Health Provider Enhanced Reimbursement

In an effort to increase the number of Board authorized providers in the behavioral health to render care and treatment to injured workers, the WCB has established WCB specific modifier 1B.

- Provides a 20 percent reimbursement increase for certain E/M and psychotherapy services.
- The following types of codes may not be appended with modifier 1B: diagnostic testing codes, procedural codes, and E/M visit codes 99202-99205, and 99211-99215.
- Behavioral Health consultation codes may use modifier 1B.
- ** Modifier 1B may be used by psychologists and LCSWs with the appropriate telehealth codes.
- May only be used by the following WCB authorized Behavioral Health providers:
 - a. Licensed psychiatrist
 - b. Licensed physician with a specialty rating code from American Board of Psychiatry & Neurology as published on the WCB webpage
 - c. Board certified psychiatric nurse practitioner (NP)
 - d. Appropriately certified physician assistant (PA) with eligible supervising physician
 - e. Licensed psychologist
 - f. Licensed clinical social worker

** See current Telehealth Ground Rule and webpage: <https://www.wcb.ny.gov/telehealth/>

See **Appendix** for Behavioral Health Provider Enhanced Rating Codes.

11. Non-Schedule and Schedule Permanency Evaluations

Non-schedule: Code 99245 is used for examinations and reports of non-schedule permanency evaluations performed by an authorized physician.

Schedule: Code 99243 is used for examinations and reports of schedule permanency evaluations performed by an authorized physician.

12. Telehealth

Effective July 11, 2023, the NYS Workers' Compensation Board adopted *permanent* regulations for telehealth appointments in certain situations. Telemedicine is not available to all provider types.

Treatment may be rendered by telehealth when medically appropriate and subject to the restrictions contained in the currently published regulations.

1. **Non Behavioral Health** Physicians, Nurse Practitioners, Physician Assistants, and Podiatrists may only bill:
 - E/M code **99212**
2. **Behavioral Health** Psychiatrists, Psych PAs, Psych NPs may bill:
 - E/M codes **99202-99204, 99212**
 - Psychotherapy/Combination/crisis codes: **90832-90834, 90836-90840**
 - Group therapy: **90853**
3. See the **Behavioral Health** Fee Schedule for Psychologist and LCSW telehealth billing guidelines.
4. All eligible provider types should use:
 - Modifier **95** for two-way Audio and Visual communication
 - Modifier **93** for Audio only
 - Place of service (POS) code **10** for patient located in their home
 - POS code **02** for patient located in a healthcare setting that is not their home
5. Modifier **1B** may *not* be used with E/M codes but may be billed with applicable psychotherapy/group therapy telehealth codes.

Updates or modifications to WCB Telemedicine regulations may supersede the content published in this edition of the WCB Fee Schedule.

All current rules and restrictions for telehealth are found on the WCB webpage: <https://www.wcb.ny.gov/telehealth/>

13. Electronic Billing

Providers may offset the cost of using an electronic submission partner by using code 99080 as a "By Report" (BR) code, up to a maximum value of one dollar. The code should be placed on the same CMS1500 form for which the billable services payment and the electronic submission costs are being requested. The price listed by the provider for code 99080 should accurately reflect the actual cost incurred by the provider for the electronic submission of the individual bill, up to a maximum of one dollar.

Please see any current guidance on our webpage.

14. Billing for Residents and Fellows: (Non-surgical)

Treatment rendered by residents and fellows can only be billed by the Board authorized supervising physician. Non-surgical service codes should be appended with modifier 1R. Services with modifier 1R must be billed and reimbursed at the same amount payable to the authorized supervising physician.

- A. Physicians cannot additionally bill for supervision of the resident.
- B. All codes billed should accurately reflect work performed by the resident/fellow. Documentation in the report/narrative should include all details.
- C. Non-authorized out-of-state physicians may not bill for residents/fellows.
- D. Payment shall not be made for observation, or for simple assistance such as closing basic surgical fields or work typically performed by nursing/technical staff.
- E. The name of the resident/fellow does not need to be documented on the CMS1500 form.
- F. All CMS1500 Narrative requirements do apply to any bills submitted. <https://www.wcb.ny.gov/CMS-1500/>
- G. Also see modifier description 1R.

99202–99499

EVALUATION AND MANAGEMENT

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD
■	99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	7.75	XXX
■	99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	11.97	XXX
■	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	17.92	XXX
■	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	23.63	XXX
■	99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional	2.50	XXX
■	99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	6.07	XXX
■	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	9.74	XXX
■	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	13.72	XXX
■	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	19.32	XXX
■	99221	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	14.12	XXX
■	99222	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.	19.02	XXX
■	99223	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.	23.34	XXX

EVALUATION AND MANAGEMENT**99202–99499****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD
■	99231	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.	7.44	XXX
■	99232	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.	10.15	XXX
■	99233	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.	14.97	XXX
■	99234	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	13.95	XXX
■	99235	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.	18.94	XXX
■	99236	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.	23.84	XXX
■	99238	Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter	8.79	XXX
■	99239	Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter	10.99	XXX
■	99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	12.94	XXX
■	99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	16.49	XXX
■	99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	21.56	XXX
■	99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.	27.23	XXX

99202–99499

EVALUATION AND MANAGEMENT

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD
■	99252	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.	15.39	XXX
■	99253	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	18.94	XXX
■	99254	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	23.67	XXX
■	99255	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.	29.76	XXX
■	99281	Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional	6.59	XXX
■	99282	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making	8.88	XXX
■	99283	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making	13.36	XXX
■	99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making	19.95	XXX
■	99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making	29.76	XXX
	99288	Physician or other qualified health care professional direction of emergency medical systems (EMS) emergency care, advanced life support	14.00	XXX
	99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	33.82	XXX
+	99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)	16.91	ZZZ
■	99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.	8.46	XXX
■	99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.	11.84	XXX
■	99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.	14.37	XXX

EVALUATION AND MANAGEMENT**99202–99499****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD
■	99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	4.73	XXX
■	99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	6.43	XXX
■	99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	9.30	XXX
■	99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	12.68	XXX
■	99315	Nursing facility discharge management; 30 minutes or less total time on the date of the encounter	8.79	XXX
■	99316	Nursing facility discharge management; more than 30 minutes total time on the date of the encounter	10.99	XXX
■	99341	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	7.69	XXX
■	99342	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	9.64	XXX
■	99344	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	17.76	XXX
■	99345	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.	24.01	XXX
■	99347	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	6.00	XXX
■	99348	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	7.69	XXX
■	99349	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	11.16	XXX

99202–99499

EVALUATION AND MANAGEMENT

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD
■	99350	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	17.84	XXX
	99358	Prolonged evaluation and management service before and/or after direct patient care; first hour	18.60	XXX
+	99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)	9.30	ZZZ
	99360	Standby service, requiring prolonged attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	12.68	XXX
	99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional	4.57	XXX
	99367	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician	6.09	XXX
	99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional	3.89	XXX
	99374	Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	NC	XXX
	99375	Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	NC	XXX
	99377	Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	NC	XXX

EVALUATION AND MANAGEMENT**99202–99499****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD
99378	Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	NC	XXX
99379	Supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	NC	XXX
99380	Supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	NC	XXX
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	1.69	XXX
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	3.38	XXX
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	4.06	XXX
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	7.95	XXX
■ + 99415	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)	1.92	ZZZ
■ + 99416	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service)	0.89	ZZZ
■ + 99417	Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)	5.99	ZZZ
■ + 99418	Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service)	8.05	ZZZ
99429	Unlisted preventive medicine service	NC	XXX

99202–99499

EVALUATION AND MANAGEMENT

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	5.07	XXX
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	8.46	XXX
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	10.99	XXX
■ 99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	3.65	XXX
■ 99447	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review	7.23	XXX
■ 99448	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review	10.88	XXX
■ 99449	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	14.53	XXX
99450	Basic life and/or disability examination that includes: Measurement of height, weight, and blood pressure; Completion of a medical history following a life insurance pro forma; Collection of blood sample and/or urinalysis complying with "chain of custody" protocols; and Completion of necessary documentation/certificates.	NC	XXX
99455	Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.	BR	XXX
99456	Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.	BR	XXX

EVALUATION AND MANAGEMENT**99202–99499****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD
■ +	99459	Pelvic examination (List separately in addition to code for primary procedure)	4.16	ZZZ
■	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination, Medical decision making of moderate or high complexity, Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (eg, home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 60 minutes of total time is spent on the date of the encounter.	45.97	XXX
■	99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.	9.23	XXX
■	99487	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	17.99	XXX
■ +	99489	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	8.96	ZZZ
■	99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	8.14	XXX

99202–99499

EVALUATION AND MANAGEMENT

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD
■	99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.	30.65	XXX
■	99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.	24.49	XXX
+	99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)	12.66	ZZZ
■	99495	Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, At least moderate level of medical decision making during the service period, Face-to-face visit, within 14 calendar days of discharge	31.74	XXX
■	99496	Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, High level of medical decision making during the service period, Face-to-face visit, within 7 calendar days of discharge	44.94	XXX
	99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	16.35	XXX
+	99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)	14.43	ZZZ
	99499	Unlisted evaluation and management service	BR	XXX

3 Anesthesia

The anesthesia base units are adapted from the American Society of Anesthesiologists' (ASA) *Relative Value Guide*®.

The fee for a procedure or service in this section is determined by multiplying the ASA basic value and other units by the anesthesia conversion factor, subject to the ground rules, instructions, and definitions of the schedule.

CONVERSION FACTORS

Regional conversion factors for services rendered on or after TBD.

Section	Region I	Region II	Region III	Region IV
Anesthesia	\$23.88	\$23.88	\$27.34	\$29.71

ANESTHESIA GROUND RULES

Definitions and rules pertaining to Anesthesia services are as follows:

Note: Rules used by all providers in reporting their services are presented in the General Ground Rules in the Introduction and General Guidelines section.

1A. NYS Medical Treatment Guidelines

Treatment of work-related injuries should be in accordance with any applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.

1B. General and CRNA Services

Anesthesia services are listed for each procedure in the Anesthesia section and for certain procedures in other sections. The codes are to be used only when the anesthesia is personally administered by an anesthesiologist or a certified registered nurse anesthetist (CRNA) under the supervision of an anesthesiologist. The anesthesiologist or CRNA must remain in constant attendance during the procedure for the sole purpose of rendering such anesthesia service.

The bill for CRNA services must be submitted by the supervising anesthesiologist, using accurate and appropriate codes. The bill for CRNA services should be limited to anesthesia administration that is within their NYS scope of practice.

Anesthesia Modifiers QY or QK should be used.

Reimbursement will be at 80 percent of the Physician's Fee Schedule.

Supervision of a CRNA requires that the supervising anesthesiologist be present in the office suite or operating room area at all times during the procedure.

The following services are included in the provision of anesthesia when performed on the same date and are not reported separately:

- Pre- and post-operative visits
- Administration of the anesthetic, fluids and/or blood
- Usual monitoring services
 - Blood pressure
 - Capnography
 - ECG
 - Mass spectrometry
 - Oximetry
 - Temperature

Intra-arterial, flow directed catheters (Swan-Ganz), and central venous are methods of monitoring that may be separately reported.

2. Monitoring Services

When an anesthesiologist is required to participate in and be responsible for monitoring the general care of the patient during a surgical procedure but does not administer anesthesia, these services are charged on the basis of the extent of the services rendered.

Payment will be made on the basis of the time units the anesthesiologist is in constant contact attendance for the sole purpose of monitoring services; basic anesthesia unit values will not be added.

3. Anesthesia Administered by Other Than an Anesthesiologist

Anesthesia fees are not payable when local infiltration, digital or regional block, or topical anesthesia is administered by the operating surgeon or surgical assistants. These services are included in the surgical procedure.

4. Miscellaneous

- A. For cardiopulmonary resuscitation (separate procedure unrelated to the administration of anesthesia) see 92950.
- B. For obstetrical anesthesia refer to Ground Rule 6: Calculation of Total Anesthesia Values.
- C. Values for office, home, and hospital visits, consultations and other medical services, x-ray, surgery, and laboratory procedures are listed in the Evaluation and Management, Surgery, Radiology, Pathology and Laboratory, Medicine, and Physical Medicine sections.
- D. A consultation fee is not payable to an anesthesiologist examining the patient prior to administering anesthesia to that patient. No additional charge is to be made for routine follow-up care and observation.
- E. Materials and supplies used to administer anesthesia are included in the total anesthesia fee. Separate charges by the anesthesiologist or the hospital for supplies and materials are not allowed.

5. Billing

Anesthesia services are to be billed using procedure codes 00100–01999. Surgical codes billed with a modifier are not acceptable. Use appropriate modifiers to designate unusual or additional conditions that may apply. The basic anesthesia unit value includes recovery room care. No additional time units are allowed for recovery room observation and monitoring.

6. Calculation of Total Anesthesia Values

The total anesthesia value is calculated by adding the listed basic value and time units. A basic value is listed in the *ASA Relative Value Guide*® for most procedures. This includes the values of all anesthesia services except the value of the actual time spent administering the anesthesia or in the unusual detention with the patient.

The time units are computed by allowing one unit for each 15 minutes, or fraction thereof, of anesthesia time. A fraction of time is defined as one minute. Therefore, 16 minutes constitutes two time units.

Anesthesia time begins when the anesthesiologist starts physically to prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends not more than 15 minutes after service in the operating room is concluded and the patient is placed under postoperative supervision.

If the anesthesia time extends beyond three hours, 1.0 unit for each 10 minutes, or fraction thereof, is allowed after the first three hours. This does not apply to obstetrical anesthesia for which 15 minute time increments are applicable for the entire duration of the service. Actual time of beginning and duration of anesthesia time may require documentation, such as a copy of the anesthesia record in the hospital file. Fees when applicable are identical for general, spinal, regional, or hypothermia anesthesia.

When multiple surgical procedures are performed during the same period of anesthesia, only the greatest basic value of the various surgical procedures will be used. For example, when a bronchoscopy with a basic value of 6.0 units is followed by a thoracostomy with a basic value of 12.0 units during the same period of anesthesia, the basic value to be used is only 12.0 units. To this value are added time units applicable for the entire period of anesthesia time for the multiple procedures performed. The examples below illustrate two calculations:

Example

In a procedure with a basic value of 3.0 units requiring one hour and forty-five minutes of anesthesia time, the time units total 7.0 and are added to the basic value of 3.0, resulting in a value of 10.0 units for this anesthesia service. Multiply the 10.0 units by the anesthesia conversion factor for your region to calculate the fee expressed in dollars.

Example

In a procedure with a basic unit value of 25.0 units requiring four hours and twenty minutes of anesthesia time, the total value will be determined as follows:

Basic unit value	=	25.0 units
First three hours (15-minute increments)	=	12.0 units
Subsequent 80 minutes (10-minute increments)	=	8.0 units
Total	=	45.0 units

To calculate the fee expressed in dollars, multiply 45.0 units by the anesthesia conversion factor for your region.

List basic unit values and time unit values separately; the sum of these values is the total anesthesia value, as per the following format:

Step 1:

	Procedure Number Units
+	Anesthesia Modifier Units
=	Basic Value Units

Step 2:

	Basic Value Units
+	Time Units (Anesthesia Time / 15 (or 10))
=	Total Units

Step 3:

	Total Units
×	Dollar Conversion Factor
=	Total Dollar Amount

7. Physical Status Modifiers

Physical status modifiers reflect the patient's state of health. Individuals undergoing surgery may be healthy or may have varying degrees of systemic disease. A patient's health status affects the work related to providing the anesthesia service. Use modifiers P1–P6 to report the patient's health status.

See the ASA *Relative Value Guide*® for units allowed for each modifier.

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

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

8. Modifiers

Bill using the correct anesthesia codes 00100–01999. Add appropriate anesthesia modifiers to the procedure number to indicate that billing is for unusual or complicated circumstances.

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used with anesthesia procedures are as follows:

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

23 Unusual Anesthesia

Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

32 Mandated Services

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

Modifier QK

Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals. The supervising anesthesiologist must bill at 80 percent of the physician fee schedule for that code.

Modifier QY

Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist. The supervising anesthesiologist must bill at 80 percent of the physician fee schedule for that code.

9. Qualifying Circumstances

Codes 99100–99140 identify circumstances that affect the anesthesia services provided. These add-on codes are only to be used with an anesthesia code to recognize the difficult circumstances under which the anesthesia care was administered. When appropriate, more than one qualifying circumstance code may be used.

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

List basic unit values and time unit values separately; the sum of these values is the total anesthesia value, as per the following format:

Step 1:

	Procedure Number Units
+	Anesthesia Modifier Units
+	Qualifying Circumstances Units
=	Basic Value Units

Step 2:

	Basic Value Units
+	Time Units (Anesthesia Time / 15 (or 10))
=	Total Units

Step 3:

	Total Units
×	Dollar Conversion Factor
=	Total Dollar Amount

Example

In a procedure with a basic unit value of 25.0 units requiring four hours and twenty minutes of anesthesia time, and qualifying circumstances of 99140, the total value will be determined as follows:

Basic unit value	=	25.0 units
99140	=	2.0 units
First three hours (15-minute increments)	=	12.0 units
Subsequent 80 minutes (10-minute increments)	=	8.0 units
Total	=	47.0 units

To calculate the fee expressed in dollars, multiply 47.0 units by the anesthesia conversion factor for your region.

10. Supplemental Skills

When warranted by the necessity of supplemental skills, values for the services of two or more providers will be allowed. Substantiate by report justifying the need.

11. Moderate (Conscious) Sedation

Sedation with or without analgesia is used to achieve a state of depressed consciousness while maintaining the patient's ability to control their own breathing as well as respond to stimulation. The use of these codes requires the presence of an independent trained observer to assist the provider in monitoring the patient's level of consciousness and physiological status.

Conscious sedation includes pre- and post-sedation evaluations, administration of the sedation, and monitoring of cardiorespiratory function.

Codes 99151–99153 identify moderate (conscious) sedation services provided by the same provider performing the diagnostic or therapeutic service that the sedation supports. CPT codes 99155–99157 identify moderate (conscious) sedation services provided by a second provider other than the health care professional performing the diagnostic or therapeutic service. When moderate (conscious) sedation services are provided by a second provider in a facility setting or non-facility setting, the conscious sedation service may be billed separately. See General Ground Rule 12 for additional guidelines related to reporting of moderate (conscious) sedation.

ANESTHESIA**00100-01999, 99100-99140****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value
00100	Anesthesia for procedures on salivary glands, including biopsy	5.00
00102	Anesthesia for procedures involving plastic repair of cleft lip	6.00
00103	Anesthesia for reconstructive procedures of eyelid (eg, blepharoplasty, ptosis surgery)	5.00
00104	Anesthesia for electroconvulsive therapy	4.00
00120	Anesthesia for procedures on external, middle, and inner ear including biopsy; not otherwise specified	5.00
00124	Anesthesia for procedures on external, middle, and inner ear including biopsy; otoscopy	4.00
00126	Anesthesia for procedures on external, middle, and inner ear including biopsy; tympanotomy	4.00
00140	Anesthesia for procedures on eye; not otherwise specified	5.00
00142	Anesthesia for procedures on eye; lens surgery	4.00
00144	Anesthesia for procedures on eye; corneal transplant	6.00
00145	Anesthesia for procedures on eye; vitreoretinal surgery	6.00
00147	Anesthesia for procedures on eye; iridectomy	6.00
00148	Anesthesia for procedures on eye; ophthalmoscopy	4.00
00160	Anesthesia for procedures on nose and accessory sinuses; not otherwise specified	5.00
00162	Anesthesia for procedures on nose and accessory sinuses; radical surgery	7.00
00164	Anesthesia for procedures on nose and accessory sinuses; biopsy, soft tissue	4.00
00170	Anesthesia for intraoral procedures, including biopsy; not otherwise specified	5.00
00172	Anesthesia for intraoral procedures, including biopsy; repair of cleft palate	6.00
00174	Anesthesia for intraoral procedures, including biopsy; excision of retropharyngeal tumor	6.00
00176	Anesthesia for intraoral procedures, including biopsy; radical surgery	7.00
00190	Anesthesia for procedures on facial bones or skull; not otherwise specified	5.00
00192	Anesthesia for procedures on facial bones or skull; radical surgery (including prognathism)	7.00
00210	Anesthesia for intracranial procedures; not otherwise specified	11.00
00211	Anesthesia for intracranial procedures; craniotomy or craniectomy for evacuation of hematoma	10.00
00212	Anesthesia for intracranial procedures; subdural taps	5.00
00214	Anesthesia for intracranial procedures; burr holes, including ventriculography	9.00
00215	Anesthesia for intracranial procedures; cranioplasty or elevation of depressed skull fracture, extradural (simple or compound)	9.00
00216	Anesthesia for intracranial procedures; vascular procedures	15.00
00218	Anesthesia for intracranial procedures; procedures in sitting position	13.00
00220	Anesthesia for intracranial procedures; cerebrospinal fluid shunting procedures	10.00
00222	Anesthesia for intracranial procedures; electrocoagulation of intracranial nerve	6.00
00300	Anesthesia for all procedures on the integumentary system, muscles and nerves of head, neck, and posterior trunk, not otherwise specified	5.00
00320	Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; not otherwise specified, age 1 year or older	6.00
00322	Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; needle biopsy of thyroid	3.00
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10.00
00352	Anesthesia for procedures on major vessels of neck; simple ligation	5.00

00100-01999, 99100-99140**ANESTHESIA**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified	3.00
00402	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; reconstructive procedures on breast (eg, reduction or augmentation mammoplasty, muscle flaps)	5.00
00404	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; radical or modified radical procedures on breast	5.00
00406	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; radical or modified radical procedures on breast with internal mammary node dissection	13.00
00410	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; electrical conversion of arrhythmias	4.00
00450	Anesthesia for procedures on clavicle and scapula; not otherwise specified	5.00
00454	Anesthesia for procedures on clavicle and scapula; biopsy of clavicle	3.00
00470	Anesthesia for partial rib resection; not otherwise specified	6.00
00472	Anesthesia for partial rib resection; thoracoplasty (any type)	10.00
00474	Anesthesia for partial rib resection; radical procedures (eg, pectus excavatum)	13.00
00500	Anesthesia for all procedures on esophagus	15.00
00520	Anesthesia for closed chest procedures; (including bronchoscopy) not otherwise specified	6.00
00522	Anesthesia for closed chest procedures; needle biopsy of pleura	4.00
00524	Anesthesia for closed chest procedures; pneumocentesis	4.00
00528	Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy not utilizing 1 lung ventilation	8.00
00529	Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy utilizing 1 lung ventilation	11.00
00530	Anesthesia for permanent transvenous pacemaker insertion	4.00
00532	Anesthesia for access to central venous circulation	4.00
00534	Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator	7.00
00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation	10.00
00539	Anesthesia for tracheobronchial reconstruction	18.00
00540	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified	12.00
00541	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing 1 lung ventilation	15.00
00542	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); decortication	15.00
00546	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); pulmonary resection with thoracoplasty	15.00
00548	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); intrathoracic procedures on the trachea and bronchi	17.00
00550	Anesthesia for sternal debridement	10.00
00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	15.00

ANESTHESIA**00100-01999, 99100-99140****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value
00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age 1 year or older, for all noncoronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than 1 month after original operation	20.00
00563	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest	25.00
00566	Anesthesia for direct coronary artery bypass grafting; without pump oxygenator	25.00
00567	Anesthesia for direct coronary artery bypass grafting; with pump oxygenator	18.00
00580	Anesthesia for heart transplant or heart/lung transplant	20.00
00600	Anesthesia for procedures on cervical spine and cord; not otherwise specified	10.00
00604	Anesthesia for procedures on cervical spine and cord; procedures with patient in the sitting position	13.00
00620	Anesthesia for procedures on thoracic spine and cord, not otherwise specified	10.00
00625	Anesthesia for procedures on the thoracic spine and cord, via an anterior transthoracic approach; not utilizing 1 lung ventilation	13.00
00626	Anesthesia for procedures on the thoracic spine and cord, via an anterior transthoracic approach; utilizing 1 lung ventilation	15.00
00630	Anesthesia for procedures in lumbar region; not otherwise specified	8.00
00632	Anesthesia for procedures in lumbar region; lumbar sympathectomy	7.00
00635	Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture	4.00
00640	Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine	3.00
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)	13.00
00700	Anesthesia for procedures on upper anterior abdominal wall; not otherwise specified	4.00
00702	Anesthesia for procedures on upper anterior abdominal wall; percutaneous liver biopsy	4.00
00730	Anesthesia for procedures on upper posterior abdominal wall	5.00
00731	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified	5.00
00732	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)	6.00
00750	Anesthesia for hernia repairs in upper abdomen; not otherwise specified	4.00
00752	Anesthesia for hernia repairs in upper abdomen; lumbar and ventral (incisional) hernias and/or wound dehiscence	6.00
00754	Anesthesia for hernia repairs in upper abdomen; omphalocele	7.00
00756	Anesthesia for hernia repairs in upper abdomen; transabdominal repair of diaphragmatic hernia	7.00
00770	Anesthesia for all procedures on major abdominal blood vessels	15.00
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	7.00
00792	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; partial hepatectomy or management of liver hemorrhage (excluding liver biopsy)	13.00
00794	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; pancreatectomy, partial or total (eg, Whipple procedure)	8.00
00796	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)	30.00

00100-01999, 99100-99140

ANESTHESIA

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value
00797	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity	11.00
00800	Anesthesia for procedures on lower anterior abdominal wall; not otherwise specified	4.00
00802	Anesthesia for procedures on lower anterior abdominal wall; panniculectomy	5.00
00811	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified	4.00
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	4.00
00813	Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum	5.00
00820	Anesthesia for procedures on lower posterior abdominal wall	5.00
00830	Anesthesia for hernia repairs in lower abdomen; not otherwise specified	4.00
00832	Anesthesia for hernia repairs in lower abdomen; ventral and incisional hernias	6.00
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified	6.00
00842	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; amniocentesis	4.00
00844	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; abdominoperineal resection	7.00
00846	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; radical hysterectomy	8.00
00848	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; pelvic exenteration	8.00
00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/ transection	6.00
00860	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified	6.00
00862	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal procedures, including upper one-third of ureter, or donor nephrectomy	7.00
00864	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; total cystectomy	8.00
00865	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; radical prostatectomy (suprapubic, retropubic)	7.00
00866	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; adrenalectomy	10.00
00868	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal transplant (recipient)	10.00
00870	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; cystolithotomy	5.00
00872	Anesthesia for lithotripsy, extracorporeal shock wave; with water bath	7.00
00873	Anesthesia for lithotripsy, extracorporeal shock wave; without water bath	5.00
00880	Anesthesia for procedures on major lower abdominal vessels; not otherwise specified	15.00
00882	Anesthesia for procedures on major lower abdominal vessels; inferior vena cava ligation	10.00
00902	Anesthesia for; anorectal procedure	5.00
00904	Anesthesia for; radical perineal procedure	7.00

ANESTHESIA**00100-01999, 99100-99140****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value
00906	Anesthesia for; vulvectomy	4.00
00908	Anesthesia for; perineal prostatectomy	6.00
00910	Anesthesia for transurethral procedures (including urethrocystoscopy); not otherwise specified	3.00
00912	Anesthesia for transurethral procedures (including urethrocystoscopy); transurethral resection of bladder tumor(s)	5.00
00914	Anesthesia for transurethral procedures (including urethrocystoscopy); transurethral resection of prostate	5.00
00916	Anesthesia for transurethral procedures (including urethrocystoscopy); post-transurethral resection bleeding	5.00
00918	Anesthesia for transurethral procedures (including urethrocystoscopy); with fragmentation, manipulation and/or removal of ureteral calculus	5.00
00920	Anesthesia for procedures on male genitalia (including open urethral procedures); not otherwise specified	3.00
00921	Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral	3.00
00922	Anesthesia for procedures on male genitalia (including open urethral procedures); seminal vesicles	6.00
00924	Anesthesia for procedures on male genitalia (including open urethral procedures); undescended testis, unilateral or bilateral	4.00
00926	Anesthesia for procedures on male genitalia (including open urethral procedures); radical orchiectomy, inguinal	4.00
00928	Anesthesia for procedures on male genitalia (including open urethral procedures); radical orchiectomy, abdominal	6.00
00930	Anesthesia for procedures on male genitalia (including open urethral procedures); orchiopexy, unilateral or bilateral	4.00
00932	Anesthesia for procedures on male genitalia (including open urethral procedures); complete amputation of penis	4.00
00934	Anesthesia for procedures on male genitalia (including open urethral procedures); radical amputation of penis with bilateral inguinal lymphadenectomy	6.00
00936	Anesthesia for procedures on male genitalia (including open urethral procedures); radical amputation of penis with bilateral inguinal and iliac lymphadenectomy	8.00
00938	Anesthesia for procedures on male genitalia (including open urethral procedures); insertion of penile prosthesis (perineal approach)	4.00
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified	3.00
00942	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); colpotomy, vaginectomy, colporrhaphy, and open urethral procedures	4.00
00944	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal hysterectomy	6.00
00948	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); cervical cerclage	4.00
00950	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); culdoscopy	5.00
00952	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography	4.00
01112	Anesthesia for bone marrow aspiration and/or biopsy, anterior or posterior iliac crest	5.00

00100-01999, 99100-99140**ANESTHESIA**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value
01120	Anesthesia for procedures on bony pelvis	6.00
01130	Anesthesia for body cast application or revision	3.00
01140	Anesthesia for interpelviabdominal (hindquarter) amputation	15.00
01150	Anesthesia for radical procedures for tumor of pelvis, except hindquarter amputation	10.00
01160	Anesthesia for closed procedures involving symphysis pubis or sacroiliac joint	4.00
01170	Anesthesia for open procedures involving symphysis pubis or sacroiliac joint	8.00
01173	Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum	12.00
01200	Anesthesia for all closed procedures involving hip joint	4.00
01202	Anesthesia for arthroscopic procedures of hip joint	4.00
01210	Anesthesia for open procedures involving hip joint; not otherwise specified	6.00
01212	Anesthesia for open procedures involving hip joint; hip disarticulation	10.00
01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	8.00
01215	Anesthesia for open procedures involving hip joint; revision of total hip arthroplasty	10.00
01220	Anesthesia for all closed procedures involving upper two-thirds of femur	4.00
01230	Anesthesia for open procedures involving upper two-thirds of femur; not otherwise specified	6.00
01232	Anesthesia for open procedures involving upper two-thirds of femur; amputation	5.00
01234	Anesthesia for open procedures involving upper two-thirds of femur; radical resection	8.00
01250	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of upper leg	4.00
01260	Anesthesia for all procedures involving veins of upper leg, including exploration	3.00
01270	Anesthesia for procedures involving arteries of upper leg, including bypass graft; not otherwise specified	8.00
01272	Anesthesia for procedures involving arteries of upper leg, including bypass graft; femoral artery ligation	4.00
01274	Anesthesia for procedures involving arteries of upper leg, including bypass graft; femoral artery embolectomy	6.00
01320	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of knee and/or popliteal area	4.00
01340	Anesthesia for all closed procedures on lower one-third of femur	4.00
01360	Anesthesia for all open procedures on lower one-third of femur	5.00
01380	Anesthesia for all closed procedures on knee joint	3.00
01382	Anesthesia for diagnostic arthroscopic procedures of knee joint	3.00
01390	Anesthesia for all closed procedures on upper ends of tibia, fibula, and/or patella	3.00
01392	Anesthesia for all open procedures on upper ends of tibia, fibula, and/or patella	4.00
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified	4.00
01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	7.00
01404	Anesthesia for open or surgical arthroscopic procedures on knee joint; disarticulation at knee	5.00
01420	Anesthesia for all cast applications, removal, or repair involving knee joint	3.00
01430	Anesthesia for procedures on veins of knee and popliteal area; not otherwise specified	3.00
01432	Anesthesia for procedures on veins of knee and popliteal area; arteriovenous fistula	6.00
01440	Anesthesia for procedures on arteries of knee and popliteal area; not otherwise specified	8.00

ANESTHESIA**00100-01999, 99100-99140****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value
01442	Anesthesia for procedures on arteries of knee and popliteal area; popliteal thromboendarterectomy, with or without patch graft	8.00
01444	Anesthesia for procedures on arteries of knee and popliteal area; popliteal excision and graft or repair for occlusion or aneurysm	8.00
01462	Anesthesia for all closed procedures on lower leg, ankle, and foot	3.00
01464	Anesthesia for arthroscopic procedures of ankle and/or foot	3.00
01470	Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; not otherwise specified	3.00
01472	Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; repair of ruptured Achilles tendon, with or without graft	5.00
01474	Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; gastrocnemius recession (eg, Strayer procedure)	5.00
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified	3.00
01482	Anesthesia for open procedures on bones of lower leg, ankle, and foot; radical resection (including below knee amputation)	4.00
01484	Anesthesia for open procedures on bones of lower leg, ankle, and foot; osteotomy or osteoplasty of tibia and/or fibula	4.00
01486	Anesthesia for open procedures on bones of lower leg, ankle, and foot; total ankle replacement	7.00
01490	Anesthesia for lower leg cast application, removal, or repair	3.00
01500	Anesthesia for procedures on arteries of lower leg, including bypass graft; not otherwise specified	8.00
01502	Anesthesia for procedures on arteries of lower leg, including bypass graft; embolectomy, direct or with catheter	6.00
01520	Anesthesia for procedures on veins of lower leg; not otherwise specified	3.00
01522	Anesthesia for procedures on veins of lower leg; venous thrombectomy, direct or with catheter	5.00
01610	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla	5.00
01620	Anesthesia for all closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint	4.00
01622	Anesthesia for diagnostic arthroscopic procedures of shoulder joint	4.00
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5.00
01634	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; shoulder disarticulation	9.00
01636	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; interthoracoscaphular (forequarter) amputation	15.00
01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	10.00
01650	Anesthesia for procedures on arteries of shoulder and axilla; not otherwise specified	6.00
01652	Anesthesia for procedures on arteries of shoulder and axilla; axillary-brachial aneurysm	10.00
01654	Anesthesia for procedures on arteries of shoulder and axilla; bypass graft	8.00
01656	Anesthesia for procedures on arteries of shoulder and axilla; axillary-femoral bypass graft	10.00
01670	Anesthesia for all procedures on veins of shoulder and axilla	4.00
01680	Anesthesia for shoulder cast application, removal or repair, not otherwise specified	3.00

00100-01999, 99100-99140**ANESTHESIA**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value
01710	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; not otherwise specified	3.00
01712	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenotomy, elbow to shoulder, open	5.00
01714	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenoplasty, elbow to shoulder	5.00
01716	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenodesis, rupture of long tendon of biceps	5.00
01730	Anesthesia for all closed procedures on humerus and elbow	3.00
01732	Anesthesia for diagnostic arthroscopic procedures of elbow joint	3.00
01740	Anesthesia for open or surgical arthroscopic procedures of the elbow; not otherwise specified	4.00
01742	Anesthesia for open or surgical arthroscopic procedures of the elbow; osteotomy of humerus	5.00
01744	Anesthesia for open or surgical arthroscopic procedures of the elbow; repair of nonunion or malunion of humerus	5.00
01756	Anesthesia for open or surgical arthroscopic procedures of the elbow; radical procedures	6.00
01758	Anesthesia for open or surgical arthroscopic procedures of the elbow; excision of cyst or tumor of humerus	5.00
01760	Anesthesia for open or surgical arthroscopic procedures of the elbow; total elbow replacement	7.00
01770	Anesthesia for procedures on arteries of upper arm and elbow; not otherwise specified	6.00
01772	Anesthesia for procedures on arteries of upper arm and elbow; embolectomy	6.00
01780	Anesthesia for procedures on veins of upper arm and elbow; not otherwise specified	3.00
01782	Anesthesia for procedures on veins of upper arm and elbow; phleborrhaphy	4.00
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3.00
01820	Anesthesia for all closed procedures on radius, ulna, wrist, or hand bones	3.00
01829	Anesthesia for diagnostic arthroscopic procedures on the wrist	3.00
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified	3.00
01832	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; total wrist replacement	6.00
01840	Anesthesia for procedures on arteries of forearm, wrist, and hand; not otherwise specified	6.00
01842	Anesthesia for procedures on arteries of forearm, wrist, and hand; embolectomy	6.00
01844	Anesthesia for vascular shunt, or shunt revision, any type (eg, dialysis)	6.00
01850	Anesthesia for procedures on veins of forearm, wrist, and hand; not otherwise specified	3.00
01852	Anesthesia for procedures on veins of forearm, wrist, and hand; phleborrhaphy	4.00
01860	Anesthesia for forearm, wrist, or hand cast application, removal, or repair	3.00
01916	Anesthesia for diagnostic arteriography/venography	5.00
01920	Anesthesia for cardiac catheterization including coronary angiography and ventriculography (not to include Swan-Ganz catheter)	7.00
01922	Anesthesia for non-invasive imaging or radiation therapy	7.00
01924	Anesthesia for therapeutic interventional radiological procedures involving the arterial system; not otherwise specified	6.00
01925	Anesthesia for therapeutic interventional radiological procedures involving the arterial system; carotid or coronary	8.00

ANESTHESIA**00100-01999, 99100-99140****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value
	01926	Anesthesia for therapeutic interventional radiological procedures involving the arterial system; intracranial, intracardiac, or aortic	10.00
	01930	Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified	5.00
	01931	Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); intrahepatic or portal circulation (eg, transvenous intrahepatic portosystemic shunt[s] [TIPS])	7.00
	01932	Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); intrathoracic or jugular	7.00
	01933	Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); intracranial	8.00
■	01937	Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic	4.00
■	01938	Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral	4.00
■	01939	Anesthesia for percutaneous image-guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic	4.00
■	01940	Anesthesia for percutaneous image-guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral	4.00
■	01941	Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic	5.00
■	01942	Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral	5.00
	01951	Anesthesia for second- and third-degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; less than 4% total body surface area	3.00
	01952	Anesthesia for second- and third-degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; between 4% and 9% of total body surface area	5.00
+	01953	Anesthesia for second- and third-degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; each additional 9% total body surface area or part thereof (List separately in addition to code for primary procedure)	1.00
	01958	Anesthesia for external cephalic version procedure	5.00
	01960	Anesthesia for vaginal delivery only	5.00
	01961	Anesthesia for cesarean delivery only	7.00
	01962	Anesthesia for urgent hysterectomy following delivery	8.00
	01963	Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care	10.00
	01965	Anesthesia for incomplete or missed abortion procedures	4.00
	01966	Anesthesia for induced abortion procedures	4.00
	01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)	5.00
+	01968	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)	3.00
+	01969	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)	5.00

00100-01999, 99100-99140**ANESTHESIA**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value
	01990	Physiological support for harvesting of organ(s) from brain-dead patient	7.00
	01991	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); other than the prone position	3.00
	01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); prone position	5.00
	01996	Daily hospital management of epidural or subarachnoid continuous drug administration	3.00
	01999	Unlisted anesthesia procedure(s)	0.00
+	99100	Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure)	1.00
+	99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)	5.00
+	99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)	5.00
+	99140	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure)	2.00

4 Surgery

The relative value units in this section were determined uniquely for surgery services. Use the surgery conversion factor when determining fee amounts. The surgery conversion factor is not applicable to any other section.

The fee for a procedure or service in this section is determined by multiplying the relative value unit by the surgery conversion factor, subject to the ground rules, instructions, and definitions of the schedule.

To ensure uniformity of billing when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately. After which, charges for products may be added.

CONVERSION FACTORS

Regional conversion factors for services rendered on or after TBD.

Section	Region I	Region II	Region III	Region IV
Surgery	\$202.53	\$202.53	\$231.78	\$251.94

SURGERY GROUND RULES

Definitions and items pertaining to surgery are as follows:

Note: Rules used by all physicians in reporting their services are presented in the General Ground Rules in the Introduction and General Guidelines section.

1A. NYS Medical Treatment Guidelines

Treatment of work-related injuries should be in accordance with any applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or

Workers' Compensation Board has approved a variance. All other treatments require prior authorization.

1B. Package or Global Fee Concept

Listed values for all surgical procedures include the surgery, local infiltration, digital or regional block, and/or topical anesthesia when used and the normal follow-up care for the period indicated in days in the column headed "FUD." (See Surgery Ground Rule 6: Follow Up-Aftercare.) (For preoperative visits, see Surgery Ground Rule 2: Immediate Preoperative Visits and Other Services.)

Payment is for the procedure coded and described, irrespective of the methods or appliances used to perform the procedure. The relative value units are applicable to all physicians who perform the listed services.

2. Immediate Preoperative Visits and Other Services

Under most circumstances, including ordinary referrals, the immediate preoperative visit in the hospital or elsewhere necessary to examine the patient, complete the hospital records and initiate the treatment program is included in the listed value for the surgical procedure.

Additional charges may be warranted for preoperative services under the following circumstances:

- A. When the preoperative visit is the initial visit (e.g., an emergency) and prolonged detention or evaluation is required to prepare the patient or to establish the need for and type of surgical procedure.
- B. When the preoperative visit is an initial consultation, as defined in the Evaluation and Management section.
- C. When procedures not usually part of the basic surgical procedure (e.g., myelography prior to laminectomy, bronchoscopy prior to chest surgery) are provided during the immediate preoperative period.

3. Emergency Situations

When a surgical procedure is performed in an emergency situation between the hours of 10:00 p.m. and 7:00 a.m., or on Sunday or legal holidays and is in response to calls received during those hours or on those days, an additional charge of one-third of the applicable fee, or one-third of the highest fee where multiple services or procedures are

performed, may be warranted. The additional fee is not applicable in a standard situation unless an emergency exists or arises. For example, it will not apply when the procedure is performed early or late for the convenience of the patient, provider, or hospital.

Circumstances justifying the additional payment should be set forth in a statement accompanying the bill.

4. Follow-up Care for Diagnostic Procedures

Diagnostic procedures are performed to evaluate the patient's complaints or symptoms. Diagnostic procedures include endoscopy, arthroscopy, injection procedures, and biopsies. Follow-up care for diagnostic procedures include only care directly related to recovery from the diagnostic procedure itself. Nonsurgical care of the condition identified by the diagnostic procedures or treatment of other concomitant conditions are not included and may be listed separately.

5. Multiple or Bilateral Procedures/Add-On Codes

When multiple procedures, unrelated to the major procedure and adding significant time or complexity, are provided at the same operative session, payment is for the procedure with the highest allowance plus half of the lesser procedures. The same rule applies for bilateral procedures when such are not specifically identified in the schedule.

It is appropriate to designate multiple procedures that are rendered on the same date by separate entries.

This can be reported by using the multiple procedure modifier 51.

Multiple related procedures shall not warrant any additional fees. Related procedures are those without which the principal procedure cannot be adequately performed.

Some related procedures supplement the primary procedure or provide additional treatment or diagnostic information. These services may be reported in addition to the primary procedure. Do not add modifier 51 if these services are noted as (+) add-on or modifier 51 exempt services (Ⓢ or Ⓣ). When the same provider performs these additional or supplemental procedures, the procedures are exempt from the multiple procedure calculation and are not subject to the 50 percent reduction.

If more than one provider is involved in performing additional or supplemental procedures, they will be considered co-surgeons and the applicable fee for the principal procedure will apply and be prorated.

A second category of codes that are exempt from the multiple procedure calculation and are not subject to the 50 percent reduction are CPT codes identified as "modifier 51 exempt."

"Add-on" (+) and "modifier 51 exempt" (Ⓢ or Ⓣ) codes are designated with the appropriate icons and are also addressed in the *Introduction and General Guidelines* section, Ground Rules 13 and 14.

6. Follow-up or Aftercare

- A. Normal postoperative care is included with all services assigned follow-up days of 0, 10, or 90. Uncommon or unusual complications, recurrence, or the presence of other diseases or injuries requiring significant additional services concurrent with the procedures or during the listed period of follow-up care, may warrant additional charges. Additional charges must be substantiated by report.
- B. When an additional surgical procedure is performed during the follow-up period and is related to the previously performed procedure, but is not an intrinsic part of the latter, the additional procedure will be paid at one-half the allowed fee. In these instances, the follow-up periods will continue concurrently.
- C. When multiple procedures and/or services are performed concurrently or sequentially within the same operative or treatment setting, the longest follow-up period will apply to all procedures.

7. Separate or Independent Procedures

Certain procedures are an inherent portion of a procedure or service, and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate entity not immediately related to other services, the indicated value for a separate procedure is applicable. Therefore, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be considered a separate procedure.

If a CPT code description includes the term "separate procedure," the CPT code may not be used with a related procedure in an anatomically related region often through the same skin incision, or surgical approach.

See also any currently published WCB policies and/or guidance.

8. Primary, Secondary, or Delayed Procedures

A primary procedure refers to one that is attempted or performed for the first time, irrespective of the time relationship to the date of the injury or the onset of the condition being treated. For example, if a tendon was lacerated and the provider elected to close the laceration without suturing the tendon, the first direct repair of the tendon would constitute a delayed but primary repair. In this example, if the first repair is unsuccessful, any subsequent repair of the tendon would be a secondary procedure. Delayed procedures have the same values as primary procedures.

9. Narrative Reports

A detailed narrative report must be submitted with all services provided. Physicians & Nurse Practitioners narrative reports must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Physician Assistants must include Work Status & Temporary Impairment Percentages. Providers are strongly encouraged to use the narrative template format found on the WCB webpage [CMS-1500 Requirements](#).

Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/assessment of the patient.

Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed.

Any ordered medications, durable medical equipment, tests, or procedures should be thoroughly explained.

All entries in the medical record must be legible to another reader.

The surgeon must submit all codes, including those for any NP/PA, Residents/Fellows, surgical assistants, on the same bill.

If multiple pages are submitted for one procedure, the total charge should appear on the last page.

10. Miscellaneous and By Report Codes

- Providers should only use codes listed in the Fee Schedule. When billing a service or procedure, select the CPT code from the WCB Fee schedule that accurately identifies the service or procedure performed. If no such code is available, report the service or procedure using the closest appropriate **Miscellaneous** code in the Fee Schedule (often ending in -99). These codes may also be titled "Unlisted," "Unspecified," or "Not Otherwise Specified".
- By Report (BR) in the Relative Value (RVU) column represents services that too variable to permit assignment of RVUs. Fees for such procedures need to be justified with additional information.
 - The inclusion of a miscellaneous or by report code in this Fee Schedule does not guarantee reimbursement. All codes billed should be based on medical necessity and be in alignment with all applicable Medical Treatment Guidelines and Fee Schedule Ground Rules. Reimbursement may be dependent on multiple factors, including but not necessarily limited to, causal relationship, clinical necessity and appropriateness of the fees submitted.

- It is the responsibility of the provider to ensure all information required to process a miscellaneous or by report procedure is included with the bill. If required information is missing, or if there is a valid code that describes the procedure, then the code may not be reimbursed.
- Nearly all miscellaneous and by report codes, require prior authorization (PAR). If a procedure or item is not recommended or not addressed in an applicable WCB Medical Treatment Guideline (MTG), then prior authorization is always required. If the procedure or item involves a body part or condition for which there is no MTG and costs over \$1,000 then prior authorization must be obtained.
- While emergency procedures/items do not require prior authorization, the circumstances must be identified and explained in the procedure record. The codes billed may be subject to review and non-payment.
- When a miscellaneous or by report code is used, the actual service/item should be identified on the bill, narrative note, and in an additional attached report.
- The price billed must be substantiated by indicating the closest comparable code found in the current fee schedule and/or with a manufacturer's invoice.
- Documentation should include: any decision making, medical necessity and explanation why an existing fee schedule code could not be used.
- Any PARs including identification numbers should also be submitted with bills.
- Miscellaneous and by report codes should not be billed merely to describe a proprietary product or procedure, when an existing fee schedule code adequately describes the procedure or item.
- Surgical miscellaneous or by report codes may require additional documentation including: time, skill, equipment necessary, diagnosis, pertinent history, and physical findings, size/ location/number of lesions or procedures.

11. Multiple Case Numbers

If a claimant has more than one WCB claim/number, it is permissible to bill services for both claims on the same date of service. Separate bills should be submitted for each claim/visit. However the total time billed for each claim number should not exceed the actual face-to-face time spent with the patient. The visits need to be scheduled and documented as two distinct and sequential office visits, with two distinct and separate office visit notes.

12. Concurrent Services by More Than One Provider

Charges for concurrent services of two or more providers may be warranted under the following circumstances:

- A. **Identifiable medical services** provided prior to or during the surgical procedure or in the postoperative period (e.g., diabetic management, operative monitoring of cardiac or brain conditions, management of conditions not within the accepted scope of the primary surgeon) are to be billed for by the provider rendering the service. The services should be identified by the appropriate code and relative value unit. Such payable fees are unrelated to the surgeon's fees.
- B. **Surgical Assistants (Modifier 80):** Identify surgery performed by code number, appropriate modifier, and description of procedures. Assistants should bill at 16 percent of the code fee. The codes must coincide with those of the primary surgeon. Assistants' fees are not payable when the hospital provides intern or resident staff to assist at surgery. Providers must document in their operative report why an assistant is required for the surgery. The operative report should document, with specificity, the activities the assistant surgeon performed. A separate operative note by the assistant surgeon or specific documentation of the assistant's activities within the primary surgeon's operative note is acceptable. Modifier 80 should not be used for Physician Assistant, Nurse Practitioner, Residents, or Fellows Nurse Practitioner services rendered during surgery (see Modifier 83 and 84).
- C. **Two surgeons (Modifier 62):** Under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical problem (e.g., urologist and a general surgeon in the creation of an ileal conduit). By prior agreement/contract, the total value for the procedures may be apportioned by the providers in relation to the responsibility and work done. The total value may be increased by 25 percent in lieu of the assistant's charge. Under these circumstances, the services of each surgeon should be identified using the code number and appropriate modifier.
- D. **Co-surgeons:** Under certain circumstances, two surgeons (usually with similar skills) may function simultaneously as primary surgeons performing distinct parts of a total surgical service (e.g., two surgeons simultaneously applying skin grafts to different parts of the body or two surgeons repairing different fractures in the same patient). By prior agreement, the total value may be apportioned by the providers in relation to the responsibility and work done. The total value for the procedures shall not, however, be increased but shall be prorated between the co-surgeons. Under these circumstances, the services of each surgeon should be identified using the code number and appropriate modifier.
- E. **Surgical Team (Modifier 66):** Under some circumstances highly complex procedures (e.g., open heart or organ transplant surgery) requiring the concomitant services of several providers, often of different specialties, plus other highly skilled, specially trained personnel, and various types of complex equipment are carried out under the "surgical team" concept with a single fee charged for the total service. The services covered vary widely and a single value cannot be assigned. These situations should be identified by the code and appropriate modifier. The value should be supported by a report to include itemization of the provider services, paramedical personnel, and equipment involved.
- F. **Services of Physician Assistants (PA) and Nurse Practitioners (NP) assisting during surgical procedures (Modifier 83):** The operating physician should bill at 10.7 percent of the total physician fee schedule allowance for the surgical procedures performed by the NP/PA. Identify the services by adding modifier 83 to the specific procedure codes done by the NP/PA. Payment will be made to the supervising physician performing the surgery. This modifier is valid for surgery only. NPs and PAs cannot bill for surgery independently. Modifier 83 is not used for NP/PA independently billing non-surgical services.
- G. **Radiology codes billed during procedures/surgery:** The same Radiology code should not be used by two providers during the same procedure. Codes billed with modifier 26 for the PC split, cannot be billed by two providers during the same procedure.
- H. **Residents and Fellows assisting during surgical procedures:** Surgery codes with modifier 84 must only be billed by the Board authorized supervising physician and will be reimbursed at 16 percent of the applicable physician code fee. See Ground Rule for Residents and Fellows and Modifier descriptions for further details.

13. Surgery and Follow-up Care Provided by Different Providers

When one provider performs the surgical procedure itself and another provides the follow-up care, the value may be apportioned between them by agreement and in accordance with medical ethics. Use the appropriate modifier to identify and indicate whether the value is for the procedure or the follow-up care, rather than the whole. The "global fee" is not increased, but is prorated between the providers.

14. Repeat Procedure by Another Provider

A basic procedure performed by another provider may have to be repeated. Identify the repeated procedure using the appropriate modifier and submit an explanatory note.

15. Proration of Scheduled Relative Value Unit Fee

When the schedule specifies a relative value unit fee for a definite treatment with an inclusive period of aftercare (follow-up days), and the patient transferred from one provider to another provider, the employer (or carrier) is only responsible for the total amount listed in the schedule. Such amount is to be apportioned between the providers. If the concerned providers agree on the amounts to be prorated to each, they shall render separate bills accordingly. When treatment is terminated by the departure of the patient from New York State before the expiration of the stated period of follow-up days, the fee shall be the portion of the appropriate fee having regard for the fact that usually the greater portion is earned at the time of the original operation or service. When treatment is terminated by the death of the patient before the expiration of follow-up days, the full fee is payable, subject to proration where applicable.

16. Materials Supplied by Provider: Pharmaceuticals and Durable Medical Equipment**A) Pharmacy**

A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of:

1. Persons practicing in hospitals as defined in section 2801 of the public health law;
2. The dispensing of drugs at no charge to their patients;
3. Persons whose practices are situated ten miles or more from a registered pharmacy;
4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution;
5. The dispensing of drugs in a medical emergency as defined in subdivision 6 of section 6810 of the State Education Law.

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070. Identify the product being given with the NDC number and amount of product being used. Except in emergencies, any medications must follow all WCB Formulary and applicable Medical Treatment Guidelines. Any variations require Prior Authorization (PAR).

B) Durable Medical Equipment

All durable medical equipment (DME) supplies shall be billed and paid using the WCB Durable Medical Equipment Fee Schedule. The WCB DME Fee Schedule is available on the Board's website. Any item identified as requiring prior authorization in the DME Fee Schedule or not listed in the DME Fee Schedule may not be billed without such prior authorization. Medical necessity should be documented for all prescribed DME. Prescription or order form must be completed by the provider and accurately describe the item needed. Appropriate HCPCS codes should be billed for items. All miscellaneous/unlisted codes, or codes without a listed price require prior authorization (PAR) and manufacturer's invoice. Also see Surgery Ground Rule 19 regarding post procedure casting/splinting DME.

Do not bill for or report supplies that are customarily included in surgical packages, such as gauze, sponges, Steri-strips, and dressings; drug screening supplies; and hot and cold packs. These items are included in the fee for the medical services in which such supplies are used.

17. Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting provider, such procedures are to be billed directly to the insurance carrier by the laboratory.

18. Surgical Destruction

Destruction or ablation of tissue is considered an inherent portion of surgical procedures and may be performed by any of the following methods used alone or in combination: electrosurgery, cryosurgery, laser, and chemical treatment. Unless specified by the CPT code description, destruction by any method does not change the selection of code to report the surgical service.

19. Fractures and Dislocations

The terms "closed" and "open" are used with reference to the type of procedure (e.g., fracture or dislocation) and to the type of reduction.

A) Casting and Strapping Guidelines

Application of casts and strapping codes are used to report replacement procedures during or after the period of follow-up care. These codes can also be used when the cast application or strapping is an initial service performed to stabilize or protect a fracture, injury, or dislocation without a restorative treatment or procedure. Restorative treatment or procedure rendered by another provider following the application of the initial cast, splint, or strap may be reported with a treatment of fracture or dislocation code.

Codes found in the application of casts and strapping section (29000–29799) should be reported separately when:

- The cast application or strapping is a replacement procedure used during or after the period of follow-up care.
- The cast application or strapping is an initial service performed without restorative treatment or procedures to stabilize or protect a fracture, injury, or dislocation, and to afford comfort to a patient.
- An initial casting or strapping when no other treatment or procedure is performed or will be performed by the same provider.
- A provider performs the initial application of a cast or strapping subsequent to another provider having performed a restorative treatment or procedure.

A provider who applies the initial cast, strap, or splint and also assumes all of the subsequent fracture, dislocation, or injury care cannot use the application of casts and strapping codes as an initial service. The first cast, splint, or strap application is included as a part of the service of the treatment of the fracture and dislocation codes. If no fracture care code is reported, for instance for a sprain, then it is appropriate to report the cast application.

B) Re-reduction

Re-reduction of a fracture and/or dislocation, performed by the primary provider, may warrant an additional payment when performed during the inclusive aftercare period. See Surgery Ground Rule 6: Follow up or Aftercare.

C) Bone, Cartilage, and Fascial Grafts

Listed relative value units for most graft procedures include obtaining the graft. When a second surgeon obtains the graft, the relative value unit of the total procedure will not be increased but in accordance with Surgery Ground Rule 12D, the relative value unit may be apportioned by the co-surgeons. Procedures 20900–20922 are NOT to be used with procedures which include the graft as part of the descriptor. Procedures 20900–20922 can be used in those unusual circumstances when a graft is used that is not included in the descriptor.

Unless separately listed, when an alloplastic implant or non-autogenous graft is used in a procedure which “includes obtaining graft,” the relative value unit is to be the same as for using a local bone graft. The phrase “iliac or other autogenous bone graft” refers only to grafts obtained from an anatomical site distinct from

the primary operative area and obtained through a separate incision. Plastic and/or metallic implant or non-autogenous graft materials are to be valued at the cost to the provider.

D) Dislocations Complicated by a Fracture

Increase the relative value unit of the fracture/dislocation by 50 percent. The additional charge is not applicable to ankle fractures/dislocations.

E) Multiple Injuries

For concurrent care of multiple injuries, not contiguous and not in the same hand or foot, and not otherwise specified, see Surgery Ground Rule 5. Superficial injuries not requiring extensive care do not carry cumulative or additional allowances.

20. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used with surgical procedures are as follows:

1R∞ Non-surgical services provided by residents and fellows

Billed and payable at the same applicable rate as the WCB authorized, supervising physician. 1R can be used for E/M codes, such as office visits, as well as for stand-alone procedures not performed during a surgery i.e., injections. This modifier is not used for assistance at surgery. See modifier 84.

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

23 Unusual Anesthesia

Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

24 Unrelated Evaluation and Management Services by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component

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

32 Mandated Services

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

47 Anesthesia by Surgeon

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

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate 5-digit code. **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

51 Multiple Procedures

When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes. (see Appendix D)

New York State Guideline: See Ground Rule 13 in the General Ground Rules in this fee schedule.

52 Reduced Services

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

53 Discontinued Procedure

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

54 Surgical Care Only

When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only

When 1 physician or other qualified health care professional performs the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only

When 1 physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery

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

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more

extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

62 Two Surgeons

When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure[s]) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of an additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

66 Surgical Team

Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating individual with the addition of modifier 66 to the basic procedure number used for reporting services.

76 Repeat Procedure or Service by the Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following the initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 Assistant Surgeon

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

81 Minimum Assistant Surgeon

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

82 Assistant Surgeon (when qualified resident surgeon not available)

The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).

83∞ Services of Physician Assistants (PA) and Nurse Practitioners (NP) assisting during surgical procedures:

The operating physician must bill at 10.7 percent of the total physician fee schedule allowance for the surgical procedures performed by the NP/PA.

Identify the services by adding modifier 83 to the specific procedure codes done by the NP/PA. Payment will be made to the supervising physician performing the surgery. This modifier is valid for surgery only. NPs and PAs cannot bill for surgery independently.

84∞ Assistance at surgery provided by residents and fellows

This modifier should be appended to the individual codes representing work actually performed by the resident/fellow while assisting the WCB authorized, supervising physician.

This modifier should not be used for E/M codes or for procedures not performed during a surgery i.e., injections. See Modifier 1R.

90 Reference (Outside) Laboratory

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

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

21. Electronic Billing:

Providers may offset the cost of using an electronic submission partner by using code 99080 as a "By Report" (BR) code, up to a maximum value of one dollar. The code should be placed on the same CMS1500 form for which the billable services payment and the electronic submission costs are being requested. The price listed by the provider for code 99080 should accurately reflect the actual cost incurred by the provider for the electronic submission of the individual bill, up to a maximum of one dollar. Please see any current guidance on our webpage.

22. Billing for Residents and Fellows

Treatment rendered by residents and fellows can only be billed by the Board authorized supervising physician.

Non-surgical service codes should be appended with modifier 1R. Services with modifier 1R must be billed and reimbursed at the same amount payable to the authorized supervising physician.

Assistant at surgery codes should be appended with modifier 84. Surgery codes with modifier 84 must be billed and reimbursed at 16 percent of the applicable physician code fee.

All Fee Schedule Ground Rules for multiple procedures apply. Also see WCB webpage and any current bulletins for additional guidance.

- A. Physicians cannot additionally bill for supervision of the resident.
- B. If the supervising surgeon bills for a resident/fellow assisting at surgery, only one additional assistant (NP/PA-modifier 83) may be billed, and only if documentation supports the necessity of the additional assistance.
- C. When applicable, modifier 84 should be appended to the individual codes of the surgery.
- D. All codes billed should accurately reflect work performed by the resident/fellow. Documentation in the operative/procedure report shall include all details. Payment may be decided based on review of documentation, as well as the usual and customary standards of CPT/CMS billing guidelines for allowance of assistants at surgery.
- E. Non-authorized out-of-state physicians may not bill for residents/fellows.
- F. Surgeons should not bill for services performed by a resident/fellow that would not normally be billed by another type of assistant at surgery. Payment shall not be made for observation, or for simple assistance such as closing basic surgical fields or work typically performed by nursing/technical staff.
- G. The name of the resident/fellow does not need to be documented on the CMS1500 form.
- H. All CMS1500 Narrative requirements do apply to any bills submitted. <https://www.wcb.ny.gov/CMS-1500/>

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
■ +	10004	Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure)	0.35	ZZZ	
■	10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion	0.86	XXX	
■ +	10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)	0.39	ZZZ	
■	10007	Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion	1.96	XXX	
■ +	10008	Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion (List separately in addition to code for primary procedure)	0.92	ZZZ	
■	10009	Fine needle aspiration biopsy, including CT guidance; first lesion	2.71	XXX	
■ +	10010	Fine needle aspiration biopsy, including CT guidance; each additional lesion (List separately in addition to code for primary procedure)	1.52	ZZZ	
■	10011	Fine needle aspiration biopsy, including MR guidance; first lesion	2.21	XXX	
■ +	10012	Fine needle aspiration biopsy, including MR guidance; each additional lesion (List separately in addition to code for primary procedure)	1.18	ZZZ	
■	10021	Fine needle aspiration biopsy, without imaging guidance; first lesion	0.38	XXX	
	10030	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous	3.55	000	
	10035	Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion	3.26	000	
+	10036	Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; each additional lesion (List separately in addition to code for primary procedure)	2.86	ZZZ	
	10040	Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)	0.18	010	
	10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	0.29	010	
	10061	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple	0.90	010	
	10080	Incision and drainage of pilonidal cyst; simple	0.45	010	
	10081	Incision and drainage of pilonidal cyst; complicated	1.08	010	
	10120	Incision and removal of foreign body, subcutaneous tissues; simple	0.36	010	
	10121	Incision and removal of foreign body, subcutaneous tissues; complicated	1.08	010	
	10140	Incision and drainage of hematoma, seroma or fluid collection	0.54	010	
	10160	Puncture aspiration of abscess, hematoma, bulla, or cyst	0.29	010	
	10180	Incision and drainage, complex, postoperative wound infection	1.62	010	
	11000	Debridement of extensive eczematous or infected skin; up to 10% of body surface	0.25	000	
+	11001	Debridement of extensive eczematous or infected skin; each additional 10% of the body surface, or part thereof (List separately in addition to code for primary procedure)	0.20	ZZZ	
	11004	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum	3.41	000	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	11005	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure	4.67	000	
	11006	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure	4.31	000	
+	11008	Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)	1.75	ZZZ	
	11010	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues	1.10	010	
	11011	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, and muscle	1.98	000	
	11012	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone	2.42	000	
	11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	1.10	000	
	11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less	1.98	000	
	11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	2.42	000	
+	11045	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	0.18	ZZZ	
+	11046	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	0.45	ZZZ	
+	11047	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	0.90	ZZZ	
	11055	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion	0.18	000	
	11056	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions	0.22	000	
	11057	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions	0.36	000	
■	11102	Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion	0.64	000	
■ +	11103	Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); each separate/additional lesion (List separately in addition to code for primary procedure)	0.32	ZZZ	
■	11104	Punch biopsy of skin (including simple closure, when performed); single lesion	0.80	000	
■ +	11105	Punch biopsy of skin (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)	0.38	ZZZ	
■	11106	Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); single lesion	0.99	000	
■ +	11107	Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)	0.45	ZZZ	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	0.31	010	
+	11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)	0.25	ZZZ	
	11300	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less	0.29	000	
	11301	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm	0.36	000	
	11302	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	0.43	000	
	11303	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm	0.54	000	
	11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	0.31	000	
	11306	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	0.38	000	
	11307	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	0.45	000	
	11308	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm	0.52	000	
	11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	0.36	000	
	11311	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm	0.43	000	
	11312	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm	0.49	000	
	11313	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm	0.56	000	
	11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less	0.43	010	
	11401	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm	0.54	010	
	11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm	0.72	010	
	11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm	0.92	010	
	11404	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm	1.30	010	
	11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm	1.84	010	
	11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	0.47	010	
	11421	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm	0.61	010	
	11422	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm	0.76	010	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	1.12	010	
11424	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm	1.44	010	
11426	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm	1.98	010	
11440	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less	0.56	010	
11441	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm	0.74	010	
11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm	0.99	010	
11443	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm	1.26	010	
11444	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm	1.62	010	
11446	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm	2.31	010	
11450	Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair	2.69	090	
11451	Excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair	3.05	090	
11462	Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with simple or intermediate repair	2.33	090	
11463	Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with complex repair	2.65	090	
11470	Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with simple or intermediate repair	2.33	090	
11471	Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with complex repair	2.65	090	
11600	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.5 cm or less	0.70	010	
11601	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm	0.76	010	
11602	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm	1.01	010	
11603	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm	1.26	010	
11604	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm	1.66	010	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
11606	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm	2.42	010	
11620	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	0.99	010	
11621	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm	1.17	010	
11622	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm	1.39	010	
11623	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	1.71	010	
11624	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm	2.15	010	
11626	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm	2.69	010	
11640	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less	1.08	010	
11641	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm	1.39	010	
11642	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm	1.75	010	
11643	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm	2.24	010	
11644	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm	2.60	010	
11646	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm	3.23	010	
11719	Trimming of nondystrophic nails, any number	0.18	000	
11720	Debridement of nail(s) by any method(s); 1 to 5	0.16	000	
11721	Debridement of nail(s) by any method(s); 6 or more	0.24	000	
11730	Avulsion of nail plate, partial or complete, simple; single	0.34	000	
+	11732	Avulsion of nail plate, partial or complete, simple; each additional nail plate (List separately in addition to code for primary procedure)	0.25	ZZZ
	11740	Evacuation of subungual hematoma	0.27	000
	11750	Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal;	1.21	010
	11755	Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)	0.54	000
	11760	Repair of nail bed	1.48	010
	11762	Reconstruction of nail bed with graft	2.15	010
	11765	Wedge excision of skin of nail fold (eg, for ingrown toenail)	0.81	010
	11770	Excision of pilonidal cyst or sinus; simple	2.38	010
	11771	Excision of pilonidal cyst or sinus; extensive	3.41	090
	11772	Excision of pilonidal cyst or sinus; complicated	3.84	090
	11900	Injection, intralesional; up to and including 7 lesions	0.22	000

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	11901	Injection, intralesional; more than 7 lesions	0.34	000	
	11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	2.24	000	
	11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm	4.49	000	
+	11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	2.24	ZZZ	
	11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	0.99	000	
	11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc	1.08	000	
	11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	1.17	000	
	11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	0.83	000	
	11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion	2.70	090	
■	11970	Replacement of tissue expander with permanent implant	7.90	090	
■	11971	Removal of tissue expander without insertion of implant	1.53	090	
	11976	Removal, implantable contraceptive capsules	0.74	000	
	11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	0.74	000	
■	11981	Insertion, drug-delivery implant (ie, bioresorbable, biodegradable, non-biodegradable)	0.74	000	
■	11982	Removal, non-biodegradable drug delivery implant	0.74	000	
■	11983	Removal with reinsertion, non-biodegradable drug delivery implant	0.81	000	
	12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	0.39	000	
	12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm	0.50	000	
	12004	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm	0.66	000	
	12005	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm	0.81	000	
	12006	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm	0.99	000	
	12007	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm	1.78	000	
	12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	0.50	000	
	12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	0.61	000	
	12014	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm	0.84	000	
	12015	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm	1.10	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
12016	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm	1.37	000	
12017	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm	2.79	000	
12018	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm	2.41	000	
12020	Treatment of superficial wound dehiscence; simple closure	0.88	010	
12021	Treatment of superficial wound dehiscence; with packing	0.93	010	
12031	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less	0.54	010	
12032	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm	0.75	010	
12034	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm	0.97	010	
12035	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm	1.33	010	
12036	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm	1.73	010	
12037	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); over 30.0 cm	2.18	010	
12041	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less	0.68	010	
12042	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm	0.86	010	
12044	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm	1.13	010	
12045	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm	1.49	010	
12046	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm	1.94	010	
12047	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; over 30.0 cm	2.29	010	
12051	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	0.86	010	
12052	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	1.08	010	
12053	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm	1.44	010	
12054	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm	1.89	010	
12055	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm	2.43	010	
12056	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm	3.10	010	
12057	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm	2.60	010	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	13100	Repair, complex, trunk; 1.1 cm to 2.5 cm	0.85	010	
	13101	Repair, complex, trunk; 2.6 cm to 7.5 cm	1.53	010	
+	13102	Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)	0.61	ZZZ	
	13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm	1.35	010	
	13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	2.60	010	
+	13122	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)	0.83	ZZZ	
	13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm	1.35	010	
	13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm	3.50	010	
+	13133	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)	1.21	ZZZ	
	13151	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm	2.00	010	
	13152	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm	4.00	010	
+	13153	Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)	1.55	ZZZ	
	13160	Secondary closure of surgical wound or dehiscence, extensive or complicated	2.60	090	
	14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less	2.74	090	
	14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm	3.95	090	
	14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less	3.90	090	
	14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm	5.20	090	
	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	5.20	090	
	14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm	6.70	090	
	14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	6.70	090	
	14061	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm	9.40	090	
	14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm	6.64	090	
+	14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	1.53	ZZZ	
	14350	Filletted finger or toe flap, including preparation of recipient site	3.99	090	
	15002	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children	1.89	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	15003	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)	0.45	ZZZ	
	15004	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children	2.24	000	
+	15005	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)	0.72	ZZZ	
	15040	Harvest of skin for tissue cultured skin autograft, 100 sq cm or less	1.66	000	
	15050	Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area (except on face), up to defect size 2 cm diameter	2.00	090	
	15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	5.21	090	
+	15101	Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	1.39	ZZZ	
	15110	Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	5.03	090	
+	15111	Epidermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	0.83	ZZZ	
	15115	Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children	4.89	090	
+	15116	Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	1.10	ZZZ	
	15120	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	5.12	090	
+	15121	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	1.80	ZZZ	
	15130	Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	3.97	090	
+	15131	Dermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	0.67	ZZZ	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	15135	Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children	5.07	090	
+	15136	Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	0.63	ZZZ	
	15150	Tissue cultured skin autograft, trunk, arms, legs; first 25 sq cm or less	4.00	090	
+	15151	Tissue cultured skin autograft, trunk, arms, legs; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)	0.88	ZZZ	
+	15152	Tissue cultured skin autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	1.08	ZZZ	
	15155	Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 25 sq cm or less	4.02	090	
+	15156	Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)	1.17	ZZZ	
+	15157	Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	1.35	ZZZ	
	15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less	2.78	090	
+	15201	Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	1.39	ZZZ	
	15220	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less	3.90	090	
+	15221	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	1.90	ZZZ	
	15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less	5.30	090	
+	15241	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	2.60	ZZZ	
	15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less	6.50	090	
+	15261	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	3.20	ZZZ	
	15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	0.66	000	
+	15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	0.13	ZZZ	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	1.58	000	
+	15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	0.33	ZZZ	
	15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	0.77	000	
+	15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	0.19	ZZZ	
	15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	1.64	000	
+	15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	0.41	ZZZ	
	15570	Formation of direct or tubed pedicle, with or without transfer; trunk	4.50	090	
	15572	Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs	5.00	090	
	15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet	5.75	090	
	15576	Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral	5.00	090	
	15600	Delay of flap or sectioning of flap (division and inset); at trunk	2.60	090	
	15610	Delay of flap or sectioning of flap (division and inset); at scalp, arms, or legs	3.20	090	
	15620	Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet	5.40	090	
	15630	Delay of flap or sectioning of flap (division and inset); at eyelids, nose, ears, or lips	5.40	090	
	15650	Transfer, intermediate, of any pedicle flap (eg, abdomen to wrist, Walking tube), any location	3.40	090	
	15730	Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)	9.80	090	
	15731	Forehead flap with preservation of vascular pedicle (eg, axial pattern flap, paramedian forehead flap)	7.63	090	
	15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)	10.37	090	
	15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk	9.43	090	
	15736	Muscle, myocutaneous, or fasciocutaneous flap; upper extremity	8.08	090	
	15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity	8.08	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	15740	Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel	7.80	090	
	15750	Flap; neurovascular pedicle	6.50	090	
	15756	Free muscle or myocutaneous flap with microvascular anastomosis	18.09	090	
	15757	Free skin flap with microvascular anastomosis	21.28	090	
	15758	Free fascial flap with microvascular anastomosis	23.43	090	
	15760	Graft; composite (eg, full thickness of external ear or nasal ala), including primary closure, donor area	6.50	090	
■	15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)	3.89	090	
	15770	Graft; derma-fat-fascia	5.14	090	
■	15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	4.00	090	
■ +	15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)	1.25	ZZZ	
■	15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate	3.91	090	
■ +	15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)	1.22	ZZZ	
	15775	Punch graft for hair transplant; 1 to 15 punch grafts	0.50	000	
	15776	Punch graft for hair transplant; more than 15 punch grafts	2.00	000	
+	15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	1.62	ZZZ	
■	15778	Implantation of absorbable mesh or other prosthesis for delayed closure of defect(s) (ie, external genitalia, perineum, abdominal wall) due to soft tissue infection or trauma	3.14	000	
	15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	7.80	090	
	15781	Dermabrasion; segmental, face	2.50	090	
	15782	Dermabrasion; regional, other than face	2.50	090	
	15783	Dermabrasion; superficial, any site (eg, tattoo removal)	1.00	090	
	15786	Abrasion; single lesion (eg, keratosis, scar)	0.36	010	
+	15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)	0.20	ZZZ	
	15788	Chemical peel, facial; epidermal	2.65	090	
	15789	Chemical peel, facial; dermal	3.20	090	
	15792	Chemical peel, nonfacial; epidermal	1.00	090	
	15793	Chemical peel, nonfacial; dermal	1.51	090	
	15819	Cervicoplasty	3.04	090	
	15820	Blepharoplasty, lower eyelid;	3.00	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	3.00	090	
	15822	Blepharoplasty, upper eyelid;	3.03	090	
	15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	4.00	090	
	15824	Rhytidectomy; forehead	4.28	000	
	15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	5.18	000	
	15826	Rhytidectomy; glabellar frown lines	4.28	000	
	15828	Rhytidectomy; cheek, chin, and neck	13.61	000	
	15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	10.00	000	
	15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	8.98	090	
	15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	6.28	090	
	15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	6.28	090	
	15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	6.28	090	
	15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	6.28	090	
	15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	4.28	090	
	15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	3.04	090	
	15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	2.59	090	
	15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	2.98	090	
	15840	Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)	15.00	090	
	15841	Graft for facial nerve paralysis; free muscle graft (including obtaining graft)	15.00	090	
	15842	Graft for facial nerve paralysis; free muscle flap by microsurgical technique	13.47	090	
	15845	Graft for facial nerve paralysis; regional muscle transfer	11.22	090	
+	15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)	3.14	YYY	
■	15851	Removal of sutures or staples requiring anesthesia (ie, general anesthesia, moderate sedation)	0.31	000	
	15852	Dressing change (for other than burns) under anesthesia (other than local)	0.35	000	
■ +	15853	Removal of sutures or staples not requiring anesthesia (List separately in addition to E/M code)	0.07	ZZZ	
■ +	15854	Removal of sutures and staples not requiring anesthesia (List separately in addition to E/M code)	0.09	ZZZ	
	15860	Intravenous injection of agent (eg, fluorescein) to test vascular flow in flap or graft	0.90	000	
	15876	Suction assisted lipectomy; head and neck	BR	000	
	15877	Suction assisted lipectomy; trunk	BR	000	
	15878	Suction assisted lipectomy; upper extremity	BR	000	
	15879	Suction assisted lipectomy; lower extremity	BR	000	
	15920	Excision, coccygeal pressure ulcer, with coccygectomy; with primary suture	4.49	090	
	15922	Excision, coccygeal pressure ulcer, with coccygectomy; with flap closure	6.28	090	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
15931	Excision, sacral pressure ulcer, with primary suture;	4.49	090	
15933	Excision, sacral pressure ulcer, with primary suture; with ostectomy	10.30	090	
15934	Excision, sacral pressure ulcer, with skin flap closure;	6.28	090	
15935	Excision, sacral pressure ulcer, with skin flap closure; with ostectomy	7.63	090	
15936	Excision, sacral pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure;	4.49	090	
15937	Excision, sacral pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure; with ostectomy	5.84	090	
15940	Excision, ischial pressure ulcer, with primary suture;	4.49	090	
15941	Excision, ischial pressure ulcer, with primary suture; with ostectomy (ischiectomy)	7.90	090	
15944	Excision, ischial pressure ulcer, with skin flap closure;	10.80	090	
15945	Excision, ischial pressure ulcer, with skin flap closure; with ostectomy	10.80	090	
15946	Excision, ischial pressure ulcer, with ostectomy, in preparation for muscle or myocutaneous flap or skin graft closure	10.80	090	
15950	Excision, trochanteric pressure ulcer, with primary suture;	5.30	090	
15951	Excision, trochanteric pressure ulcer, with primary suture; with ostectomy	7.20	090	
15952	Excision, trochanteric pressure ulcer, with skin flap closure;	8.20	090	
15953	Excision, trochanteric pressure ulcer, with skin flap closure; with ostectomy	8.30	090	
15956	Excision, trochanteric pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure;	4.49	090	
15958	Excision, trochanteric pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure; with ostectomy	5.84	090	
15999	Unlisted procedure, excision pressure ulcer	BR	YYY	
16000	Initial treatment, first degree burn, when no more than local treatment is required	0.25	000	
16020	Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)	0.38	000	
16025	Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)	0.61	000	
16030	Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (eg, more than 1 extremity, or greater than 10% total body surface area)	0.90	000	
16035	Escharotomy; initial incision	2.50	000	
+	16036 Escharotomy; each additional incision (List separately in addition to code for primary procedure)	1.12	ZZZ	
	17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion	0.26	010	
+	17003 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)	0.13	ZZZ	
■	17004 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions	1.08	010	
	17106 Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	1.24	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	2.50	090	
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	3.54	090	
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions	0.27	010	
17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions	BR	010	
17250	Chemical cauterization of granulation tissue (ie, proud flesh)	0.22	000	
17260	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5 cm or less	0.45	010	
17261	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm	0.61	010	
17262	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	0.74	010	
17263	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 2.1 to 3.0 cm	0.83	010	
17264	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 3.1 to 4.0 cm	0.92	010	
17266	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter over 4.0 cm	1.14	010	
17270	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	0.54	010	
17271	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	0.67	010	
17272	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	0.81	010	
17273	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 2.1 to 3.0 cm	0.97	010	
17274	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 3.1 to 4.0 cm	1.05	010	
17276	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter over 4.0 cm	1.19	010	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
17280	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	0.65	010	
17281	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm	0.79	010	
17282	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm	0.92	010	
17283	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 2.1 to 3.0 cm	1.05	010	
17284	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 3.1 to 4.0 cm	1.19	010	
17286	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 4.0 cm	1.32	010	
17311	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks	3.32	000	
+ 17312	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)	2.02	ZZZ	
17313	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks	3.05	000	
+ 17314	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)	1.89	ZZZ	
+ 17315	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure)	0.40	ZZZ	
17340	Cryotherapy (CO2 slush, liquid N2) for acne	0.15	010	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	17360	Chemical exfoliation for acne (eg, acne paste, acid)	0.15	010	
	17380	Electrolysis epilation, each 30 minutes	0.22	000	
	17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	BR	YYY	
	19000	Puncture aspiration of cyst of breast;	0.22	000	
+	19001	Puncture aspiration of cyst of breast; each additional cyst (List separately in addition to code for primary procedure)	0.25	ZZZ	
	19020	Mastotomy with exploration or drainage of abscess, deep	1.70	090	
	19030	Injection procedure only for mammary ductogram or galactogram	0.32	000	
	19081	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance	4.35	000	
+	19082	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)	3.59	ZZZ	
	19083	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance	4.23	000	
+	19084	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)	3.45	ZZZ	
	19085	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance	6.32	000	
+	19086	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)	5.12	ZZZ	
	19100	Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)	0.43	000	
	19101	Biopsy of breast; open, incisional	1.80	010	
	19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	11.22	000	
	19110	Nipple exploration, with or without excision of a solitary lactiferous duct or a papilloma lactiferous duct	2.02	090	
	19112	Excision of lactiferous duct fistula	2.11	090	
	19120	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, 1 or more lesions	2.45	090	
	19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	2.69	090	
+	19126	Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker (List separately in addition to code for primary procedure)	1.35	ZZZ	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	19281	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance	0.74	000	
+	19282	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)	1.05	ZZZ	
	19283	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance	1.71	000	
+	19284	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)	1.29	ZZZ	
	19285	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance	3.26	000	
+	19286	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)	2.86	ZZZ	
	19287	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance	5.41	000	
+	19288	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)	4.37	ZZZ	
+	19294	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with partial mastectomy (List separately in addition to code for primary procedure)	1.25	ZZZ	
	19296	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy	35.02	000	
+	19297	Placement of radiotherapy afterloading expandable catheter (single or multichannel) 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)	0.70	ZZZ	
	19298	Placement of radiotherapy after loading 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	13.29	000	
	19300	Mastectomy for gynecomastia	3.59	090	
	19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	2.78	090	
	19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	6.28	090	
	19303	Mastectomy, simple, complete	4.85	090	
	19305	Mastectomy, radical, including pectoral muscles, axillary lymph nodes	6.28	090	
	19306	Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)	7.18	090	
	19307	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle	7.27	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	19316	Mastopexy	7.63	090	
■	19318	Breast reduction	10.00	090	
■	19325	Breast augmentation with implant	5.84	090	
■	19328	Removal of intact breast implant	3.77	090	
■	19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)	3.00	090	
■	19340	Insertion of breast implant on same day of mastectomy (ie, immediate)	3.54	090	
■	19342	Insertion or replacement of breast implant on separate day from mastectomy	6.90	090	
	19350	Nipple/areola reconstruction	6.90	090	
	19355	Correction of inverted nipples	0.89	090	
■	19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)	10.00	090	
■	19361	Breast reconstruction; with latissimus dorsi flap	16.00	090	
■	19364	Breast reconstruction; with free flap (eg, fTRAM, DIEP, SIEA, GAP flap)	10.37	090	
■	19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap	21.00	090	
■	19368	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)	24.00	090	
■	19369	Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap	20.67	090	
■	19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy	4.50	090	
■	19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents	7.00	090	
■	19380	Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)	3.85	090	
	19396	Preparation of moulage for custom breast implant	0.45	000	
	19499	Unlisted procedure, breast	BR	YYY	
	20100	Exploration of penetrating wound (separate procedure); neck	5.12	010	
	20101	Exploration of penetrating wound (separate procedure); chest	6.99	010	
	20102	Exploration of penetrating wound (separate procedure); abdomen/flank/back	6.05	010	
	20103	Exploration of penetrating wound (separate procedure); extremity	5.41	010	
	20150	Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision	6.73	090	
	20200	Biopsy, muscle; superficial	0.70	000	
	20205	Biopsy, muscle; deep	1.40	000	
	20206	Biopsy, muscle, percutaneous needle	0.25	000	
	20220	Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)	0.80	000	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
20225	Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)	2.02	000	
20240	Biopsy, bone, open; superficial (eg, sternum, spinous process, rib, patella, olecranon process, calcaneus, tarsal, metatarsal, carpal, metacarpal, phalanx)	1.71	000	
20245	Biopsy, bone, open; deep (eg, humeral shaft, ischium, femoral shaft)	2.90	000	
20250	Biopsy, vertebral body, open; thoracic	5.00	010	
20251	Biopsy, vertebral body, open; lumbar or cervical	3.00	010	
20500	Injection of sinus tract; therapeutic (separate procedure)	0.25	010	
20501	Injection of sinus tract; diagnostic (sinogram)	0.25	000	
20520	Removal of foreign body in muscle or tendon sheath; simple	0.60	010	
20525	Removal of foreign body in muscle or tendon sheath; deep or complicated	2.60	010	
20526	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel	0.31	000	
20527	Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)	0.75	000	
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	0.44	000	
20551	Injection(s); single tendon origin/insertion	0.44	000	
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	0.47	000	
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles	0.52	000	
20555	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)	2.17	000	
■ 20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	0.25	XXX	
■ 20561	Needle insertion(s) without injection(s); 3 or more muscles	0.36	XXX	
20600	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance	0.28	000	
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting	0.71	000	
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance	0.31	000	
20606	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting	0.79	000	
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	0.25	000	
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	0.89	000	
20612	Aspiration and/or injection of ganglion cyst(s) any location	0.31	000	
20615	Aspiration and injection for treatment of bone cyst	0.80	010	
20650	Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)	0.70	010	
20660	Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)	2.00	000	
20661	Application of halo, including removal; cranial	2.00	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	20662	Application of halo, including removal; pelvic	2.00	090	
	20663	Application of halo, including removal; femoral	2.00	090	
	20664	Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta)	5.36	090	
	20665	Removal of tongs or halo applied by another individual	0.20	010	
	20670	Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)	0.35	010	
	20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	2.40	090	
	20690	Application of a uniplane (pins or wires in 1 plane), unilateral, external fixation system	3.52	090	
	20692	Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)	4.92	090	
	20693	Adjustment or revision of external fixation system requiring anesthesia (eg, new pin[s] or wire[s] and/or new ring[s] or bar[s])	2.59	090	
	20694	Removal, under anesthesia, of external fixation system	1.97	090	
	20696	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)	7.25	090	
⊖	20697	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each	8.59	000	
■ +	20700	Manual preparation and insertion of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)	0.81	ZZZ	
■ +	20701	Removal of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)	0.62	ZZZ	
■ +	20702	Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)	1.39	ZZZ	
■ +	20703	Removal of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)	1.02	ZZZ	
■ +	20704	Manual preparation and insertion of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)	1.46	ZZZ	
■ +	20705	Removal of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)	1.21	ZZZ	
	20802	Replantation, arm (includes surgical neck of humerus through elbow joint), complete amputation	35.30	090	
	20805	Replantation, forearm (includes radius and ulna to radial carpal joint), complete amputation	43.20	090	
	20808	Replantation, hand (includes hand through metacarpophalangeal joints), complete amputation	53.71	090	
	20816	Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon), complete amputation	26.48	090	
	20822	Replantation, digit, excluding thumb (includes distal tip to sublimis tendon insertion), complete amputation	21.89	090	
	20824	Replantation, thumb (includes carpometacarpal joint to MP joint), complete amputation	26.48	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	20827	Replantation, thumb (includes distal tip to MP joint), complete amputation	22.51	090	
	20838	Replantation, foot, complete amputation	35.30	090	
	20900	Bone graft, any donor area; minor or small (eg, dowel or button)	1.60	000	
	20902	Bone graft, any donor area; major or large	3.20	000	
	20910	Cartilage graft; costochondral	3.20	090	
	20912	Cartilage graft; nasal septum	3.42	090	
	20920	Fascia lata graft; by stripper	1.30	090	
	20922	Fascia lata graft; by incision and area exposure, complex or sheet	2.70	090	
	20924	Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)	2.17	090	
+	20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)	1.19	XXX	
+	20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)	1.45	ZZZ	
■ +	20932	Allograft, includes templating, cutting, placement and internal fixation, when performed; osteoarticular, including articular surface and contiguous bone (List separately in addition to code for primary procedure)	7.83	ZZZ	
■ +	20933	Allograft, includes templating, cutting, placement and internal fixation, when performed; hemicortical intercalary, partial (ie, hemicylindrical) (List separately in addition to code for primary procedure)	7.18	ZZZ	
■ +	20934	Allograft, includes templating, cutting, placement and internal fixation, when performed; intercalary, complete (ie, cylindrical) (List separately in addition to code for primary procedure)	7.82	ZZZ	
+	20936	Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision (List separately in addition to code for primary procedure)	1.81	XXX	
+	20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)	3.16	ZZZ	
+	20938	Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)	3.93	ZZZ	
+	20939	Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (List separately in addition to code for primary procedure)	0.71	ZZZ	
	20950	Monitoring of interstitial fluid pressure (includes insertion of device, eg, wick catheter technique, needle manometer technique) in detection of muscle compartment syndrome	0.72	000	
	20955	Bone graft with microvascular anastomosis; fibula	15.53	090	
	20956	Bone graft with microvascular anastomosis; iliac crest	15.53	090	
	20957	Bone graft with microvascular anastomosis; metatarsal	15.53	090	
	20962	Bone graft with microvascular anastomosis; other than fibula, iliac crest, or metatarsal	11.64	090	
	20969	Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, metatarsal, or great toe	15.53	090	
	20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest	15.53	090	
	20972	Free osteocutaneous flap with microvascular anastomosis; metatarsal	20.70	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	20973	Free osteocutaneous flap with microvascular anastomosis; great toe with web space	22.05	090	
⊖	20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)	2.59	000	
⊖	20975	Electrical stimulation to aid bone healing; invasive (operative)	4.14	000	
	20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)	2.59	000	
	20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	4.05	000	
	20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation	59.06	000	
+	20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	0.83	ZZZ	
	20999	Unlisted procedure, musculoskeletal system, general	BR	YYY	
	21010	Arthrotomy, temporomandibular joint	11.46	090	
	21011	Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm	1.86	090	
	21012	Excision, tumor, soft tissue of face or scalp, subcutaneous; 2 cm or greater	1.97	090	
	21013	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm	3.31	090	
	21014	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); 2 cm or greater	3.52	090	
	21015	Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm	4.36	090	
	21016	Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; 2 cm or greater	7.45	090	
	21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible	7.16	090	
	21026	Excision of bone (eg, for osteomyelitis or bone abscess); facial bone(s)	7.67	090	
	21029	Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)	8.59	090	
	21030	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage	13.54	090	
	21031	Excision of torus mandibularis	3.95	090	
	21032	Excision of maxillary torus palatinus	3.95	090	
	21034	Excision of malignant tumor of maxilla or zygoma	13.63	090	
	21040	Excision of benign tumor or cyst of mandible, by enucleation and/or curettage	4.86	090	
	21044	Excision of malignant tumor of mandible;	8.20	090	
	21045	Excision of malignant tumor of mandible; radical resection	13.63	090	
	21046	Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion[s])	14.28	090	
	21047	Excision of benign tumor or cyst of mandible; requiring extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion[s])	15.73	090	
	21048	Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion[s])	14.28	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
21049	Excision of benign tumor or cyst of maxilla; requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion[s])	15.73	090	
21050	Condylectomy, temporomandibular joint (separate procedure)	11.76	090	
21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)	11.76	090	
21070	Coronoidectomy (separate procedure)	11.76	090	
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)	2.07	090	
21076	Impression and custom preparation; surgical obturator prosthesis	7.87	010	
21077	Impression and custom preparation; orbital prosthesis	19.79	090	
21079	Impression and custom preparation; interim obturator prosthesis	13.11	090	
21080	Impression and custom preparation; definitive obturator prosthesis	14.72	090	
21081	Impression and custom preparation; mandibular resection prosthesis	13.42	090	
21082	Impression and custom preparation; palatal augmentation prosthesis	12.24	090	
21083	Impression and custom preparation; palatal lift prosthesis	11.32	090	
21084	Impression and custom preparation; speech aid prosthesis	13.22	090	
21085	Impression and custom preparation; oral surgical splint	5.27	010	
21086	Impression and custom preparation; auricular prosthesis	14.62	090	
21087	Impression and custom preparation; nasal prosthesis	14.62	090	
21088	Impression and custom preparation; facial prosthesis	BR	090	
21089	Unlisted maxillofacial prosthetic procedure	BR	YYY	
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)	1.28	090	
21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal	5.24	090	
21116	Injection procedure for temporomandibular joint arthrography	0.25	000	
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	7.26	090	
21121	Genioplasty; sliding osteotomy, single piece	8.89	090	
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	11.76	090	
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	13.09	090	
21125	Augmentation, mandibular body or angle; prosthetic material	8.08	090	
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)	11.25	090	
21137	Reduction forehead; contouring only	10.32	090	
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)	12.88	090	
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall	15.44	090	
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft	19.18	090	
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft	20.15	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft	20.86	090	
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	21.01	090	
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)	21.98	090	
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)	23.01	090	
21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)	24.95	090	
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	28.02	090	
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	30.16	090	
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I	34.77	090	
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I	42.43	090	
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I	49.29	090	
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	18.81	090	
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	29.66	090	
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	24.54	090	
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	27.61	090	
21181	Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial	9.71	090	
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm	30.43	090	
21183	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 sq cm but less than 80 sq cm	33.33	090	
21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm	36.12	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	23.72	090	
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	22.96	090	
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	26.36	090	
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	22.40	090	
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	17.49	090	
21198	Osteotomy, mandible, segmental;	11.66	090	
21199	Osteotomy, mandible, segmental; with genioglossus advancement	21.42	090	
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	17.49	090	
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	3.46	090	
21209	Osteoplasty, facial bones; reduction	6.65	090	
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	11.66	090	
21215	Graft, bone; mandible (includes obtaining graft)	17.49	090	
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	15.71	090	
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	5.83	090	
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	13.93	090	
21242	Arthroplasty, temporomandibular joint, with allograft	17.39	090	
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement	25.06	090	
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)	14.32	090	
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	18.41	090	
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	20.35	090	
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)	19.94	090	
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	15.85	090	
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	20.45	090	
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)	16.88	090	
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)	22.50	090	
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach	22.90	090	
21261	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach	28.63	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
21263	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement	37.84	090	
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach	36.81	090	
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach	44.99	090	
21270	Malar augmentation, prosthetic material	9.21	090	
21275	Secondary revision of orbitocraniofacial reconstruction	22.50	090	
21280	Medial canthopexy (separate procedure)	7.78	090	
21282	Lateral canthopexy	6.14	090	
21295	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach	12.37	090	
21296	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); intraoral approach	10.13	090	
21299	Unlisted craniofacial and maxillofacial procedure	BR	YYY	
■ 21315	Closed treatment of nasal bone fracture with manipulation; without stabilization	0.79	000	
■ 21320	Closed treatment of nasal bone fracture with manipulation; with stabilization	1.98	000	
21325	Open treatment of nasal fracture; uncomplicated	2.67	090	
21330	Open treatment of nasal fracture; complicated, with internal and/or external skeletal fixation	6.22	090	
21335	Open treatment of nasal fracture; with concomitant open treatment of fractured septum	11.16	090	
21336	Open treatment of nasal septal fracture, with or without stabilization	4.50	090	
21337	Closed treatment of nasal septal fracture, with or without stabilization	2.87	090	
21338	Open treatment of nasoethmoid fracture; without external fixation	7.16	090	
21339	Open treatment of nasoethmoid fracture; with external fixation	7.87	090	
21340	Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus	10.32	090	
21343	Open treatment of depressed frontal sinus fracture	9.82	090	
21344	Open treatment of complicated (eg, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches	15.03	090	
21345	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint	9.61	090	
21346	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation	12.27	090	
21347	Open treatment of nasomaxillary complex fracture (LeFort II type); requiring multiple open approaches	14.62	090	
21348	Open treatment of nasomaxillary complex fracture (LeFort II type); with bone grafting (includes obtaining graft)	14.72	090	
21355	Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation	0.79	010	
21356	Open treatment of depressed zygomatic arch fracture (eg, Gillies approach)	5.12	010	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	4.64	090	
21365	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches	8.60	090	
21366	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with bone grafting (includes obtaining graft)	13.80	090	
21385	Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation)	7.90	090	
21386	Open treatment of orbital floor blowout fracture; periorbital approach	8.50	090	
21387	Open treatment of orbital floor blowout fracture; combined approach	9.88	090	
21390	Open treatment of orbital floor blowout fracture; periorbital approach, with alloplastic or other implant	9.19	090	
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)	11.86	090	
21400	Closed treatment of fracture of orbit, except blowout; without manipulation	1.19	090	
21401	Closed treatment of fracture of orbit, except blowout; with manipulation	3.95	090	
21406	Open treatment of fracture of orbit, except blowout; without implant	4.64	090	
21407	Open treatment of fracture of orbit, except blowout; with implant	5.24	090	
21408	Open treatment of fracture of orbit, except blowout; with bone grafting (includes obtaining graft)	10.23	090	
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint	5.24	090	
21422	Open treatment of palatal or maxillary fracture (LeFort I type);	8.99	090	
21423	Open treatment of palatal or maxillary fracture (LeFort I type); complicated (comminuted or involving cranial nerve foramina), multiple approaches	9.41	090	
21431	Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint	5.24	090	
21432	Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation	5.24	090	
21433	Open treatment of craniofacial separation (LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches	15.34	090	
21435	Open treatment of craniofacial separation (LeFort III type); complicated, utilizing internal and/or external fixation techniques (eg, head cap, halo device, and/or intermaxillary fixation)	17.49	090	
21436	Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)	20.45	090	
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)	3.36	090	
21445	Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)	3.99	090	
21450	Closed treatment of mandibular fracture; without manipulation	3.36	090	
21451	Closed treatment of mandibular fracture; with manipulation	6.75	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
21452	Percutaneous treatment of mandibular fracture, with external fixation	7.87	090	
21453	Closed treatment of mandibular fracture with interdental fixation	5.24	090	
21454	Open treatment of mandibular fracture with external fixation	8.49	090	
21461	Open treatment of mandibular fracture; without interdental fixation	9.58	090	
21462	Open treatment of mandibular fracture; with interdental fixation	9.88	090	
21465	Open treatment of mandibular condylar fracture	12.27	090	
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints	14.82	090	
21480	Closed treatment of temporomandibular dislocation; initial or subsequent	0.59	000	
21485	Closed treatment of temporomandibular dislocation; complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent	2.25	090	
21490	Open treatment of temporomandibular dislocation	9.58	090	
21497	Interdental wiring, for condition other than fracture	1.28	090	
21499	Unlisted musculoskeletal procedure, head	BR	YYY	
21501	Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax;	3.26	090	
21502	Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax; with partial rib osteotomy	3.95	090	
21510	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax	4.87	090	
21550	Biopsy, soft tissue of neck or thorax	1.03	010	
21552	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater	2.38	090	
21554	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); 5 cm or greater	4.14	090	
21555	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm	2.00	090	
21556	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm	5.14	090	
21557	Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; less than 5 cm	13.09	090	
21558	Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; 5 cm or greater	7.35	090	
21600	Excision of rib, partial	3.85	090	
■ 21601	Excision of chest wall tumor including rib(s)	11.96	090	
■ 21602	Excision of chest wall tumor involving rib(s), with plastic reconstruction; without mediastinal lymphadenectomy	16.13	090	
■ 21603	Excision of chest wall tumor involving rib(s), with plastic reconstruction; with mediastinal lymphadenectomy	17.49	090	
21610	Costotransversectomy (separate procedure)	3.85	090	
21615	Excision first and/or cervical rib;	9.68	090	
21616	Excision first and/or cervical rib; with sympathectomy	11.86	090	
21620	Osteotomy of sternum, partial	8.28	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
21627	Sternal debridement	8.69	090	
21630	Radical resection of sternum;	12.78	090	
21632	Radical resection of sternum; with mediastinal lymphadenectomy	18.92	090	
21685	Hyoid myotomy and suspension	6.73	090	
21700	Division of scalenus anticus; without resection of cervical rib	6.04	090	
21705	Division of scalenus anticus; with resection of cervical rib	7.26	090	
21720	Division of sternocleidomastoid for torticollis, open operation; without cast application	4.86	090	
21725	Division of sternocleidomastoid for torticollis, open operation; with cast application	5.47	090	
21740	Reconstructive repair of pectus excavatum or carinatum; open	12.94	090	
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy	9.83	090	
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy	12.94	090	
21750	Closure of median sternotomy separation with or without debridement (separate procedure)	6.21	090	
21811	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs	6.32	000	
21812	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4-6 ribs	7.69	000	
21813	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs	10.48	000	
21820	Closed treatment of sternum fracture	1.98	090	
21825	Open treatment of sternum fracture with or without skeletal fixation	8.63	090	
21899	Unlisted procedure, neck or thorax	BR	YYY	
21920	Biopsy, soft tissue of back or flank; superficial	0.69	010	
21925	Biopsy, soft tissue of back or flank; deep	2.45	090	
21930	Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm	3.88	090	
21931	Excision, tumor, soft tissue of back or flank, subcutaneous; 3 cm or greater	3.52	090	
21932	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); less than 5 cm	4.55	090	
21933	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); 5 cm or greater	4.97	090	
21935	Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; less than 5 cm	8.69	090	
21936	Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; 5 cm or greater	9.63	090	
22010	Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic	5.59	090	
22015	Incision and drainage, open, of deep abscess (subfascial), posterior spine; lumbar, sacral, or lumbosacral	5.49	090	
22100	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical	5.24	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	22101	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; thoracic	5.24	090	
	22102	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; lumbar	6.84	090	
+	22103	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; each additional segment (List separately in addition to code for primary procedure)	1.38	ZZZ	
	22110	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical	6.14	090	
	22112	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; thoracic	6.14	090	
	22114	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; lumbar	6.14	090	
+	22116	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)	1.84	ZZZ	
	22206	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); thoracic	26.39	090	
	22207	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); lumbar	25.56	090	
+	22208	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)	7.66	ZZZ	
	22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical	18.10	090	
	22212	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic	17.59	090	
	22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar	17.89	090	
+	22216	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (List separately in addition to primary procedure)	5.36	ZZZ	
	22220	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical	19.12	090	
	22222	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic	18.61	090	
	22224	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar	18.92	090	
+	22226	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)	5.67	ZZZ	
	22310	Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing	2.37	090	
	22315	Closed treatment of vertebral fracture(s) and/or dislocation(s) requiring casting or bracing, with and including casting and/or bracing by manipulation or traction	4.64	090	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	22318	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; without grafting	22.51	090	
	22319	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; with grafting	26.44	090	
	22325	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar	15.81	090	
	22326	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; cervical	17.42	090	
	22327	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; thoracic	15.81	090	
+	22328	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; each additional fractured vertebra or dislocated segment (List separately in addition to code for primary procedure)	3.69	ZZZ	
	22505	Manipulation of spine requiring anesthesia, any region	0.00	010	
	22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	13.46	010	
	22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	12.94	010	
+	22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)	4.45	ZZZ	
	22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	3.52	010	
	22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar	3.31	010	
+	22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	1.55	ZZZ	
	22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	10.87	010	
+	22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	8.80	ZZZ	
	22532	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	19.36	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	18.11	090	
+	22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)	9.01	ZZZ	
	22548	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process	19.76	090	
	22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2	18.42	090	
+	22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)	5.28	ZZZ	
	22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	19.76	090	
	22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	20.75	090	
	22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	15.81	090	
+	22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)	3.88	ZZZ	
	22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace	21.32	090	
	22590	Arthrodesis, posterior technique, craniocervical (occiput-C2)	18.28	090	
	22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)	18.28	090	
■	22600	Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment	16.08	090	
■	22610	Arthrodesis, posterior or posterolateral technique, single interspace; thoracic (with lateral transverse technique, when performed)	15.81	090	
■	22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)	15.81	090	
■ +	22614	Arthrodesis, posterior or posterolateral technique, single interspace; each additional interspace (List separately in addition to code for primary procedure)	3.87	ZZZ	
■	22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar;	18.92	090	
■ +	22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar; each additional interspace (List separately in addition to code for primary procedure)	5.67	ZZZ	
■	22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar;	19.80	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■ +	22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar; each additional interspace (List separately in addition to code for primary procedure)	5.34	ZZZ	
	22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments	19.51	090	
	22802	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments	21.16	090	
	22804	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments	25.41	090	
	22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments	16.97	090	
	22810	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments	20.45	090	
	22812	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments	23.72	090	
	22818	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments	35.02	090	
	22819	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments	44.34	090	
	22830	Exploration of spinal fusion	16.36	090	
■	22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments	17.87	090	
■	22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments	19.69	090	
■	22838	Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed	19.95	090	
+	22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	9.57	ZZZ	
+	22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)	2.98	XXX	
+	22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)	11.76	ZZZ	
+	22843	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)	12.93	ZZZ	
+	22844	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure)	14.22	ZZZ	
+	22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)	12.27	ZZZ	
+	22846	Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)	13.50	ZZZ	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	22847	Anterior instrumentation; 8 or more vertebral segments (List separately in addition to code for primary procedure)	14.83	ZZZ	
+	22848	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)	5.29	ZZZ	
	22849	Reinsertion of spinal fixation device	9.71	090	
	22850	Removal of posterior nonsegmental instrumentation (eg, Harrington rod)	6.65	090	
	22852	Removal of posterior segmental instrumentation	7.67	090	
+	22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)	2.67	ZZZ	
+	22854	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	3.45	ZZZ	
	22855	Removal of anterior instrumentation	12.78	090	
	22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical	19.15	090	
■	22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar	19.35	090	
+	22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)	5.47	ZZZ	
+	22859	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	3.45	ZZZ	
■ +	22860	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)	4.30	ZZZ	
	22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	23.60	090	
	22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	23.60	090	
	22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	21.94	090	
	22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	22.98	090	
	22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	9.88	090	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
+	22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	2.52	ZZZ	
	22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	5.61	090	
+	22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	1.45	ZZZ	
	22899	Unlisted procedure, spine	BR	YYY	
	22900	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm	5.14	090	
	22901	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); 5 cm or greater	3.31	090	
	22902	Excision, tumor, soft tissue of abdominal wall, subcutaneous; less than 3 cm	2.07	090	
	22903	Excision, tumor, soft tissue of abdominal wall, subcutaneous; 3 cm or greater	2.17	090	
	22904	Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; less than 5 cm	5.28	090	
	22905	Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; 5 cm or greater	6.83	090	
	22999	Unlisted procedure, abdomen, musculoskeletal system	BR	YYY	
	23000	Removal of subdeltoid calcareous deposits, open	3.11	090	
	23020	Capsular contracture release (eg, Sever type procedure)	7.21	090	
	23030	Incision and drainage, shoulder area; deep abscess or hematoma	3.23	010	
	23031	Incision and drainage, shoulder area; infected bursa	0.99	010	
	23035	Incision, bone cortex (eg, osteomyelitis or bone abscess), shoulder area	4.45	090	
	23040	Arthrotomy, glenohumeral joint, including exploration, drainage, or removal of foreign body	7.29	090	
	23044	Arthrotomy, acromioclavicular, sternoclavicular joint, including exploration, drainage, or removal of foreign body	4.32	090	
	23065	Biopsy, soft tissue of shoulder area; superficial	0.71	010	
	23066	Biopsy, soft tissue of shoulder area; deep	3.23	090	
	23071	Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater	1.86	090	
	23073	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); 5 cm or greater	4.81	090	
	23075	Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm	1.98	090	
	23076	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm	3.45	090	
	23077	Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; less than 5 cm	21.98	090	
	23078	Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; 5 cm or greater	9.11	090	
	23100	Arthrotomy, glenohumeral joint, including biopsy	7.21	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
23101	Arthrotomy, acromioclavicular joint or sternoclavicular joint, including biopsy and/or excision of torn cartilage	3.26	090	
23105	Arthrotomy; glenohumeral joint, with synovectomy, with or without biopsy	9.88	090	
23106	Arthrotomy; sternoclavicular joint, with synovectomy, with or without biopsy	3.95	090	
23107	Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body	9.88	090	
23120	Claviculectomy; partial	6.47	090	
23125	Claviculectomy; total	9.88	090	
23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release	6.47	090	
23140	Excision or curettage of bone cyst or benign tumor of clavicle or scapula;	3.95	090	
23145	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with autograft (includes obtaining graft)	5.93	090	
23146	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with allograft	4.64	090	
23150	Excision or curettage of bone cyst or benign tumor of proximal humerus;	8.63	090	
23155	Excision or curettage of bone cyst or benign tumor of proximal humerus; with autograft (includes obtaining graft)	10.79	090	
23156	Excision or curettage of bone cyst or benign tumor of proximal humerus; with allograft	8.63	090	
23170	Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle	5.18	090	
23172	Sequestrectomy (eg, for osteomyelitis or bone abscess), scapula	6.47	090	
23174	Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck	8.60	090	
23180	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), clavicle	6.47	090	
23182	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), scapula	7.77	090	
23184	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), proximal humerus	3.45	090	
23190	Ostectomy of scapula, partial (eg, superior medial angle)	7.77	090	
23195	Resection, humeral head	6.47	090	
23200	Radical resection of tumor; clavicle	8.63	090	
23210	Radical resection of tumor; scapula	10.79	090	
23220	Radical resection of tumor, proximal humerus	12.94	090	
23330	Removal of foreign body, shoulder; subcutaneous	3.95	010	
23333	Removal of foreign body, shoulder; deep (subfascial or intramuscular)	4.90	090	
23334	Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component	11.35	090	
23335	Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid components (eg, total shoulder)	13.51	090	
23350	Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography	0.52	000	
23395	Muscle transfer, any type, shoulder or upper arm; single	13.34	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
23397	Muscle transfer, any type, shoulder or upper arm; multiple	14.33	090	
23400	Scapulopexy (eg, Sprengels deformity or for paralysis)	14.33	090	
23405	Tenotomy, shoulder area; single tendon	5.24	090	
23406	Tenotomy, shoulder area; multiple tendons through same incision	7.90	090	
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	9.19	090	
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	10.37	090	
23415	Coracoacromial ligament release, with or without acromioplasty	3.95	090	
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	11.86	090	
23430	Tenodesis of long tendon of biceps	7.90	090	
23440	Resection or transplantation of long tendon of biceps	7.90	090	
23450	Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation	10.87	090	
23455	Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)	12.35	090	
23460	Capsulorrhaphy, anterior, any type; with bone block	13.34	090	
23462	Capsulorrhaphy, anterior, any type; with coracoid process transfer	11.86	090	
23465	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block	11.36	090	
23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability	12.48	090	
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	12.84	090	
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	19.76	090	
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	17.15	090	
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	18.52	090	
23480	Osteotomy, clavicle, with or without internal fixation;	6.62	090	
23485	Osteotomy, clavicle, with or without internal fixation; with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation)	7.90	090	
23490	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; clavicle	6.14	090	
23491	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; proximal humerus	7.67	090	
23500	Closed treatment of clavicular fracture; without manipulation	1.29	090	
23505	Closed treatment of clavicular fracture; with manipulation	1.94	090	
23515	Open treatment of clavicular fracture, includes internal fixation, when performed	7.77	090	
23520	Closed treatment of sternoclavicular dislocation; without manipulation	1.78	090	
23525	Closed treatment of sternoclavicular dislocation; with manipulation	1.78	090	
23530	Open treatment of sternoclavicular dislocation, acute or chronic;	6.62	090	
23532	Open treatment of sternoclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)	7.21	090	
23540	Closed treatment of acromioclavicular dislocation; without manipulation	0.59	090	
23545	Closed treatment of acromioclavicular dislocation; with manipulation	2.15	090	
23550	Open treatment of acromioclavicular dislocation, acute or chronic;	7.90	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
23552	Open treatment of acromioclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)	8.60	090	
23570	Closed treatment of scapular fracture; without manipulation	1.88	090	
23575	Closed treatment of scapular fracture; with manipulation, with or without skeletal traction (with or without shoulder joint involvement)	2.59	090	
23585	Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation, when performed	7.90	090	
23600	Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation	2.81	090	
23605	Closed treatment of proximal humeral (surgical or anatomical neck) fracture; with manipulation, with or without skeletal traction	4.32	090	
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed;	11.66	090	
23616	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; with proximal humeral prosthetic replacement	12.27	090	
23620	Closed treatment of greater humeral tuberosity fracture; without manipulation	1.29	090	
23625	Closed treatment of greater humeral tuberosity fracture; with manipulation	1.94	090	
23630	Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed	5.93	090	
23650	Closed treatment of shoulder dislocation, with manipulation; without anesthesia	0.99	090	
23655	Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia	3.23	090	
23660	Open treatment of acute shoulder dislocation	10.79	090	
23665	Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation	1.98	090	
23670	Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed	9.49	090	
23675	Closed treatment of shoulder dislocation, with surgical or anatomical neck fracture, with manipulation	2.67	090	
23680	Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed	12.51	090	
23700	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)	3.23	010	
23800	Arthrodesis, glenohumeral joint;	12.84	090	
23802	Arthrodesis, glenohumeral joint; with autogenous graft (includes obtaining graft)	14.33	090	
23900	Interthoracoscapular amputation (forequarter)	19.76	090	
23920	Disarticulation of shoulder;	14.33	090	
23921	Disarticulation of shoulder; secondary closure or scar revision	2.67	090	
23929	Unlisted procedure, shoulder	BR	YYY	
23930	Incision and drainage, upper arm or elbow area; deep abscess or hematoma	4.74	010	
23931	Incision and drainage, upper arm or elbow area; bursa	3.06	010	
23935	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), humerus or elbow	7.77	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
24000	Arthrotomy, elbow, including exploration, drainage, or removal of foreign body	6.62	090	
24006	Arthrotomy of the elbow, with capsular excision for capsular release (separate procedure)	5.62	090	
24065	Biopsy, soft tissue of upper arm or elbow area; superficial	0.61	010	
24066	Biopsy, soft tissue of upper arm or elbow area; deep (subfascial or intramuscular)	3.45	090	
24071	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; 3 cm or greater	3.31	090	
24073	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); 5 cm or greater	4.66	090	
24075	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm	1.81	090	
24076	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	3.31	090	
24077	Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; less than 5 cm	10.23	090	
24079	Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; 5 cm or greater	8.69	090	
24100	Arthrotomy, elbow; with synovial biopsy only	5.93	090	
24101	Arthrotomy, elbow; with joint exploration, with or without biopsy, with or without removal of loose or foreign body	6.72	090	
24102	Arthrotomy, elbow; with synovectomy	9.19	090	
24105	Excision, olecranon bursa	2.87	090	
24110	Excision or curettage of bone cyst or benign tumor, humerus;	6.22	090	
24115	Excision or curettage of bone cyst or benign tumor, humerus; with autograft (includes obtaining graft)	8.20	090	
24116	Excision or curettage of bone cyst or benign tumor, humerus; with allograft	6.92	090	
24120	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process;	5.24	090	
24125	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with autograft (includes obtaining graft)	6.62	090	
24126	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with allograft	5.93	090	
24130	Excision, radial head	6.47	090	
24134	Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus	8.60	090	
24136	Sequestrectomy (eg, for osteomyelitis or bone abscess), radial head or neck	6.14	090	
24138	Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process	6.14	090	
24140	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), humerus	7.90	090	
24145	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), radial head or neck	6.47	090	
24147	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), olecranon process	3.95	090	
24149	Radical resection of capsule, soft tissue, and heterotopic bone, elbow, with contracture release (separate procedure)	7.87	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
24150	Radical resection of tumor, shaft or distal humerus	15.81	090	
24152	Radical resection of tumor, radial head or neck	8.50	090	
24155	Resection of elbow joint (arthrectomy)	9.88	090	
24160	Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar components	3.95	090	
24164	Removal of prosthesis, includes debridement and synovectomy when performed; radial head	2.67	090	
24200	Removal of foreign body, upper arm or elbow area; subcutaneous	0.30	010	
24201	Removal of foreign body, upper arm or elbow area; deep (subfascial or intramuscular)	1.19	090	
24220	Injection procedure for elbow arthrography	0.30	000	
24300	Manipulation, elbow, under anesthesia	3.75	090	
24301	Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331)	7.21	090	
24305	Tendon lengthening, upper arm or elbow, each tendon	6.47	090	
24310	Tenotomy, open, elbow to shoulder, each tendon	5.18	090	
24320	Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure)	7.77	090	
24330	Flexor-plasty, elbow (eg, Steindler type advancement);	7.90	090	
24331	Flexor-plasty, elbow (eg, Steindler type advancement); with extensor advancement	10.37	090	
24332	Tenolysis, triceps	4.45	090	
24340	Tenodesis of biceps tendon at elbow (separate procedure)	7.33	090	
24341	Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)	6.96	090	
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft	10.79	090	
24343	Repair lateral collateral ligament, elbow, with local tissue	7.04	090	
24344	Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)	8.44	090	
24345	Repair medial collateral ligament, elbow, with local tissue	7.04	090	
24346	Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)	8.44	090	
24357	Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); percutaneous	3.83	090	
24358	Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open	4.35	090	
24359	Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment	5.18	090	
24360	Arthroplasty, elbow; with membrane (eg, fascial)	10.28	090	
24361	Arthroplasty, elbow; with distal humeral prosthetic replacement	10.28	090	
24362	Arthroplasty, elbow; with implant and fascia lata ligament reconstruction	10.28	090	
24363	Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)	13.24	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
24365	Arthroplasty, radial head;	6.47	090	
24366	Arthroplasty, radial head; with implant	7.33	090	
24370	Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component	16.30	090	
24371	Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component	19.01	090	
24400	Osteotomy, humerus, with or without internal fixation	10.37	090	
24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)	11.86	090	
24420	Osteoplasty, humerus (eg, shortening or lengthening) (excluding 64876)	10.37	090	
24430	Repair of nonunion or malunion, humerus; without graft (eg, compression technique)	11.36	090	
24435	Repair of nonunion or malunion, humerus; with iliac or other autograft (includes obtaining graft)	13.34	090	
24470	Hemiepiphyseal arrest (eg, cubitus varus or valgus, distal humerus)	6.62	090	
24495	Decompression fasciotomy, forearm, with brachial artery exploration	4.94	090	
24498	Prophylactic treatment (nailing, pinning, plating or wiring), with or without methylmethacrylate, humeral shaft	8.18	090	
24500	Closed treatment of humeral shaft fracture; without manipulation	1.94	090	
24505	Closed treatment of humeral shaft fracture; with manipulation, with or without skeletal traction	3.67	090	
24515	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage	12.07	090	
24516	Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws	12.07	090	
24530	Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; without manipulation	3.23	090	
24535	Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; with manipulation, with or without skin or skeletal traction	6.47	090	
24538	Percutaneous skeletal fixation of supracondylar or transcondylar humeral fracture, with or without intercondylar extension	8.63	090	
24545	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension	10.79	090	
24546	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension	12.94	090	
24560	Closed treatment of humeral epicondylar fracture, medial or lateral; without manipulation	1.29	090	
24565	Closed treatment of humeral epicondylar fracture, medial or lateral; with manipulation	2.15	090	
24566	Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation	5.18	090	
24575	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	6.47	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
24576	Closed treatment of humeral condylar fracture, medial or lateral; without manipulation	3.45	090	
24577	Closed treatment of humeral condylar fracture, medial or lateral; with manipulation	5.18	090	
24579	Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed	8.63	090	
24582	Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral, with manipulation	6.47	090	
24586	Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius);	12.07	090	
24587	Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius); with implant arthroplasty	11.65	090	
24600	Treatment of closed elbow dislocation; without anesthesia	1.19	090	
24605	Treatment of closed elbow dislocation; requiring anesthesia	3.23	090	
24615	Open treatment of acute or chronic elbow dislocation	7.77	090	
24620	Closed treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with manipulation	3.23	090	
24635	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed	10.79	090	
24640	Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation	0.79	010	
24650	Closed treatment of radial head or neck fracture; without manipulation	1.29	090	
24655	Closed treatment of radial head or neck fracture; with manipulation	2.15	090	
24665	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed;	6.47	090	
24666	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed; with radial head prosthetic replacement	6.62	090	
24670	Closed treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]); without manipulation	1.94	090	
24675	Closed treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]); with manipulation	6.47	090	
24685	Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed	7.77	090	
24800	Arthrodesis, elbow joint; local	12.07	090	
24802	Arthrodesis, elbow joint; with autogenous graft (includes obtaining graft)	12.94	090	
24900	Amputation, arm through humerus; with primary closure	10.79	090	
24920	Amputation, arm through humerus; open, circular (guillotine)	8.63	090	
24925	Amputation, arm through humerus; secondary closure or scar revision	1.98	090	
24930	Amputation, arm through humerus; re-amputation	7.77	090	
24931	Amputation, arm through humerus; with implant	12.07	090	
24935	Stump elongation, upper extremity	2.37	090	
24940	Cineplasty, upper extremity, complete procedure	10.97	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
24999	Unlisted procedure, humerus or elbow	BR	YYY	
25000	Incision, extensor tendon sheath, wrist (eg, deQuervains disease)	3.13	090	
25001	Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)	3.00	090	
25020	Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; without debridement of nonviable muscle and/or nerve	5.18	090	
25023	Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; with debridement of nonviable muscle and/or nerve	6.47	090	
25024	Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; without debridement of nonviable muscle and/or nerve	4.66	090	
25025	Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve	6.05	090	
25028	Incision and drainage, forearm and/or wrist; deep abscess or hematoma	3.67	090	
25031	Incision and drainage, forearm and/or wrist; bursa	3.23	090	
25035	Incision, deep, bone cortex, forearm and/or wrist (eg, osteomyelitis or bone abscess)	5.18	090	
25040	Arthrotomy, radiocarpal or midcarpal joint, with exploration, drainage, or removal of foreign body	3.56	090	
25065	Biopsy, soft tissue of forearm and/or wrist; superficial	1.08	010	
25066	Biopsy, soft tissue of forearm and/or wrist; deep (subfascial or intramuscular)	3.23	090	
25071	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater	4.09	090	
25073	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater	5.69	090	
25075	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm	1.86	090	
25076	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm	3.11	090	
25077	Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; less than 3 cm	10.23	090	
25078	Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; 3 cm or greater	9.94	090	
25085	Capsulotomy, wrist (eg, contracture)	5.34	090	
25100	Arthrotomy, wrist joint; with biopsy	5.34	090	
25101	Arthrotomy, wrist joint; with joint exploration, with or without biopsy, with or without removal of loose or foreign body	6.04	090	
25105	Arthrotomy, wrist joint; with synovectomy	6.91	090	
25107	Arthrotomy, distal radioulnar joint including repair of triangular cartilage, complex	4.45	090	
25109	Excision of tendon, forearm and/or wrist, flexor or extensor, each	4.35	090	
25110	Excision, lesion of tendon sheath, forearm and/or wrist	3.23	090	
25111	Excision of ganglion, wrist (dorsal or volar); primary	3.45	090	
25112	Excision of ganglion, wrist (dorsal or volar); recurrent	4.32	090	
25115	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors	6.72	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
25116	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum	7.77	090	
25118	Synovectomy, extensor tendon sheath, wrist, single compartment;	6.72	090	
25119	Synovectomy, extensor tendon sheath, wrist, single compartment; with resection of distal ulna	6.91	090	
25120	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process);	5.34	090	
25125	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with autograft (includes obtaining graft)	6.62	090	
25126	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with allograft	5.73	090	
25130	Excision or curettage of bone cyst or benign tumor of carpal bones;	3.88	090	
25135	Excision or curettage of bone cyst or benign tumor of carpal bones; with autograft (includes obtaining graft)	6.47	090	
25136	Excision or curettage of bone cyst or benign tumor of carpal bones; with allograft	5.61	090	
25145	Sequestrectomy (eg, for osteomyelitis or bone abscess), forearm and/or wrist	6.14	090	
25150	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); ulna	5.34	090	
25151	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); radius	5.34	090	
25170	Radical resection of tumor, radius or ulna	8.50	090	
25210	Carpectomy; 1 bone	5.18	090	
25215	Carpectomy; all bones of proximal row	7.77	090	
25230	Radial styloidectomy (separate procedure)	4.15	090	
25240	Excision distal ulna partial or complete (eg, Darrach type or matched resection)	4.74	090	
25246	Injection procedure for wrist arthrography	0.30	000	
25248	Exploration with removal of deep foreign body, forearm or wrist	3.88	090	
25250	Removal of wrist prosthesis; (separate procedure)	3.23	090	
25251	Removal of wrist prosthesis; complicated, including total wrist	3.67	090	
25259	Manipulation, wrist, under anesthesia	6.55	090	
25260	Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle	5.18	090	
25263	Repair, tendon or muscle, flexor, forearm and/or wrist; secondary, single, each tendon or muscle	6.04	090	
25265	Repair, tendon or muscle, flexor, forearm and/or wrist; secondary, with free graft (includes obtaining graft), each tendon or muscle	7.90	090	
25270	Repair, tendon or muscle, extensor, forearm and/or wrist; primary, single, each tendon or muscle	3.56	090	
25272	Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, single, each tendon or muscle	4.45	090	
25274	Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, with free graft (includes obtaining graft), each tendon or muscle	5.34	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
25275	Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)	5.18	090	
25280	Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single, each tendon	4.45	090	
25290	Tenotomy, open, flexor or extensor tendon, forearm and/or wrist, single, each tendon	3.45	090	
25295	Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each tendon	4.05	090	
25300	Tenodesis at wrist; flexors of fingers	7.11	090	
25301	Tenodesis at wrist; extensors of fingers	6.22	090	
25310	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon	6.22	090	
25312	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; with tendon graft(s) (includes obtaining graft), each tendon	7.11	090	
25315	Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist;	7.11	090	
25316	Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist; with tendon(s) transfer	10.23	090	
25320	Capsulorrhaphy or reconstruction, wrist, open (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability	8.80	090	
25332	Arthroplasty, wrist, with or without interposition, with or without external or internal fixation	7.41	090	
25335	Centralization of wrist on ulna (eg, radial club hand)	12.84	090	
25337	Reconstruction for stabilization of unstable distal ulna or distal radioulnar joint, secondary by soft tissue stabilization (eg, tendon transfer, tendon graft or weave, or tenodesis) with or without open reduction of distal radioulnar joint	8.69	090	
25350	Osteotomy, radius; distal third	6.62	090	
25355	Osteotomy, radius; middle or proximal third	7.90	090	
25360	Osteotomy; ulna	6.62	090	
25365	Osteotomy; radius AND ulna	9.19	090	
25370	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna	8.60	090	
25375	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius AND ulna	10.57	090	
25390	Osteoplasty, radius OR ulna; shortening	6.62	090	
25391	Osteoplasty, radius OR ulna; lengthening with autograft	8.20	090	
25392	Osteoplasty, radius AND ulna; shortening (excluding 64876)	9.19	090	
25393	Osteoplasty, radius AND ulna; lengthening with autograft	10.37	090	
25394	Osteoplasty, carpal bone, shortening	5.18	090	
25400	Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique)	9.92	090	
25405	Repair of nonunion or malunion, radius OR ulna; with autograft (includes obtaining graft)	10.79	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
25415	Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)	10.35	090	
25420	Repair of nonunion or malunion, radius AND ulna; with autograft (includes obtaining graft)	12.07	090	
25425	Repair of defect with autograft; radius OR ulna	8.20	090	
25426	Repair of defect with autograft; radius AND ulna	10.37	090	
25430	Insertion of vascular pedicle into carpal bone (eg, Hori procedure)	7.45	090	
25431	Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone	7.76	090	
25440	Repair of nonunion, scaphoid carpal (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)	9.49	090	
25441	Arthroplasty with prosthetic replacement; distal radius	4.94	090	
25442	Arthroplasty with prosthetic replacement; distal ulna	4.94	090	
25443	Arthroplasty with prosthetic replacement; scaphoid carpal (navicular)	8.80	090	
25444	Arthroplasty with prosthetic replacement; lunate	7.33	090	
25445	Arthroplasty with prosthetic replacement; trapezium	7.33	090	
25446	Arthroplasty with prosthetic replacement; distal radius and partial or entire carpus (total wrist)	11.16	090	
25447	Arthroplasty, interposition, intercarpal or carpometacarpal joints	4.32	090	
25449	Revision of arthroplasty, including removal of implant, wrist joint	7.41	090	
25450	Epiphyseal arrest by epiphysiodesis or stapling; distal radius OR ulna	5.18	090	
25455	Epiphyseal arrest by epiphysiodesis or stapling; distal radius AND ulna	6.47	090	
25490	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radius	5.62	090	
25491	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; ulna	5.62	090	
25492	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radius AND ulna	6.65	090	
25500	Closed treatment of radial shaft fracture; without manipulation	1.53	090	
25505	Closed treatment of radial shaft fracture; with manipulation	2.87	090	
25515	Open treatment of radial shaft fracture, includes internal fixation, when performed	6.62	090	
25520	Closed treatment of radial shaft fracture and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation)	2.64	090	
25525	Open treatment of radial shaft fracture, includes internal fixation, when performed, and closed treatment of distal radioulnar joint dislocation (Galeazzi fracture/ dislocation), includes percutaneous skeletal fixation, when performed	6.73	090	
25526	Open treatment of radial shaft fracture, includes internal fixation, when performed, and open treatment of distal radioulnar joint dislocation (Galeazzi fracture/ dislocation), includes internal fixation, when performed, includes repair of triangular fibrocartilage complex	7.76	090	
25530	Closed treatment of ulnar shaft fracture; without manipulation	1.64	090	
25535	Closed treatment of ulnar shaft fracture; with manipulation	2.67	090	
25545	Open treatment of ulnar shaft fracture, includes internal fixation, when performed	5.24	090	
25560	Closed treatment of radial and ulnar shaft fractures; without manipulation	2.37	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
25565	Closed treatment of radial and ulnar shaft fractures; with manipulation	3.95	090	
25574	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius OR ulna	4.64	090	
25575	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna	10.79	090	
25600	Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; without manipulation	1.94	090	
25605	Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation	3.23	090	
25606	Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation	5.07	090	
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	5.07	090	
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments	6.31	090	
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments	7.45	090	
25622	Closed treatment of carpal scaphoid (navicular) fracture; without manipulation	2.15	090	
25624	Closed treatment of carpal scaphoid (navicular) fracture; with manipulation	3.23	090	
25628	Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed	7.77	090	
25630	Closed treatment of carpal bone fracture (excluding carpal scaphoid [navicular]); without manipulation, each bone	1.56	090	
25635	Closed treatment of carpal bone fracture (excluding carpal scaphoid [navicular]); with manipulation, each bone	2.67	090	
25645	Open treatment of carpal bone fracture (other than carpal scaphoid [navicular]), each bone	3.88	090	
25650	Closed treatment of ulnar styloid fracture	1.08	090	
25651	Percutaneous skeletal fixation of ulnar styloid fracture	3.62	090	
25652	Open treatment of ulnar styloid fracture	4.55	090	
25660	Closed treatment of radiocarpal or intercarpal dislocation, 1 or more bones, with manipulation	4.32	090	
25670	Open treatment of radiocarpal or intercarpal dislocation, 1 or more bones	8.63	090	
25671	Percutaneous skeletal fixation of distal radioulnar dislocation	3.31	090	
25675	Closed treatment of distal radioulnar dislocation with manipulation	1.98	090	
25676	Open treatment of distal radioulnar dislocation, acute or chronic	5.18	090	
25680	Closed treatment of trans-scaphoperilunar type of fracture dislocation, with manipulation	5.18	090	
25685	Open treatment of trans-scaphoperilunar type of fracture dislocation	10.35	090	
25690	Closed treatment of lunate dislocation, with manipulation	3.26	090	
25695	Open treatment of lunate dislocation	5.18	090	
25800	Arthrodesis, wrist; complete, without bone graft (includes radiocarpal and/or intercarpal and/or carpometacarpal joints)	10.35	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
25805	Arthrodesis, wrist; with sliding graft	11.21	090	
25810	Arthrodesis, wrist; with iliac or other autograft (includes obtaining graft)	12.07	090	
25820	Arthrodesis, wrist; limited, without bone graft (eg, intercarpal or radiocarpal)	8.20	090	
25825	Arthrodesis, wrist; with autograft (includes obtaining graft)	9.49	090	
25830	Arthrodesis, distal radioulnar joint with segmental resection of ulna, with or without bone graft (eg, Sauve-Kapandji procedure)	8.18	090	
25900	Amputation, forearm, through radius and ulna;	7.77	090	
25905	Amputation, forearm, through radius and ulna; open, circular (guillotine)	6.91	090	
25907	Amputation, forearm, through radius and ulna; secondary closure or scar revision	1.98	090	
25909	Amputation, forearm, through radius and ulna; re-amputation	5.93	090	
25915	Krukenberg procedure	5.93	090	
25920	Disarticulation through wrist;	5.24	090	
25922	Disarticulation through wrist; secondary closure or scar revision	1.98	090	
25924	Disarticulation through wrist; re-amputation	4.32	090	
25927	Transmetacarpal amputation;	5.93	090	
25929	Transmetacarpal amputation; secondary closure or scar revision	1.98	090	
25931	Transmetacarpal amputation; re-amputation	4.74	090	
25999	Unlisted procedure, forearm or wrist	BR	YYY	
26010	Drainage of finger abscess; simple	0.64	010	
26011	Drainage of finger abscess; complicated (eg, felon)	1.68	010	
26020	Drainage of tendon sheath, digit and/or palm, each	3.26	090	
26025	Drainage of palmar bursa; single, bursa	3.51	090	
26030	Drainage of palmar bursa; multiple bursa	4.94	090	
26034	Incision, bone cortex, hand or finger (eg, osteomyelitis or bone abscess)	3.45	090	
26035	Decompression fingers and/or hand, injection injury (eg, grease gun)	8.20	090	
26037	Decompressive fasciotomy, hand (excludes 26035)	3.88	090	
26040	Fasciotomy, palmar (eg, Dupuytren's contracture); percutaneous	3.23	090	
26045	Fasciotomy, palmar (eg, Dupuytren's contracture); open, partial	3.67	090	
26055	Tendon sheath incision (eg, for trigger finger)	3.23	090	
26060	Tenotomy, percutaneous, single, each digit	3.23	090	
26070	Arthrotomy, with exploration, drainage, or removal of loose or foreign body; carpometacarpal joint	3.26	090	
26075	Arthrotomy, with exploration, drainage, or removal of loose or foreign body; metacarpophalangeal joint, each	3.23	090	
26080	Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each	3.23	090	
26100	Arthrotomy with biopsy; carpometacarpal joint, each	3.26	090	
26105	Arthrotomy with biopsy; metacarpophalangeal joint, each	2.47	090	
26110	Arthrotomy with biopsy; interphalangeal joint, each	3.23	090	
26111	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; 1.5 cm or greater	2.74	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
26113	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater	4.19	090	
26115	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm	2.07	090	
26116	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm	3.31	090	
26117	Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; less than 3 cm	10.74	090	
26118	Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; 3 cm or greater	8.28	090	
26121	Fasciectomy, palm only, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft)	6.65	090	
26123	Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft);	6.62	090	
+	26125 Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft); each additional digit (List separately in addition to code for primary procedure)	3.23	ZZZ	
26130	Synovectomy, carpometacarpal joint	4.15	090	
26135	Synovectomy, metacarpophalangeal joint including intrinsic release and extensor hood reconstruction, each digit	4.94	090	
26140	Synovectomy, proximal interphalangeal joint, including extensor reconstruction, each interphalangeal joint	4.15	090	
26145	Synovectomy, tendon sheath, radical (tenosynovectomy), flexor tendon, palm and/or finger, each tendon	4.94	090	
26160	Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger	3.23	090	
26170	Excision of tendon, palm, flexor or extensor, single, each tendon	3.23	090	
26180	Excision of tendon, finger, flexor or extensor, each tendon	3.23	090	
26185	Sesamoidectomy, thumb or finger (separate procedure)	2.76	090	
26200	Excision or curettage of bone cyst or benign tumor of metacarpal;	4.15	090	
26205	Excision or curettage of bone cyst or benign tumor of metacarpal; with autograft (includes obtaining graft)	5.34	090	
26210	Excision or curettage of bone cyst or benign tumor of proximal, middle, or distal phalanx of finger;	3.75	090	
26215	Excision or curettage of bone cyst or benign tumor of proximal, middle, or distal phalanx of finger; with autograft (includes obtaining graft)	4.94	090	
26230	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); metacarpal	3.26	090	
26235	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); proximal or middle phalanx of finger	3.45	090	
26236	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); distal phalanx of finger	3.23	090	
26250	Radical resection of tumor, metacarpal	5.18	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
26260	Radical resection of tumor, proximal or middle phalanx of finger	4.94	090	
26262	Radical resection of tumor, distal phalanx of finger	4.94	090	
26320	Removal of implant from finger or hand	3.23	090	
26340	Manipulation, finger joint, under anesthesia, each joint	2.50	090	
26341	Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord	0.98	010	
26350	Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land); primary or secondary without free graft, each tendon	5.28	090	
26352	Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land); secondary with free graft (includes obtaining graft), each tendon	8.20	090	
26356	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon	7.25	090	
26357	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, without free graft, each tendon	8.80	090	
26358	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, with free graft (includes obtaining graft), each tendon	9.83	090	
26370	Repair or advancement of profundus tendon, with intact superficialis tendon; primary, each tendon	4.15	090	
26372	Repair or advancement of profundus tendon, with intact superficialis tendon; secondary with free graft (includes obtaining graft), each tendon	4.54	090	
26373	Repair or advancement of profundus tendon, with intact superficialis tendon; secondary without free graft, each tendon	4.15	090	
26390	Excision flexor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod	6.21	090	
26392	Removal of synthetic rod and insertion of flexor tendon graft, hand or finger (includes obtaining graft), each rod	7.25	090	
26410	Repair, extensor tendon, hand, primary or secondary; without free graft, each tendon	1.78	090	
26412	Repair, extensor tendon, hand, primary or secondary; with free graft (includes obtaining graft), each tendon	4.15	090	
26415	Excision of extensor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod	4.55	090	
26416	Removal of synthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each rod	4.86	090	
26418	Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon	2.07	090	
26420	Repair, extensor tendon, finger, primary or secondary; with free graft (includes obtaining graft) each tendon	4.15	090	
26426	Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); using local tissue(s), including lateral band(s), each finger	5.18	090	
26428	Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); with free graft (includes obtaining graft), each finger	7.25	090	
26432	Closed treatment of distal extensor tendon insertion, with or without percutaneous pinning (eg,allet finger)	3.23	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
26433	Repair of extensor tendon, distal insertion, primary or secondary; without graft (eg, mallet finger)	3.67	090	
26434	Repair of extensor tendon, distal insertion, primary or secondary; with free graft (includes obtaining graft)	2.47	090	
26437	Realignment of extensor tendon, hand, each tendon	4.09	090	
26440	Tenolysis, flexor tendon; palm OR finger, each tendon	3.54	090	
26442	Tenolysis, flexor tendon; palm AND finger, each tendon	3.95	090	
26445	Tenolysis, extensor tendon, hand OR finger, each tendon	3.21	090	
26449	Tenolysis, complex, extensor tendon, finger, including forearm, each tendon	4.75	090	
26450	Tenotomy, flexor, palm, open, each tendon	2.47	090	
26455	Tenotomy, flexor, finger, open, each tendon	3.23	090	
26460	Tenotomy, extensor, hand or finger, open, each tendon	3.23	090	
26471	Tenodesis; of proximal interphalangeal joint, each joint	4.15	090	
26474	Tenodesis; of distal joint, each joint	3.26	090	
26476	Lengthening of tendon, extensor, hand or finger, each tendon	3.23	090	
26477	Shortening of tendon, extensor, hand or finger, each tendon	3.23	090	
26478	Lengthening of tendon, flexor, hand or finger, each tendon	4.09	090	
26479	Shortening of tendon, flexor, hand or finger, each tendon	4.09	090	
26480	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon	5.24	090	
26483	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; with free tendon graft (includes obtaining graft), each tendon	6.92	090	
26485	Transfer or transplant of tendon, palmar; without free tendon graft, each tendon	6.62	090	
26489	Transfer or transplant of tendon, palmar; with free tendon graft (includes obtaining graft), each tendon	8.20	090	
26490	Opponensplasty; superficialis tendon transfer type, each tendon	6.62	090	
26492	Opponensplasty; tendon transfer with graft (includes obtaining graft), each tendon	8.20	090	
26494	Opponensplasty; hypothenar muscle transfer	7.41	090	
26496	Opponensplasty; other methods	8.18	090	
26497	Transfer of tendon to restore intrinsic function; ring and small finger	7.16	090	
26498	Transfer of tendon to restore intrinsic function; all 4 fingers	8.69	090	
26499	Correction claw finger, other methods	7.55	090	
26500	Reconstruction of tendon pulley, each tendon; with local tissues (separate procedure)	4.15	090	
26502	Reconstruction of tendon pulley, each tendon; with tendon or fascial graft (includes obtaining graft) (separate procedure)	4.94	090	
26508	Release of thenar muscle(s) (eg, thumb contracture)	4.94	090	
26510	Cross intrinsic transfer, each tendon	8.80	090	
26516	Capsulodesis, metacarpophalangeal joint; single digit	4.15	090	
26517	Capsulodesis, metacarpophalangeal joint; 2 digits	6.22	090	
26518	Capsulodesis, metacarpophalangeal joint; 3 or 4 digits	7.41	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
26520	Capsulectomy or capsulotomy; metacarpophalangeal joint, each joint	4.15	090	
26525	Capsulectomy or capsulotomy; interphalangeal joint, each joint	4.15	090	
26530	Arthroplasty, metacarpophalangeal joint; each joint	4.94	090	
26531	Arthroplasty, metacarpophalangeal joint; with prosthetic implant, each joint	5.73	090	
26535	Arthroplasty, interphalangeal joint; each joint	4.15	090	
26536	Arthroplasty, interphalangeal joint; with prosthetic implant, each joint	5.73	090	
26540	Repair of collateral ligament, metacarpophalangeal or interphalangeal joint	5.73	090	
26541	Reconstruction, collateral ligament, metacarpophalangeal joint, single; with tendon or fascial graft (includes obtaining graft)	7.01	090	
26542	Reconstruction, collateral ligament, metacarpophalangeal joint, single; with local tissue (eg, adductor advancement)	7.16	090	
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	4.94	090	
26546	Repair non-union, metacarpal or phalanx (includes obtaining bone graft with or without external or internal fixation)	5.42	090	
26548	Repair and reconstruction, finger, volar plate, interphalangeal joint	5.62	090	
26550	Pollicization of a digit	6.42	090	
26551	Transfer, toe-to-hand with microvascular anastomosis; great toe wrap-around with bone graft	21.79	090	
26553	Transfer, toe-to-hand with microvascular anastomosis; other than great toe, single	18.92	090	
26554	Transfer, toe-to-hand with microvascular anastomosis; other than great toe, double	19.15	090	
26555	Transfer, finger to another position without microvascular anastomosis	6.42	090	
26556	Transfer, free toe joint, with microvascular anastomosis	19.15	090	
26560	Repair of syndactyly (web finger) each web space; with skin flaps	5.73	090	
26561	Repair of syndactyly (web finger) each web space; with skin flaps and grafts	7.01	090	
26562	Repair of syndactyly (web finger) each web space; complex (eg, involving bone, nails)	15.34	090	
26565	Osteotomy; metacarpal, each	4.94	090	
26567	Osteotomy; phalanx of finger, each	4.94	090	
26568	Osteoplasty, lengthening, metacarpal or phalanx	6.65	090	
26580	Repair cleft hand	15.61	090	
26587	Reconstruction of polydactylous digit, soft tissue and bone	9.82	090	
26590	Repair macrodactylia, each digit	13.43	090	
26591	Repair, intrinsic muscles of hand, each muscle	2.56	090	
26593	Release, intrinsic muscles of hand, each muscle	4.31	090	
26596	Excision of constricting ring of finger, with multiple Z-plasties	7.62	090	
26600	Closed treatment of metacarpal fracture, single; without manipulation, each bone	1.13	090	
26605	Closed treatment of metacarpal fracture, single; with manipulation, each bone	1.60	090	
26607	Closed treatment of metacarpal fracture, with manipulation, with external fixation, each bone	3.67	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
26608	Percutaneous skeletal fixation of metacarpal fracture, each bone	3.67	090	
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	4.74	090	
26641	Closed treatment of carpometacarpal dislocation, thumb, with manipulation	1.38	090	
26645	Closed treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation	2.07	090	
26650	Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation	3.67	090	
26665	Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed	4.64	090	
26670	Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; without anesthesia	1.14	090	
26675	Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; requiring anesthesia	1.71	090	
26676	Percutaneous skeletal fixation of carpometacarpal dislocation, other than thumb, with manipulation, each joint	2.69	090	
26685	Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint	4.24	090	
26686	Open treatment of carpometacarpal dislocation, other than thumb; complex, multiple, or delayed reduction	5.90	090	
26700	Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia	0.59	090	
26705	Closed treatment of metacarpophalangeal dislocation, single, with manipulation; requiring anesthesia	1.68	090	
26706	Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation	2.25	090	
26715	Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed	3.95	090	
26720	Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each	0.77	090	
26725	Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; with manipulation, with or without skin or skeletal traction, each	1.09	090	
26727	Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each	2.45	090	
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each	3.23	090	
26740	Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; without manipulation, each	0.99	090	
26742	Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; with manipulation, each	1.28	090	
26746	Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each	4.15	090	
26750	Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each	0.30	090	
26755	Closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, each	0.49	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	26756	Percutaneous skeletal fixation of distal phalangeal fracture, finger or thumb, each	2.05	090	
	26765	Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each	1.48	090	
	26770	Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia	0.30	090	
	26775	Closed treatment of interphalangeal joint dislocation, single, with manipulation; requiring anesthesia	0.59	090	
	26776	Percutaneous skeletal fixation of interphalangeal joint dislocation, single, with manipulation	3.23	090	
	26785	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single	3.23	090	
	26820	Fusion in opposition, thumb, with autogenous graft (includes obtaining graft)	6.62	090	
	26841	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation;	5.24	090	
	26842	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation; with autograft (includes obtaining graft)	6.62	090	
	26843	Arthrodesis, carpometacarpal joint, digit, other than thumb, each;	5.24	090	
	26844	Arthrodesis, carpometacarpal joint, digit, other than thumb, each; with autograft (includes obtaining graft)	6.62	090	
	26850	Arthrodesis, metacarpophalangeal joint, with or without internal fixation;	4.94	090	
	26852	Arthrodesis, metacarpophalangeal joint, with or without internal fixation; with autograft (includes obtaining graft)	6.22	090	
	26860	Arthrodesis, interphalangeal joint, with or without internal fixation;	3.66	090	
+	26861	Arthrodesis, interphalangeal joint, with or without internal fixation; each additional interphalangeal joint (List separately in addition to code for primary procedure)	1.92	ZZZ	
	26862	Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft)	4.94	090	
+	26863	Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft), each additional joint (List separately in addition to code for primary procedure)	2.35	ZZZ	
	26910	Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseous transfer	4.64	090	
	26951	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	3.23	090	
	26952	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with local advancement flaps (V-Y, hood)	3.23	090	
	26989	Unlisted procedure, hands or fingers	BR	YYY	
	26990	Incision and drainage, pelvis or hip joint area; deep abscess or hematoma	5.18	090	
	26991	Incision and drainage, pelvis or hip joint area; infected bursa	5.18	090	
	26992	Incision, bone cortex, pelvis and/or hip joint (eg, osteomyelitis or bone abscess)	7.77	090	
	27000	Tenotomy, adductor of hip, percutaneous (separate procedure)	3.23	090	
	27001	Tenotomy, adductor of hip, open	4.32	090	
	27003	Tenotomy, adductor, subcutaneous, open, with obturator neurectomy	6.04	090	
	27005	Tenotomy, hip flexor(s), open (separate procedure)	6.47	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
27006	Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)	6.47	090	
27025	Fasciotomy, hip or thigh, any type	6.47	090	
27027	Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral	5.49	090	
27030	Arthrotomy, hip, with drainage (eg, infection)	7.77	090	
27033	Arthrotomy, hip, including exploration or removal of loose or foreign body	9.92	090	
27035	Denervation, hip joint, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral, or obturator nerves	11.36	090	
27036	Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas)	11.95	090	
27040	Biopsy, soft tissue of pelvis and hip area; superficial	3.23	010	
27041	Biopsy, soft tissue of pelvis and hip area; deep, subfascial or intramuscular	3.67	090	
27043	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater	2.90	090	
27045	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or greater	4.55	090	
27047	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm	3.67	090	
27048	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm	6.47	090	
27049	Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; less than 5 cm	15.85	090	
27050	Arthrotomy, with biopsy; sacroiliac joint	3.95	090	
27052	Arthrotomy, with biopsy; hip joint	9.92	090	
27054	Arthrotomy with synovectomy, hip joint	13.34	090	
27057	Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle, unilateral	5.49	090	
27059	Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater	11.07	090	
27060	Excision; ischial bursa	3.26	090	
27062	Excision; trochanteric bursa or calcification	3.67	090	
27065	Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; superficial, includes autograft, when performed	5.21	090	
27066	Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; deep (subfascial), includes autograft, when performed	7.77	090	
27067	Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; with autograft requiring separate incision	8.63	090	
27070	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial	4.74	090	
27071	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); deep (subfascial or intramuscular)	6.47	090	
27075	Radical resection of tumor; wing of ilium, 1 pubic or ischial ramus or symphysis pubis	11.86	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
27076	Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum	14.82	090	
27077	Radical resection of tumor; innominate bone, total	14.82	090	
27078	Radical resection of tumor; ischial tuberosity and greater trochanter of femur	11.86	090	
27080	Coccygectomy, primary	5.18	090	
27086	Removal of foreign body, pelvis or hip; subcutaneous tissue	3.23	010	
27087	Removal of foreign body, pelvis or hip; deep (subfascial or intramuscular)	4.45	090	
27090	Removal of hip prosthesis; (separate procedure)	9.19	090	
27091	Removal of hip prosthesis; complicated, including total hip prosthesis, methylmethacrylate with or without insertion of spacer	11.36	090	
27093	Injection procedure for hip arthrography; without anesthesia	0.59	000	
27095	Injection procedure for hip arthrography; with anesthesia	3.23	000	
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed	1.04	000	
27097	Release or recession, hamstring, proximal	7.16	090	
27098	Transfer, adductor to ischium	6.42	090	
27100	Transfer external oblique muscle to greater trochanter including fascial or tendon extension (graft)	9.88	090	
27105	Transfer paraspinal muscle to hip (includes fascial or tendon extension graft)	10.37	090	
27110	Transfer iliopsoas; to greater trochanter of femur	12.94	090	
27111	Transfer iliopsoas; to femoral neck	9.88	090	
27120	Acetabuloplasty; (eg, Whitman, Colonna, Haygroves, or cup type)	15.81	090	
27122	Acetabuloplasty; resection, femoral head (eg, Girdlestone procedure)	13.34	090	
27125	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)	13.37	090	
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	25.69	090	
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	23.29	090	
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	33.39	090	
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	29.54	090	
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	29.54	090	
27140	Osteotomy and transfer of greater trochanter of femur (separate procedure)	5.18	090	
27146	Osteotomy, iliac, acetabular or innominate bone;	13.34	090	
27147	Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip	14.62	090	
27151	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy	16.10	090	
27156	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip	18.28	090	
27158	Osteotomy, pelvis, bilateral (eg, congenital malformation)	15.34	090	
27161	Osteotomy, femoral neck (separate procedure)	14.33	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast	14.33	090	
27170	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)	15.81	090	
27175	Treatment of slipped femoral epiphysis; by traction, without reduction	6.22	090	
27176	Treatment of slipped femoral epiphysis; by single or multiple pinning, in situ	13.34	090	
27177	Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft (includes obtaining graft)	15.31	090	
27178	Open treatment of slipped femoral epiphysis; closed manipulation with single or multiple pinning	13.83	090	
27179	Open treatment of slipped femoral epiphysis; osteoplasty of femoral neck (Heyman type procedure)	10.37	090	
27181	Open treatment of slipped femoral epiphysis; osteotomy and internal fixation	15.81	090	
27185	Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur	5.69	090	
27187	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femoral neck and proximal femur	11.25	090	
27197	Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation	2.94	000	
27198	Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; with manipulation, requiring more than local anesthesia (ie, general anesthesia, moderate sedation, spinal/epidural)	0.00	000	
27200	Closed treatment of coccygeal fracture	2.47	090	
27202	Open treatment of coccygeal fracture	7.77	090	
27215	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral, for pelvic bone fracture patterns that do not disrupt the pelvic ring, includes internal fixation, when performed	10.47	090	
27216	Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes ipsilateral ilium, sacroiliac joint and/or sacrum)	8.63	090	
27217	Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes pubic symphysis and/or ipsilateral superior/inferior rami)	10.47	090	
27218	Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes ipsilateral ilium, sacroiliac joint and/or sacrum)	10.47	090	
27220	Closed treatment of acetabulum (hip socket) fracture(s); without manipulation	3.66	090	
27222	Closed treatment of acetabulum (hip socket) fracture(s); with manipulation, with or without skeletal traction	5.24	090	
27226	Open treatment of posterior or anterior acetabular wall fracture, with internal fixation	21.57	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
27227	Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation	21.57	090	
27228	Open treatment of acetabular fracture(s) involving anterior and posterior (two) columns, includes T-fracture and both column fracture with complete articular detachment, or single column or transverse fracture with associated acetabular wall fracture, with internal fixation	23.72	090	
27230	Closed treatment of femoral fracture, proximal end, neck; without manipulation	2.74	090	
27232	Closed treatment of femoral fracture, proximal end, neck; with manipulation, with or without skeletal traction	6.22	090	
27235	Percutaneous skeletal fixation of femoral fracture, proximal end, neck	13.34	090	
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	13.83	090	
27238	Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; without manipulation	2.87	090	
27240	Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with manipulation, with or without skin or skeletal traction	6.22	090	
27244	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage	12.84	090	
27245	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage	12.84	090	
27246	Closed treatment of greater trochanteric fracture, without manipulation	1.48	090	
27248	Open treatment of greater trochanteric fracture, includes internal fixation, when performed	6.47	090	
27250	Closed treatment of hip dislocation, traumatic; without anesthesia	2.47	000	
27252	Closed treatment of hip dislocation, traumatic; requiring anesthesia	3.67	090	
27253	Open treatment of hip dislocation, traumatic, without internal fixation	9.88	090	
27254	Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation	14.33	090	
27256	Treatment of spontaneous hip dislocation (developmental, including congenital or pathological), by abduction, splint or traction; without anesthesia, without manipulation	4.19	010	
27257	Treatment of spontaneous hip dislocation (developmental, including congenital or pathological), by abduction, splint or traction; with manipulation, requiring anesthesia	4.32	010	
27258	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc);	11.36	090	
27259	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc); with femoral shaft shortening	12.84	090	
27265	Closed treatment of post hip arthroplasty dislocation; without anesthesia	2.56	090	
27266	Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia	3.07	090	
27267	Closed treatment of femoral fracture, proximal end, head; without manipulation	3.21	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
27268	Closed treatment of femoral fracture, proximal end, head; with manipulation	4.14	090	
27269	Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed	10.87	090	
27275	Manipulation, hip joint, requiring general anesthesia	3.23	010	
■ 27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device	118.43	090	
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	7.32	090	
■ 27280	Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed	9.19	090	
27282	Arthrodesis, symphysis pubis (including obtaining graft)	8.40	090	
27284	Arthrodesis, hip joint (including obtaining graft);	19.76	090	
27286	Arthrodesis, hip joint (including obtaining graft); with subtrochanteric osteotomy	20.75	090	
27290	Interpelviabdominal amputation (hindquarter amputation)	32.60	090	
27295	Disarticulation of hip	19.76	090	
27299	Unlisted procedure, pelvis or hip joint	BR	YYY	
27301	Incision and drainage, deep abscess, bursa, or hematoma, thigh or knee region	3.23	090	
27303	Incision, deep, with opening of bone cortex, femur or knee (eg, osteomyelitis or bone abscess)	5.09	090	
27305	Fasciotomy, iliotibial (tenotomy), open	3.26	090	
27306	Tenotomy, percutaneous, adductor or hamstring; single tendon (separate procedure)	3.23	090	
27307	Tenotomy, percutaneous, adductor or hamstring; multiple tendons	3.88	090	
27310	Arthrotomy, knee, with exploration, drainage, or removal of foreign body (eg, infection)	7.77	090	
27323	Biopsy, soft tissue of thigh or knee area; superficial	3.23	010	
27324	Biopsy, soft tissue of thigh or knee area; deep (subfascial or intramuscular)	4.32	090	
27325	Neurectomy, hamstring muscle	5.18	090	
27326	Neurectomy, popliteal (gastrocnemius)	5.18	090	
27327	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm	3.67	090	
27328	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm	6.47	090	
27329	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; less than 5 cm	14.83	090	
27330	Arthrotomy, knee; with synovial biopsy only	7.55	090	
27331	Arthrotomy, knee; including joint exploration, biopsy, or removal of loose or foreign bodies	8.20	090	
27332	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral	8.79	090	
27333	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral	10.79	090	
27334	Arthrotomy, with synovectomy, knee; anterior OR posterior	12.94	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	27335	Arthrotomy, with synovectomy, knee; anterior AND posterior including popliteal area	13.80	090	
	27337	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater	3.73	090	
	27339	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or greater	6.52	090	
	27340	Excision, prepatellar bursa	4.32	090	
	27345	Excision of synovial cyst of popliteal space (eg, Baker's cyst)	8.63	090	
	27347	Excision of lesion of meniscus or capsule (eg, cyst, ganglion), knee	6.99	090	
	27350	Patellectomy or hemipatellectomy	8.63	090	
	27355	Excision or curettage of bone cyst or benign tumor of femur;	7.77	090	
	27356	Excision or curettage of bone cyst or benign tumor of femur; with allograft	8.63	090	
	27357	Excision or curettage of bone cyst or benign tumor of femur; with autograft (includes obtaining graft)	10.35	090	
+	27358	Excision or curettage of bone cyst or benign tumor of femur; with internal fixation (List in addition to code for primary procedure)	11.86	ZZZ	
	27360	Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess)	7.11	090	
	27364	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; 5 cm or greater	13.25	090	
	27365	Radical resection of tumor, femur or knee	12.94	090	
■	27369	Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography	1.67	000	
	27372	Removal of foreign body, deep, thigh region or knee area	3.67	090	
	27380	Suture of infrapatellar tendon; primary	7.55	090	
	27381	Suture of infrapatellar tendon; secondary reconstruction, including fascial or tendon graft	8.60	090	
	27385	Suture of quadriceps or hamstring muscle rupture; primary	8.63	090	
	27386	Suture of quadriceps or hamstring muscle rupture; secondary reconstruction, including fascial or tendon graft	10.37	090	
	27390	Tenotomy, open, hamstring, knee to hip; single tendon	3.26	090	
	27391	Tenotomy, open, hamstring, knee to hip; multiple tendons, 1 leg	4.15	090	
	27392	Tenotomy, open, hamstring, knee to hip; multiple tendons, bilateral	6.22	090	
	27393	Lengthening of hamstring tendon; single tendon	3.95	090	
	27394	Lengthening of hamstring tendon; multiple tendons, 1 leg	5.24	090	
	27395	Lengthening of hamstring tendon; multiple tendons, bilateral	7.01	090	
	27396	Transplant or transfer (with muscle redirection or rerouting), thigh (eg, extensor to flexor); single tendon	9.88	090	
	27397	Transplant or transfer (with muscle redirection or rerouting), thigh (eg, extensor to flexor); multiple tendons	11.36	090	
	27400	Transfer, tendon or muscle, hamstrings to femur (eg, Egger's type procedure)	10.37	090	
	27403	Arthrotomy with meniscus repair, knee	9.49	090	
	27405	Repair, primary, torn ligament and/or capsule, knee; collateral	10.79	090	
	27407	Repair, primary, torn ligament and/or capsule, knee; cruciate	12.07	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
27409	Repair, primary, torn ligament and/or capsule, knee; collateral and cruciate ligaments	12.94	090	
27412	Autologous chondrocyte implantation, knee	21.74	090	
27415	Osteochondral allograft, knee, open	18.11	090	
27416	Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])	10.87	090	
27418	Anterior tibial tubercleplasty (eg, Maquet type procedure)	10.74	090	
27420	Reconstruction of dislocating patella; (eg, Hauser type procedure)	10.79	090	
27422	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)	10.79	090	
27424	Reconstruction of dislocating patella; with patellectomy	10.79	090	
27425	Lateral retinacular release, open	7.76	090	
27427	Ligamentous reconstruction (augmentation), knee; extra-articular	12.07	090	
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)	12.94	090	
27429	Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular	13.80	090	
27430	Quadricepsplasty (eg, Bennett or Thompson type)	11.21	090	
27435	Capsulotomy, posterior capsular release, knee	9.19	090	
27437	Arthroplasty, patella; without prosthesis	11.36	090	
27438	Arthroplasty, patella; with prosthesis	13.63	090	
27440	Arthroplasty, knee, tibial plateau;	15.10	090	
27441	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy	16.39	090	
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;	17.25	090	
27443	Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy	17.25	090	
27445	Arthroplasty, knee, hinge prosthesis (eg, Walldius type)	17.25	090	
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	17.25	090	
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	19.46	090	
27448	Osteotomy, femur, shaft or supracondylar; without fixation	8.60	090	
27450	Osteotomy, femur, shaft or supracondylar; with fixation	12.35	090	
27454	Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft (eg, Sofield type procedure)	13.34	090	
27455	Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus [bowleg] or genu valgus [knock-knee]); before epiphyseal closure	7.90	090	
27457	Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus [bowleg] or genu valgus [knock-knee]); after epiphyseal closure	12.94	090	
27465	Osteoplasty, femur; shortening (excluding 64876)	13.34	090	
27466	Osteoplasty, femur; lengthening	17.29	090	
27468	Osteoplasty, femur; combined, lengthening and shortening with femoral segment transfer	19.76	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
27470	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)	13.34	090	
27472	Repair, nonunion or malunion, femur, distal to head and neck; with iliac or other autogenous bone graft (includes obtaining graft)	15.31	090	
27475	Arrest, epiphyseal, any method (eg, epiphysiodesis); distal femur	9.83	090	
27477	Arrest, epiphyseal, any method (eg, epiphysiodesis); tibia and fibula, proximal	10.87	090	
27479	Arrest, epiphyseal, any method (eg, epiphysiodesis); combined distal femur, proximal tibia and fibula	12.42	090	
27485	Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (eg, genu varus or valgus)	7.21	090	
27486	Revision of total knee arthroplasty, with or without allograft; 1 component	15.34	090	
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	21.57	090	
27488	Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee	12.27	090	
27495	Prophylactic treatment (nailing, pinning, plating, or wiring) with or without methylmethacrylate, femur	8.69	090	
27496	Decompression fasciotomy, thigh and/or knee, 1 compartment (flexor or extensor or adductor);	3.88	090	
27497	Decompression fasciotomy, thigh and/or knee, 1 compartment (flexor or extensor or adductor); with debridement of nonviable muscle and/or nerve	5.18	090	
27498	Decompression fasciotomy, thigh and/or knee, multiple compartments;	5.39	090	
27499	Decompression fasciotomy, thigh and/or knee, multiple compartments; with debridement of nonviable muscle and/or nerve	6.04	090	
27500	Closed treatment of femoral shaft fracture, without manipulation	3.89	090	
27501	Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, without manipulation	4.40	090	
27502	Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction	5.24	090	
27503	Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, with manipulation, with or without skin or skeletal traction	6.14	090	
27506	Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws	14.24	090	
27507	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage	14.24	090	
27508	Closed treatment of femoral fracture, distal end, medial or lateral condyle, without manipulation	2.47	090	
27509	Percutaneous skeletal fixation of femoral fracture, distal end, medial or lateral condyle, or supracondylar or transcondylar, with or without intercondylar extension, or distal femoral epiphyseal separation	6.47	090	
27510	Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation	5.24	090	
27511	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed	12.94	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed	12.94	090	
27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed	12.94	090	
27516	Closed treatment of distal femoral epiphyseal separation; without manipulation	3.06	090	
27517	Closed treatment of distal femoral epiphyseal separation; with manipulation, with or without skin or skeletal traction	4.64	090	
27519	Open treatment of distal femoral epiphyseal separation, includes internal fixation, when performed	9.92	090	
27520	Closed treatment of patellar fracture, without manipulation	1.82	090	
27524	Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair	8.63	090	
27530	Closed treatment of tibial fracture, proximal (plateau); without manipulation	2.59	090	
27532	Closed treatment of tibial fracture, proximal (plateau); with or without manipulation, with skeletal traction	4.32	090	
27535	Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed	11.21	090	
27536	Open treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal fixation	12.07	090	
27538	Closed treatment of intercondylar spine(s) and/or tuberosity fracture(s) of knee, with or without manipulation	3.26	090	
27540	Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed	10.79	090	
27550	Closed treatment of knee dislocation; without anesthesia	2.15	090	
27552	Closed treatment of knee dislocation; requiring anesthesia	3.88	090	
27556	Open treatment of knee dislocation, includes internal fixation, when performed; without primary ligamentous repair or augmentation/reconstruction	10.35	090	
27557	Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair	13.80	090	
27558	Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair, with augmentation/reconstruction	15.10	090	
27560	Closed treatment of patellar dislocation; without anesthesia	0.99	090	
27562	Closed treatment of patellar dislocation; requiring anesthesia	3.23	090	
27566	Open treatment of patellar dislocation, with or without partial or total patellectomy	10.35	090	
27570	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)	3.23	010	
27580	Arthrodesis, knee, any technique	17.25	090	
27590	Amputation, thigh, through femur, any level;	11.21	090	
27591	Amputation, thigh, through femur, any level; immediate fitting technique including first cast	12.07	090	
27592	Amputation, thigh, through femur, any level; open, circular (guillotine)	9.49	090	
27594	Amputation, thigh, through femur, any level; secondary closure or scar revision	1.98	090	
27596	Amputation, thigh, through femur, any level; re-amputation	6.47	090	
27598	Disarticulation at knee	11.21	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
27599	Unlisted procedure, femur or knee	BR	YYY	
27600	Decompression fasciotomy, leg; anterior and/or lateral compartments only	6.47	090	
27601	Decompression fasciotomy, leg; posterior compartment(s) only	6.04	090	
27602	Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s)	7.77	090	
27603	Incision and drainage, leg or ankle; deep abscess or hematoma	3.67	090	
27604	Incision and drainage, leg or ankle; infected bursa	3.67	090	
27605	Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia	3.45	010	
27606	Tenotomy, percutaneous, Achilles tendon (separate procedure); general anesthesia	3.45	010	
27607	Incision (eg, osteomyelitis or bone abscess), leg or ankle	5.18	090	
27610	Arthrotomy, ankle, including exploration, drainage, or removal of foreign body	6.47	090	
27612	Arthrotomy, posterior capsular release, ankle, with or without Achilles tendon lengthening	7.33	090	
27613	Biopsy, soft tissue of leg or ankle area; superficial	3.23	010	
27614	Biopsy, soft tissue of leg or ankle area; deep (subfascial or intramuscular)	3.88	090	
27615	Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm	6.47	090	
27616	Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; 5 cm or greater	10.56	090	
27618	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm	3.23	090	
27619	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm	3.88	090	
27620	Arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of loose or foreign body	6.47	090	
27625	Arthrotomy, with synovectomy, ankle;	9.06	090	
27626	Arthrotomy, with synovectomy, ankle; including tenosynovectomy	9.06	090	
27630	Excision of lesion of tendon sheath or capsule (eg, cyst or ganglion), leg and/or ankle	3.23	090	
27632	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; 3 cm or greater	2.48	090	
27634	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); 5 cm or greater	5.80	090	
27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula;	7.77	090	
27637	Excision or curettage of bone cyst or benign tumor, tibia or fibula; with autograft (includes obtaining graft)	9.49	090	
27638	Excision or curettage of bone cyst or benign tumor, tibia or fibula; with allograft	8.20	090	
27640	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia	7.90	090	
27641	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula	4.32	090	
27645	Radical resection of tumor; tibia	12.07	090	
27646	Radical resection of tumor; fibula	9.49	090	
27647	Radical resection of tumor; talus or calcaneus	8.63	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
27648	Injection procedure for ankle arthrography	0.40	000	
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon;	7.77	090	
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	9.49	090	
27654	Repair, secondary, Achilles tendon, with or without graft	9.92	090	
27656	Repair, fascial defect of leg	3.95	090	
27658	Repair, flexor tendon, leg; primary, without graft, each tendon	5.18	090	
27659	Repair, flexor tendon, leg; secondary, with or without graft, each tendon	6.47	090	
27664	Repair, extensor tendon, leg; primary, without graft, each tendon	3.45	090	
27665	Repair, extensor tendon, leg; secondary, with or without graft, each tendon	3.23	090	
27675	Repair, dislocating peroneal tendons; without fibular osteotomy	6.47	090	
27676	Repair, dislocating peroneal tendons; with fibular osteotomy	7.77	090	
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon	3.26	090	
27681	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision[s])	3.95	090	
27685	Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)	6.04	090	
27686	Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each	6.04	090	
27687	Gastrocnemius recession (eg, Strayer procedure)	4.64	090	
27690	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)	6.04	090	
27691	Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)	7.33	090	
+	27692	Transfer or transplant of single tendon (with muscle redirection or rerouting); each additional tendon (List separately in addition to code for primary procedure)	1.73	ZZZ
	27695	Repair, primary, disrupted ligament, ankle; collateral	6.62	090
	27696	Repair, primary, disrupted ligament, ankle; both collateral ligaments	9.19	090
	27698	Repair, secondary, disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)	9.19	090
	27700	Arthroplasty, ankle;	7.77	090
	27702	Arthroplasty, ankle; with implant (total ankle)	15.10	090
	27703	Arthroplasty, ankle; revision, total ankle	14.83	090
	27704	Removal of ankle implant	9.19	090
	27705	Osteotomy; tibia	12.07	090
	27707	Osteotomy; fibula	5.18	090
	27709	Osteotomy; tibia and fibula	14.66	090
	27712	Osteotomy; multiple, with realignment on intramedullary rod (eg, Sofield type procedure)	11.36	090
	27715	Osteoplasty, tibia and fibula, lengthening or shortening	15.81	090
	27720	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)	12.94	090

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
27722	Repair of nonunion or malunion, tibia; with sliding graft	14.24	090	
27724	Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)	15.53	090	
27725	Repair of nonunion or malunion, tibia; by synostosis, with fibula, any method	15.53	090	
27726	Repair of fibula nonunion and/or malunion with internal fixation	9.63	090	
27727	Repair of congenital pseudarthrosis, tibia	12.94	090	
27730	Arrest, epiphyseal (epiphysiodesis), open; distal tibia	5.18	090	
27732	Arrest, epiphyseal (epiphysiodesis), open; distal fibula	4.14	090	
27734	Arrest, epiphyseal (epiphysiodesis), open; distal tibia and fibula	7.25	090	
27740	Arrest, epiphyseal (epiphysiodesis), any method, combined, proximal and distal tibia and fibula;	12.94	090	
27742	Arrest, epiphyseal (epiphysiodesis), any method, combined, proximal and distal tibia and fibula; and distal femur	14.33	090	
27745	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, tibia	8.69	090	
27750	Closed treatment of tibial shaft fracture (with or without fibular fracture); without manipulation	3.95	090	
27752	Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation, with or without skeletal traction	4.48	090	
27756	Percutaneous skeletal fixation of tibial shaft fracture (with or without fibular fracture) (eg, pins or screws)	7.77	090	
27758	Open treatment of tibial shaft fracture (with or without fibular fracture), with plate/screws, with or without cerclage	12.94	090	
27759	Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage	12.94	090	
27760	Closed treatment of medial malleolus fracture; without manipulation	2.27	090	
27762	Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction	4.32	090	
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	7.77	090	
27767	Closed treatment of posterior malleolus fracture; without manipulation	1.55	090	
27768	Closed treatment of posterior malleolus fracture; with manipulation	2.59	090	
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	5.18	090	
27780	Closed treatment of proximal fibula or shaft fracture; without manipulation	1.88	090	
27781	Closed treatment of proximal fibula or shaft fracture; with manipulation	3.23	090	
27784	Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed	5.24	090	
27786	Closed treatment of distal fibular fracture (lateral malleolus); without manipulation	1.98	090	
27788	Closed treatment of distal fibular fracture (lateral malleolus); with manipulation	4.32	090	
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	7.77	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
27808	Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); without manipulation	2.59	090	
27810	Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); with manipulation	3.88	090	
27814	Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed	8.63	090	
27816	Closed treatment of trimalleolar ankle fracture; without manipulation	2.37	090	
27818	Closed treatment of trimalleolar ankle fracture; with manipulation	5.18	090	
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	9.92	090	
27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	12.07	090	
27824	Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; without manipulation	2.09	090	
27825	Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation	4.32	090	
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	7.77	090	
27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only	9.49	090	
27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula	10.79	090	
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	5.18	090	
27830	Closed treatment of proximal tibiofibular joint dislocation; without anesthesia	1.98	090	
27831	Closed treatment of proximal tibiofibular joint dislocation; requiring anesthesia	3.45	090	
27832	Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula	7.77	090	
27840	Closed treatment of ankle dislocation; without anesthesia	1.73	090	
27842	Closed treatment of ankle dislocation; requiring anesthesia, with or without percutaneous skeletal fixation	4.32	090	
27846	Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; without repair or internal fixation	7.90	090	
27848	Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; with repair or internal or external fixation	7.90	090	
27860	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)	3.23	010	
27870	Arthrodesis, ankle, open	12.07	090	
27871	Arthrodesis, tibiofibular joint, proximal or distal	11.36	090	
27880	Amputation, leg, through tibia and fibula;	12.07	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
27881	Amputation, leg, through tibia and fibula; with immediate fitting technique including application of first cast	12.94	090	
27882	Amputation, leg, through tibia and fibula; open, circular (guillotine)	11.21	090	
27884	Amputation, leg, through tibia and fibula; secondary closure or scar revision	3.23	090	
27886	Amputation, leg, through tibia and fibula; re-amputation	7.77	090	
27888	Amputation, ankle, through malleoli of tibia and fibula (eg, Syme, Pirogoff type procedures), with plastic closure and resection of nerves	11.21	090	
27889	Ankle disarticulation	11.21	090	
27892	Decompression fasciotomy, leg; anterior and/or lateral compartments only, with debridement of nonviable muscle and/or nerve	5.18	090	
27893	Decompression fasciotomy, leg; posterior compartment(s) only, with debridement of nonviable muscle and/or nerve	5.18	090	
27894	Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s), with debridement of nonviable muscle and/or nerve	7.77	090	
27899	Unlisted procedure, leg or ankle	BR	YYY	
■ 28001	Incision and drainage, bursa, foot	3.23	000	
■ 28002	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space	3.67	000	
■ 28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	3.67	000	
28005	Incision, bone cortex (eg, osteomyelitis or bone abscess), foot	4.74	090	
28008	Fasciotomy, foot and/or toe	3.23	090	
28010	Tenotomy, percutaneous, toe; single tendon	3.23	090	
28011	Tenotomy, percutaneous, toe; multiple tendons	3.23	090	
28020	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; intertarsal or tarsometatarsal joint	5.18	090	
28022	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; metatarsophalangeal joint	3.23	090	
28024	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; interphalangeal joint	3.23	090	
28035	Release, tarsal tunnel (posterior tibial nerve decompression)	5.24	090	
28039	Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater	3.42	090	
28041	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater	4.14	090	
28043	Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm	3.23	090	
28045	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm	3.67	090	
28046	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm	14.32	090	
28047	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; 3 cm or greater	8.07	090	
28050	Arthrotomy with biopsy; intertarsal or tarsometatarsal joint	3.95	090	
28052	Arthrotomy with biopsy; metatarsophalangeal joint	3.23	090	
28054	Arthrotomy with biopsy; interphalangeal joint	3.23	090	
28055	Neurectomy, intrinsic musculature of foot	3.31	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
28060	Fasciectomy, plantar fascia; partial (separate procedure)	4.74	090	
28062	Fasciectomy, plantar fascia; radical (separate procedure)	6.04	090	
28070	Synovectomy; intertarsal or tarsometatarsal joint, each	3.95	090	
28072	Synovectomy; metatarsophalangeal joint, each	3.23	090	
28080	Excision, interdigital (Morton) neuroma, single, each	3.88	090	
28086	Synovectomy, tendon sheath, foot; flexor	4.15	090	
28088	Synovectomy, tendon sheath, foot; extensor	3.26	090	
28090	Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (eg, cyst or ganglion); foot	3.23	090	
28092	Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (eg, cyst or ganglion); toe(s), each	3.23	090	
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus;	4.74	090	
28102	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with iliac or other autograft (includes obtaining graft)	5.18	090	
28103	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with allograft	4.74	090	
28104	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus;	3.62	090	
28106	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with iliac or other autograft (includes obtaining graft)	5.18	090	
28107	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with allograft	5.18	090	
28108	Excision or curettage of bone cyst or benign tumor, phalanges of foot	4.10	090	
28110	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)	3.23	090	
28111	Ostectomy, complete excision; first metatarsal head	4.64	090	
28112	Ostectomy, complete excision; other metatarsal head (second, third or fourth)	3.23	090	
28113	Ostectomy, complete excision; fifth metatarsal head	3.23	090	
28114	Ostectomy, complete excision; all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (eg, Clayton type procedure)	7.90	090	
28116	Ostectomy, excision of tarsal coalition	6.04	090	
28118	Ostectomy, calcaneus;	6.47	090	
28119	Ostectomy, calcaneus; for spur, with or without plantar fascial release	6.91	090	
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	4.32	090	
28122	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus	4.32	090	
28124	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe	3.23	090	
28126	Resection, partial or complete, phalangeal base, each toe	3.67	090	
28130	Talectomy (astragalectomy)	12.07	090	
28140	Metatarsectomy	4.74	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
28150	Phalangectomy, toe, each toe	3.23	090	
28153	Resection, condyle(s), distal end of phalanx, each toe	3.23	090	
28160	Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each	3.23	090	
28171	Radical resection of tumor; tarsal (except talus or calcaneus)	10.77	090	
28173	Radical resection of tumor; metatarsal	6.91	090	
28175	Radical resection of tumor; phalanx of toe	5.18	090	
28190	Removal of foreign body, foot; subcutaneous	3.23	010	
28192	Removal of foreign body, foot; deep	3.67	090	
28193	Removal of foreign body, foot; complicated	4.10	090	
28200	Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon	3.95	090	
28202	Repair, tendon, flexor, foot; secondary with free graft, each tendon (includes obtaining graft)	4.91	090	
28208	Repair, tendon, extensor, foot; primary or secondary, each tendon	3.23	090	
28210	Repair, tendon, extensor, foot; secondary with free graft, each tendon (includes obtaining graft)	3.23	090	
28220	Tenolysis, flexor, foot; single tendon	3.26	090	
28222	Tenolysis, flexor, foot; multiple tendons	3.95	090	
28225	Tenolysis, extensor, foot; single tendon	3.23	090	
28226	Tenolysis, extensor, foot; multiple tendons	3.23	090	
28230	Tenotomy, open, tendon flexor; foot, single or multiple tendon(s) (separate procedure)	3.23	090	
28232	Tenotomy, open, tendon flexor; toe, single tendon (separate procedure)	3.23	090	
28234	Tenotomy, open, extensor, foot or toe, each tendon	3.23	090	
28238	Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)	4.66	090	
28240	Tenotomy, lengthening, or release, abductor hallucis muscle	3.23	090	
28250	Division of plantar fascia and muscle (eg, Steindler stripping) (separate procedure)	3.26	090	
28260	Capsulotomy, midfoot; medial release only (separate procedure)	5.24	090	
28261	Capsulotomy, midfoot; with tendon lengthening	5.93	090	
28262	Capsulotomy, midfoot; extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (eg, resistant clubfoot deformity)	9.19	090	
28264	Capsulotomy, midtarsal (eg, Heyman type procedure)	7.90	090	
28270	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)	3.23	090	
28272	Capsulotomy; interphalangeal joint, each joint (separate procedure)	3.23	090	
28280	Syndactylization, toes (eg, webbing or Kelikian type procedure)	4.10	090	
28285	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)	3.23	090	
28286	Correction, cock-up fifth toe, with plastic skin closure (eg, Ruiz-Mora type procedure)	3.23	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	28288	Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head	3.23	090	
	28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant	3.52	090	
	28291	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant	5.24	090	
■	28292	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with resection of proximal phalanx base, when performed, any method	5.18	090	
■	28295	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with proximal metatarsal osteotomy, any method	9.41	090	
■	28296	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with distal metatarsal osteotomy, any method	7.77	090	
■	28297	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method	6.21	090	
■	28298	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with proximal phalanx osteotomy, any method	5.61	090	
■	28299	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with double osteotomy, any method	7.56	090	
	28300	Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation	6.91	090	
	28302	Osteotomy; talus	5.93	090	
	28304	Osteotomy, tarsal bones, other than calcaneus or talus;	5.24	090	
	28305	Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (eg, Fowler type)	5.93	090	
	28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	4.64	090	
	28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	5.18	090	
	28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	3.45	090	
	28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	6.47	090	
	28310	Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)	3.23	090	
	28312	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe	3.23	090	
	28313	Reconstruction, angular deformity of toe, soft tissue procedures only (eg, overlapping second toe, fifth toe, curly toes)	3.23	090	
	28315	Sesamoidectomy, first toe (separate procedure)	3.23	090	
	28320	Repair, nonunion or malunion; tarsal bones	4.32	090	
	28322	Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)	4.32	090	
	28340	Reconstruction, toe, macrodactyly; soft tissue resection	5.80	090	
	28341	Reconstruction, toe, macrodactyly; requiring bone resection	6.93	090	
	28344	Reconstruction, toe(s); polydactyly	3.43	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
28345	Reconstruction, toe(s); syndactyly, with or without skin graft(s), each web	4.87	090	
28360	Reconstruction, cleft foot	11.02	090	
28400	Closed treatment of calcaneal fracture; without manipulation	1.94	090	
28405	Closed treatment of calcaneal fracture; with manipulation	2.59	090	
28406	Percutaneous skeletal fixation of calcaneal fracture, with manipulation	4.32	090	
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed;	9.49	090	
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	10.35	090	
28430	Closed treatment of talus fracture; without manipulation	1.51	090	
28435	Closed treatment of talus fracture; with manipulation	2.67	090	
28436	Percutaneous skeletal fixation of talus fracture, with manipulation	3.67	090	
28445	Open treatment of talus fracture, includes internal fixation, when performed	7.77	090	
28446	Open osteochondral autograft, talus (includes obtaining graft[s])	7.76	090	
28450	Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each	1.28	090	
28455	Treatment of tarsal bone fracture (except talus and calcaneus); with manipulation, each	2.15	090	
28456	Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus), with manipulation, each	3.45	090	
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	4.10	090	
28470	Closed treatment of metatarsal fracture; without manipulation, each	1.48	090	
28475	Closed treatment of metatarsal fracture; with manipulation, each	2.37	090	
28476	Percutaneous skeletal fixation of metatarsal fracture, with manipulation, each	3.23	090	
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	3.95	090	
28490	Closed treatment of fracture great toe, phalanx or phalanges; without manipulation	0.69	090	
28495	Closed treatment of fracture great toe, phalanx or phalanges; with manipulation	0.69	090	
28496	Percutaneous skeletal fixation of fracture great toe, phalanx or phalanges, with manipulation	3.23	090	
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	3.23	090	
28510	Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each	0.64	090	
28515	Closed treatment of fracture, phalanx or phalanges, other than great toe; with manipulation, each	0.86	090	
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each	3.23	090	
28530	Closed treatment of sesamoid fracture	1.03	090	
28531	Open treatment of sesamoid fracture, with or without internal fixation	3.23	090	
28540	Closed treatment of tarsal bone dislocation, other than talotarsal; without anesthesia	1.08	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
28545	Closed treatment of tarsal bone dislocation, other than talotarsal; requiring anesthesia	3.23	090	
28546	Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation	3.88	090	
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	3.88	090	
28570	Closed treatment of talotarsal joint dislocation; without anesthesia	1.08	090	
28575	Closed treatment of talotarsal joint dislocation; requiring anesthesia	3.23	090	
28576	Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation	3.88	090	
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed	4.74	090	
28600	Closed treatment of tarsometatarsal joint dislocation; without anesthesia	0.49	090	
28605	Closed treatment of tarsometatarsal joint dislocation; requiring anesthesia	3.23	090	
28606	Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation	4.10	090	
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	4.74	090	
28630	Closed treatment of metatarsophalangeal joint dislocation; without anesthesia	0.86	010	
28635	Closed treatment of metatarsophalangeal joint dislocation; requiring anesthesia	3.23	010	
28636	Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation	4.10	010	
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	4.10	090	
28660	Closed treatment of interphalangeal joint dislocation; without anesthesia	0.40	010	
28665	Closed treatment of interphalangeal joint dislocation; requiring anesthesia	0.94	010	
28666	Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation	3.23	010	
28675	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed	3.23	090	
28705	Arthrodesis; pantalar	13.80	090	
28715	Arthrodesis; triple	12.07	090	
28725	Arthrodesis; subtalar	8.63	090	
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;	7.77	090	
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	7.77	090	
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	6.21	090	
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	3.67	090	
28750	Arthrodesis, great toe; metatarsophalangeal joint	4.64	090	
28755	Arthrodesis, great toe; interphalangeal joint	3.45	090	
28760	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure)	5.18	090	
28800	Amputation, foot; midtarsal (eg, Chopart type procedure)	7.77	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
28805	Amputation, foot; transmetatarsal	7.77	090	
28810	Amputation, metatarsal, with toe, single	5.18	090	
■ 28820	Amputation, toe; metatarsophalangeal joint	3.67	000	
■ 28825	Amputation, toe; interphalangeal joint	3.23	000	
28890	Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia	2.79	090	
28899	Unlisted procedure, foot or toes	BR	YYY	
29000	Application of halo type body cast (see 20661-20663 for insertion)	3.26	000	
29010	Application of Risser jacket, localizer, body; only	1.98	000	
29015	Application of Risser jacket, localizer, body; including head	2.47	000	
29035	Application of body cast, shoulder to hips;	0.99	000	
29040	Application of body cast, shoulder to hips; including head, Minerva type	1.68	000	
29044	Application of body cast, shoulder to hips; including 1 thigh	1.28	000	
29046	Application of body cast, shoulder to hips; including both thighs	1.38	000	
29049	Application, cast; figure-of-eight	0.52	000	
29055	Application, cast; shoulder spica	1.04	000	
29058	Application, cast; plaster Velpeau	0.62	000	
29065	Application, cast; shoulder to hand (long arm)	0.57	000	
29075	Application, cast; elbow to finger (short arm)	0.44	000	
29085	Application, cast; hand and lower forearm (gauntlet)	0.41	000	
29086	Application, cast; finger (eg, contracture)	0.31	000	
29105	Application of long arm splint (shoulder to hand)	0.35	000	
29125	Application of short arm splint (forearm to hand); static	0.30	000	
29126	Application of short arm splint (forearm to hand); dynamic	0.49	000	
29130	Application of finger splint; static	0.20	000	
29131	Application of finger splint; dynamic	0.30	000	
29200	Strapping; thorax	0.21	000	
29240	Strapping; shoulder (eg, Velpeau)	0.21	000	
29260	Strapping; elbow or wrist	0.18	000	
29280	Strapping; hand or finger	0.16	000	
29305	Application of hip spica cast; 1 leg	1.28	000	
29325	Application of hip spica cast; 1 and one-half spica or both legs	1.68	000	
29345	Application of long leg cast (thigh to toes);	0.64	000	
29355	Application of long leg cast (thigh to toes); walker or ambulatory type	0.84	000	
29358	Application of long leg cast brace	0.84	000	
29365	Application of cylinder cast (thigh to ankle)	0.41	000	
29405	Application of short leg cast (below knee to toes);	0.49	000	
29425	Application of short leg cast (below knee to toes); walking or ambulatory type	0.59	000	
29435	Application of patellar tendon bearing (PTB) cast	0.74	000	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
29440	Adding walker to previously applied cast	0.20	000	
29445	Application of rigid total contact leg cast	1.33	000	
29450	Application of clubfoot cast with molding or manipulation, long or short leg	0.30	000	
29505	Application of long leg splint (thigh to ankle or toes)	0.44	000	
29515	Application of short leg splint (calf to foot)	0.35	000	
29520	Strapping; hip	0.31	000	
29530	Strapping; knee	0.24	000	
29540	Strapping; ankle and/or foot	0.21	000	
29550	Strapping; toes	0.13	000	
29580	Strapping; Unna boot	0.29	000	
29581	Application of multi-layer compression system; leg (below knee), including ankle and foot	0.44	000	
29584	Application of multi-layer compression system; upper arm, forearm, hand, and fingers	0.69	000	
29700	Removal or bivalving; gauntlet, boot or body cast	0.25	000	
29705	Removal or bivalving; full arm or full leg cast	0.25	000	
29710	Removal or bivalving; shoulder or hip spica, Minerva, or Risser jacket, etc.	0.30	000	
29720	Repair of spica, body cast or jacket	0.15	000	
29730	Windowing of cast	0.15	000	
29740	Wedging of cast (except clubfoot casts)	0.20	000	
29750	Wedging of clubfoot cast	0.20	000	
29799	Unlisted procedure, casting or strapping	BR	YYY	
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	5.62	090	
29804	Arthroscopy, temporomandibular joint, surgical	9.61	090	
29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)	4.14	090	
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy	10.71	090	
29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion	10.87	090	
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body	7.77	090	
29820	Arthroscopy, shoulder, surgical; synovectomy, partial	7.11	090	
29821	Arthroscopy, shoulder, surgical; synovectomy, complete	7.77	090	
■ 29822	Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])	7.55	090	
■ 29823	Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])	8.20	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	29824	Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)	5.18	090	
	29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation	8.18	090	
+	29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)	1.97	ZZZ	
	29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	9.32	090	
	29828	Arthroscopy, shoulder, surgical; biceps tenodesis	9.83	090	
	29830	Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)	4.32	090	
	29834	Arthroscopy, elbow, surgical; with removal of loose body or foreign body	6.04	090	
	29835	Arthroscopy, elbow, surgical; synovectomy, partial	8.18	090	
	29836	Arthroscopy, elbow, surgical; synovectomy, complete	9.71	090	
	29837	Arthroscopy, elbow, surgical; debridement, limited	7.47	090	
	29838	Arthroscopy, elbow, surgical; debridement, extensive	9.51	090	
	29840	Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)	4.50	090	
	29843	Arthroscopy, wrist, surgical; for infection, lavage and drainage	5.12	090	
	29844	Arthroscopy, wrist, surgical; synovectomy, partial	7.16	090	
	29845	Arthroscopy, wrist, surgical; synovectomy, complete	8.18	090	
	29846	Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement	7.67	090	
	29847	Arthroscopy, wrist, surgical; internal fixation for fracture or instability	9.21	090	
	29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament	5.73	090	
	29850	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)	7.26	090	
	29851	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; with internal or external fixation (includes arthroscopy)	10.35	090	
	29855	Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed (includes arthroscopy)	10.35	090	
	29856	Arthroscopically aided treatment of tibial fracture, proximal (plateau); bicondylar, includes internal fixation, when performed (includes arthroscopy)	11.65	090	
	29860	Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)	4.35	090	
	29861	Arthroscopy, hip, surgical; with removal of loose body or foreign body	7.16	090	
	29862	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum	11.35	090	
	29863	Arthroscopy, hip, surgical; with synovectomy	9.21	090	
	29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])	16.35	090	
	29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	19.56	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral	26.50	090	
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)	3.95	090	
29871	Arthroscopy, knee, surgical; for infection, lavage and drainage	6.14	090	
29873	Arthroscopy, knee, surgical; with lateral release	7.76	090	
29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)	7.51	090	
29875	Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure)	7.16	090	
29876	Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)	8.20	090	
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)	7.11	090	
29879	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture	7.77	090	
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	10.79	090	
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	8.79	090	
29882	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)	12.07	090	
29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)	13.37	090	
29884	Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)	7.67	090	
29885	Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)	11.25	090	
29886	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion	9.00	090	
29887	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation	9.06	090	
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	17.78	090	
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	16.46	090	
29891	Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect	10.45	090	
29892	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)	12.27	090	
29893	Endoscopic plantar fasciotomy	2.56	090	
29894	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body	7.51	090	
29895	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; synovectomy, partial	7.11	090	
29897	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, limited	7.11	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
29898	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive	7.77	090	
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis	9.83	090	
29900	Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy	2.59	090	
29901	Arthroscopy, metacarpophalangeal joint, surgical; with debridement	3.11	090	
29902	Arthroscopy, metacarpophalangeal joint, surgical; with reduction of displaced ulnar collateral ligament (eg, Stenar lesion)	4.40	090	
29904	Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body	8.07	090	
29905	Arthroscopy, subtalar joint, surgical; with synovectomy	8.80	090	
29906	Arthroscopy, subtalar joint, surgical; with debridement	8.80	090	
29907	Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis	9.32	090	
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	9.73	090	
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	10.35	090	
29916	Arthroscopy, hip, surgical; with labral repair	10.35	090	
29999	Unlisted procedure, arthroscopy	BR	YYY	
30000	Drainage abscess or hematoma, nasal, internal approach	0.47	010	
30020	Drainage abscess or hematoma, nasal septum	0.66	010	
30100	Biopsy, intranasal	0.56	000	
30110	Excision, nasal polyp(s), simple	1.03	010	
30115	Excision, nasal polyp(s), extensive	2.43	090	
30117	Excision or destruction (eg, laser), intranasal lesion; internal approach	1.87	090	
30118	Excision or destruction (eg, laser), intranasal lesion; external approach (lateral rhinotomy)	4.68	090	
30120	Excision or surgical planing of skin of nose for rhinophyma	5.62	090	
30124	Excision dermoid cyst, nose; simple, skin, subcutaneous	1.87	090	
30125	Excision dermoid cyst, nose; complex, under bone or cartilage	7.02	090	
30130	Excision inferior turbinate, partial or complete, any method	2.43	090	
30140	Submucous resection inferior turbinate, partial or complete, any method	3.47	000	
30150	Rhinectomy; partial	2.81	090	
30160	Rhinectomy; total	4.68	090	
30200	Injection into turbinate(s), therapeutic	0.26	000	
30210	Displacement therapy (Proetz type)	0.14	010	
30220	Insertion, nasal septal prosthesis (button)	1.45	010	
30300	Removal foreign body, intranasal; office type procedure	0.37	010	
30310	Removal foreign body, intranasal; requiring general anesthesia	1.73	010	
30320	Removal foreign body, intranasal; by lateral rhinotomy	3.75	090	
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	7.49	090	
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	9.74	090	
30420	Rhinoplasty, primary; including major septal repair	12.92	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	3.75	090	
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	6.09	090	
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	9.74	090	
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	5.15	090	
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies	13.72	090	
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)	9.08	090	
■ 30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)	20.13	000	
■ 30469	Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling	19.58	000	
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	7.02	090	
30540	Repair choanal atresia; intranasal	5.62	090	
30545	Repair choanal atresia; transpalatine	8.43	090	
30560	Lysis intranasal synechia	0.75	010	
30580	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)	4.68	090	
30600	Repair fistula; oronasal	4.68	090	
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)	7.96	090	
30630	Repair nasal septal perforations	5.76	090	
30801	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial	0.96	010	
30802	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); intramural (ie, submucosal)	1.59	010	
30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method	0.47	000	
30903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method	0.75	000	
30905	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial	1.45	000	
30906	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent	1.36	000	
30915	Ligation arteries; ethmoidal	5.15	090	
30920	Ligation arteries; internal maxillary artery, transantral	7.96	090	
30930	Fracture nasal inferior turbinate(s), therapeutic	0.94	010	
30999	Unlisted procedure, nose	BR	YYY	
31000	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)	0.47	010	
31002	Lavage by cannulation; sphenoid sinus	0.94	010	
31020	Sinusotomy, maxillary (antrotomy); intranasal	2.72	090	
31030	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyps	6.09	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
31032	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) with removal of antrochoanal polyps	7.02	090	
31040	Pterygomaxillary fossa surgery, any approach	13.11	090	
31050	Sinusotomy, sphenoid, with or without biopsy;	9.37	090	
31051	Sinusotomy, sphenoid, with or without biopsy; with mucosal stripping or removal of polyp(s)	9.83	090	
31070	Sinusotomy frontal; external, simple (trephine operation)	4.68	090	
31075	Sinusotomy frontal; transorbital, unilateral (for mucocele or osteoma, Lynch type)	7.96	090	
31080	Sinusotomy frontal; obliterative without osteoplastic flap, brow incision (includes ablation)	9.37	090	
31081	Sinusotomy frontal; obliterative, without osteoplastic flap, coronal incision (includes ablation)	9.37	090	
31084	Sinusotomy frontal; obliterative, with osteoplastic flap, brow incision	11.24	090	
31085	Sinusotomy frontal; obliterative, with osteoplastic flap, coronal incision	11.24	090	
31086	Sinusotomy frontal; nonobliterative, with osteoplastic flap, brow incision	11.24	090	
31087	Sinusotomy frontal; nonobliterative, with osteoplastic flap, coronal incision	11.24	090	
31090	Sinusotomy, unilateral, 3 or more paranasal sinuses (frontal, maxillary, ethmoid, sphenoid)	14.05	090	
31200	Ethmoidectomy; intranasal, anterior	4.92	090	
31201	Ethmoidectomy; intranasal, total	6.56	090	
31205	Ethmoidectomy; extranasal, total	7.30	090	
31225	Maxillectomy; without orbital exenteration	14.52	090	
31230	Maxillectomy; with orbital exenteration (en bloc)	17.04	090	
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	2.34	000	
■ 31233	Nasal/sinus endoscopy, diagnostic; with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)	3.00	000	
■ 31235	Nasal/sinus endoscopy, diagnostic; with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)	6.09	000	
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	5.06	000	
31238	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage	3.28	000	
31239	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy	7.49	010	
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection	3.75	000	
31241	Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery	4.31	000	
■ 31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve	20.15	000	
■ 31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve	19.56	000	
31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed	4.83	000	
31254	Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)	6.65	000	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
31255	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior)	9.08	000	
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy;	5.24	000	
31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy	4.30	000	
31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus	4.55	000	
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	7.87	000	
31276	Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed	7.87	000	
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy;	6.56	000	
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	7.21	000	
31290	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region	8.43	010	
31291	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; sphenoid region	8.43	010	
■ 31292	Nasal/sinus endoscopy, surgical, with orbital decompression; medial or inferior wall	7.49	010	
■ 31293	Nasal/sinus endoscopy, surgical, with orbital decompression; medial and inferior wall	8.43	010	
■ 31294	Nasal/sinus endoscopy, surgical, with optic nerve decompression	9.90	010	
■ 31295	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa	16.39	000	
■ 31296	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium	18.73	000	
■ 31297	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); sphenoid sinus ostium	18.73	000	
■ 31298	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal and sphenoid sinus ostia	31.21	000	
31299	Unlisted procedure, accessory sinuses	BR	YYY	
31300	Laryngotomy (thyrotomy, laryngofissure), with removal of tumor or laryngocele, cordectomy	9.37	090	
31360	Laryngectomy; total, without radical neck dissection	12.64	090	
31365	Laryngectomy; total, with radical neck dissection	18.73	090	
31367	Laryngectomy; subtotal supraglottic, without radical neck dissection	12.64	090	
31368	Laryngectomy; subtotal supraglottic, with radical neck dissection	18.73	090	
31370	Partial laryngectomy (hemilaryngectomy); horizontal	12.64	090	
31375	Partial laryngectomy (hemilaryngectomy); laterovertical	10.30	090	
31380	Partial laryngectomy (hemilaryngectomy); anterovertical	10.30	090	
31382	Partial laryngectomy (hemilaryngectomy); antero-latero-vertical	10.30	090	
31390	Pharyngolaryngectomy, with radical neck dissection; without reconstruction	16.39	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
31395	Pharyngolaryngectomy, with radical neck dissection; with reconstruction	21.54	090	
31400	Arytenoidectomy or arytenoidopexy, external approach	8.43	090	
31420	Epiglottidectomy	7.02	090	
■ 31500	Intubation, endotracheal, emergency procedure	0.94	000	
31502	Tracheotomy tube change prior to establishment of fistula tract	0.80	000	
31505	Laryngoscopy, indirect; diagnostic (separate procedure)	0.75	000	
31510	Laryngoscopy, indirect; with biopsy	2.06	000	
31511	Laryngoscopy, indirect; with removal of foreign body	2.34	000	
31512	Laryngoscopy, indirect; with removal of lesion	2.81	000	
31513	Laryngoscopy, indirect; with vocal cord injection	3.75	000	
31515	Laryngoscopy direct, with or without tracheoscopy; for aspiration	1.40	000	
31520	Laryngoscopy direct, with or without tracheoscopy; diagnostic, newborn	1.22	000	
31525	Laryngoscopy direct, with or without tracheoscopy; diagnostic, except newborn	2.06	000	
31526	Laryngoscopy direct, with or without tracheoscopy; diagnostic, with operating microscope or telescope	2.48	000	
31527	Laryngoscopy direct, with or without tracheoscopy; with insertion of obturator	4.68	000	
31528	Laryngoscopy direct, with or without tracheoscopy; with dilation, initial	2.81	000	
31529	Laryngoscopy direct, with or without tracheoscopy; with dilation, subsequent	2.34	000	
31530	Laryngoscopy, direct, operative, with foreign body removal;	3.00	000	
31531	Laryngoscopy, direct, operative, with foreign body removal; with operating microscope or telescope	3.61	000	
31535	Laryngoscopy, direct, operative, with biopsy;	3.00	000	
31536	Laryngoscopy, direct, operative, with biopsy; with operating microscope or telescope	3.61	000	
31540	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis;	3.61	000	
31541	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope or telescope	4.31	000	
31545	Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with local tissue flap(s)	5.06	000	
31546	Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with graft(s) (includes obtaining autograft)	7.77	000	
31552	Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, age 12 years or older	13.79	090	
31554	Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, age 12 years or older	15.83	090	
31560	Laryngoscopy, direct, operative, with arytenoidectomy;	3.98	000	
31561	Laryngoscopy, direct, operative, with arytenoidectomy; with operating microscope or telescope	4.78	000	
31570	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic;	3.28	000	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
31571	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope	3.93	000	
31572	Laryngoscopy, flexible; with ablation or destruction of lesion(s) with laser, unilateral	3.98	000	
31573	Laryngoscopy, flexible; with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral	2.12	000	
31574	Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral	8.18	000	
31575	Laryngoscopy, flexible; diagnostic	0.98	000	
31576	Laryngoscopy, flexible; with biopsy(ies)	2.15	000	
31577	Laryngoscopy, flexible; with removal of foreign body(s)	3.28	000	
31578	Laryngoscopy, flexible; with removal of lesion(s), non-laser	3.75	000	
31579	Laryngoscopy, flexible or rigid telescopic, with stroboscopy	2.53	000	
31580	Laryngoplasty; for laryngeal web, with indwelling keel or stent insertion	9.37	090	
31584	Laryngoplasty; with open reduction and fixation of (eg, plating) fracture, includes tracheostomy, if performed	8.90	090	
31587	Laryngoplasty, cricoid split, without graft placement	8.43	090	
31590	Laryngeal reinnervation by neuromuscular pedicle	10.30	090	
31591	Laryngoplasty, medialization, unilateral	9.92	090	
31592	Cricotracheal resection	16.16	090	
31599	Unlisted procedure, larynx	BR	YYY	
31600	Tracheostomy, planned (separate procedure);	3.28	000	
31603	Tracheostomy, emergency procedure; transtracheal	3.75	000	
31605	Tracheostomy, emergency procedure; cricothyroid membrane	3.28	000	
31610	Tracheostomy, fenestration procedure with skin flaps	5.62	090	
31611	Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis)	6.09	090	
31612	Tracheal puncture, percutaneous with transtracheal aspiration and/or injection	0.75	000	
31613	Tracheostoma revision; simple, without flap rotation	2.81	090	
31614	Tracheostoma revision; complex, with flap rotation	5.62	090	
31615	Tracheobronchoscopy through established tracheostomy incision	1.87	000	
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	2.37	000	
31623	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings	2.48	000	
31624	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage	2.48	000	
31625	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites	2.53	000	
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	3.09	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s])	1.40	ZZZ	
	31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	2.81	000	
	31629	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)	3.28	000	
	31630	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture	3.00	000	
	31631	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)	3.75	000	
+	31632	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)	1.41	ZZZ	
+	31633	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)	1.41	ZZZ	
	31634	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed	14.61	000	
	31635	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of foreign body	4.68	000	
	31636	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus	4.21	000	
+	31637	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; each additional major bronchus stented (List separately in addition to code for primary procedure)	1.50	ZZZ	
	31638	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)	4.68	000	
	31640	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with excision of tumor	4.68	000	
	31641	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)	6.09	000	
	31643	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radioelement application	2.36	000	
	31645	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, initial	2.53	000	
	31646	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay	2.53	000	
	31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe	2.06	000	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe	1.89	000	
+	31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)	0.55	ZZZ	
+	31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s])	0.61	ZZZ	
	31652	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures	6.71	000	
	31653	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures	7.10	000	
+	31654	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s])	1.02	ZZZ	
	31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	1.89	000	
	31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	2.00	000	
	31717	Catheterization with bronchial brush biopsy	0.47	000	
	31720	Catheter aspiration (separate procedure); nasotracheal	0.47	000	
	31725	Catheter aspiration (separate procedure); tracheobronchial with fiberscope, bedside	0.94	000	
	31730	Transtracheal (percutaneous) introduction of needle wire dilator/stent or indwelling tube for oxygen therapy	0.94	000	
	31750	Tracheoplasty; cervical	9.37	090	
	31755	Tracheoplasty; tracheopharyngeal fistulization, each stage	11.24	090	
	31760	Tracheoplasty; intrathoracic	11.24	090	
	31766	Carinal reconstruction	12.46	090	
	31770	Bronchoplasty; graft repair	12.46	090	
	31775	Bronchoplasty; excision stenosis and anastomosis	12.46	090	
	31780	Excision tracheal stenosis and anastomosis; cervical	11.71	090	
	31781	Excision tracheal stenosis and anastomosis; cervicothoracic	13.11	090	
	31785	Excision of tracheal tumor or carcinoma; cervical	10.77	090	
	31786	Excision of tracheal tumor or carcinoma; thoracic	12.64	090	
	31800	Suture of tracheal wound or injury; cervical	6.09	090	
	31805	Suture of tracheal wound or injury; intrathoracic	8.43	090	
	31820	Surgical closure tracheostomy or fistula; without plastic repair	2.81	090	
	31825	Surgical closure tracheostomy or fistula; with plastic repair	3.75	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
31830	Revision of tracheostomy scar	2.81	090	
31899	Unlisted procedure, trachea, bronchi	BR	YYY	
32035	Thoracotomy; with rib resection for empyema	6.09	090	
32036	Thoracotomy; with open flap drainage for empyema	7.02	090	
32096	Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral	7.72	090	
32097	Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral	7.72	090	
32098	Thoracotomy, with biopsy(ies) of pleura	7.26	090	
32100	Thoracotomy; with exploration	7.49	090	
32110	Thoracotomy; with control of traumatic hemorrhage and/or repair of lung tear	8.62	090	
32120	Thoracotomy; for postoperative complications	9.37	090	
32124	Thoracotomy; with open intrapleural pneumonolysis	7.49	090	
32140	Thoracotomy; with cyst(s) removal, includes pleural procedure when performed	9.37	090	
32141	Thoracotomy; with resection-plectomy of bullae, includes any pleural procedure when performed	9.37	090	
32150	Thoracotomy; with removal of intrapleural foreign body or fibrin deposit	8.90	090	
32151	Thoracotomy; with removal of intrapulmonary foreign body	8.90	090	
32160	Thoracotomy; with cardiac massage	9.37	090	
32200	Pneumonostomy, with open drainage of abscess or cyst	6.09	090	
32215	Pleural scarification for repeat pneumothorax	8.24	090	
32220	Decortication, pulmonary (separate procedure); total	9.37	090	
32225	Decortication, pulmonary (separate procedure); partial	7.02	090	
32310	Pleurectomy, parietal (separate procedure)	8.90	090	
32320	Decortication and parietal pleurectomy	11.24	090	
32400	Biopsy, pleura, percutaneous needle	1.03	000	
■ 32408	Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed	6.91	000	
32440	Removal of lung, pneumonectomy;	12.17	090	
32442	Removal of lung, pneumonectomy; with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)	15.64	090	
32445	Removal of lung, pneumonectomy; extrapleural	14.05	090	
32480	Removal of lung, other than pneumonectomy; single lobe (lobectomy)	11.24	090	
32482	Removal of lung, other than pneumonectomy; 2 lobes (bilobectomy)	11.71	090	
32484	Removal of lung, other than pneumonectomy; single segment (segmentectomy)	11.24	090	
32486	Removal of lung, other than pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)	14.52	090	
32488	Removal of lung, other than pneumonectomy; with all remaining lung following previous removal of a portion of lung (completion pneumonectomy)	15.17	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	32491	Removal of lung, other than pneumonectomy; with resection-plectomy of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes any pleural procedure, when performed	11.61	090	
+	32501	Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)	2.81	ZZZ	
	32503	Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; without chest wall reconstruction(s)	16.58	090	
	32504	Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; with chest wall reconstruction	19.01	090	
	32505	Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial	8.91	090	
+	32506	Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)	1.50	ZZZ	
+	32507	Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)	1.50	ZZZ	
	32540	Extrapleural enucleation of empyema (empyemectomy)	9.37	090	
	32550	Insertion of indwelling tunneled pleural catheter with cuff	6.56	000	
	32551	Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)	1.50	000	
	32552	Removal of indwelling tunneled pleural catheter with cuff	1.40	010	
	32553	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple	1.78	000	
	32554	Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance	1.64	000	
	32555	Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance	2.35	000	
	32556	Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance	4.52	000	
	32557	Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance	4.13	000	
	32560	Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax)	2.43	000	
	32561	Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day	0.66	000	
	32562	Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day	0.61	000	
	32601	Thoracoscopy, diagnostic (separate procedure); lungs, pericardial sac, mediastinal or pleural space, without biopsy	2.81	000	
	32604	Thoracoscopy, diagnostic (separate procedure); pericardial sac, with biopsy	4.21	000	
	32606	Thoracoscopy, diagnostic (separate procedure); mediastinal space, with biopsy	3.75	000	
	32607	Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral	2.96	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	32608	Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral	3.63	000	
	32609	Thoracoscopy; with biopsy(ies) of pleura	2.51	000	
	32650	Thoracoscopy, surgical; with pleurodesis (eg, mechanical or chemical)	7.68	090	
	32651	Thoracoscopy, surgical; with partial pulmonary decortication	7.96	090	
	32652	Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis	8.24	090	
	32653	Thoracoscopy, surgical; with removal of intrapleural foreign body or fibrin deposit	7.96	090	
	32654	Thoracoscopy, surgical; with control of traumatic hemorrhage	8.43	090	
	32655	Thoracoscopy, surgical; with resection-plication of bullae, includes any pleural procedure when performed	8.90	090	
	32656	Thoracoscopy, surgical; with parietal pleurectomy	8.43	090	
	32658	Thoracoscopy, surgical; with removal of clot or foreign body from pericardial sac	10.02	090	
	32659	Thoracoscopy, surgical; with creation of pericardial window or partial resection of pericardial sac for drainage	9.83	090	
	32661	Thoracoscopy, surgical; with excision of pericardial cyst, tumor, or mass	11.24	090	
	32662	Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass	10.77	090	
	32663	Thoracoscopy, surgical; with lobectomy (single lobe)	12.17	090	
	32664	Thoracoscopy, surgical; with thoracic sympathectomy	10.49	090	
	32665	Thoracoscopy, surgical; with esophagomyotomy (Heller type)	10.30	090	
	32666	Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral	8.33	090	
+	32667	Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)	1.50	ZZZ	
+	32668	Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)	1.51	ZZZ	
	32669	Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)	12.84	090	
	32670	Thoracoscopy, surgical; with removal of two lobes (bilobectomy)	15.32	090	
	32671	Thoracoscopy, surgical; with removal of lung (pneumonectomy)	17.00	090	
	32672	Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed	14.55	090	
	32673	Thoracoscopy, surgical; with resection of thymus, unilateral or bilateral	11.46	090	
+	32674	Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)	2.06	ZZZ	
	32701	Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment	2.08	XXX	
	32800	Repair lung hernia through chest wall	7.49	090	
	32810	Closure of chest wall following open flap drainage for empyema (Clagett type procedure)	3.75	090	
	32815	Open closure of major bronchial fistula	13.11	090	
	32820	Major reconstruction, chest wall (posttraumatic)	11.71	090	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
32850	Donor pneumonectomy(s) (including cold preservation), from cadaver donor	BR	XXX	
32851	Lung transplant, single; without cardiopulmonary bypass	26.64	090	
32852	Lung transplant, single; with cardiopulmonary bypass	28.89	090	
32853	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass	33.31	090	
32854	Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass	35.56	090	
32855	Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; unilateral	BR	XXX	
32856	Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; bilateral	BR	XXX	
32900	Resection of ribs, extrapleural, all stages	6.56	090	
32905	Thoracoplasty, Schede type or extrapleural (all stages);	8.43	090	
32906	Thoracoplasty, Schede type or extrapleural (all stages); with closure of bronchopleural fistula	13.11	090	
32940	Pneumonolysis, extrapariosteal, including filling or packing procedures	5.62	090	
32960	Pneumothorax, therapeutic, intrapleural injection of air	0.70	000	
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation	49.77	000	
32997	Total lung lavage (unilateral)	0.94	000	
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency	7.02	000	
32999	Unlisted procedure, lungs and pleura	BR	YYY	
■ 33016	Pericardiocentesis, including imaging guidance, when performed	2.35	000	
■ 33017	Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; 6 years and older without congenital cardiac anomaly	2.47	000	
■ 33018	Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; birth through 5 years of age or any age with congenital cardiac anomaly	2.90	000	
■ 33019	Pericardial drainage with insertion of indwelling catheter, percutaneous, including CT guidance	2.10	000	
33020	Pericardiotomy for removal of clot or foreign body (primary procedure)	8.43	090	
33025	Creation of pericardial window or partial resection for drainage	8.62	090	
33030	Pericardiectomy, subtotal or complete; without cardiopulmonary bypass	9.83	090	
33031	Pericardiectomy, subtotal or complete; with cardiopulmonary bypass	17.79	090	
33050	Resection of pericardial cyst or tumor	9.37	090	
33120	Excision of intracardiac tumor, resection with cardiopulmonary bypass	21.07	090	
33130	Resection of external cardiac tumor	14.05	090	
33140	Transmyocardial laser revascularization, by thoracotomy; (separate procedure)	12.64	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	33141	Transmyocardial laser revascularization, by thoracotomy; performed at the time of other open cardiac procedure(s) (List separately in addition to code for primary procedure)	6.84	ZZZ	
	33202	Insertion of epicardial electrode(s); open incision (eg, thoracotomy, median sternotomy, subxiphoid approach)	7.87	090	
	33203	Insertion of epicardial electrode(s); endoscopic approach (eg, thoracoscopy, pericardioscopy)	8.05	090	
	33206	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial	7.49	090	
	33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	7.96	090	
	33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	8.43	090	
	33210	Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter (separate procedure)	3.47	000	
	33211	Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)	3.93	000	
	33212	Insertion of pacemaker pulse generator only; with existing single lead	4.03	090	
	33213	Insertion of pacemaker pulse generator only; with existing dual leads	4.31	090	
	33214	Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator)	7.96	090	
	33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	3.56	090	
	33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	3.93	090	
	33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	4.31	090	
	33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	2.29	090	
	33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	2.48	090	
	33221	Insertion of pacemaker pulse generator only; with existing multiple leads	4.31	090	
	33222	Relocation of skin pocket for pacemaker	3.75	090	
	33223	Relocation of skin pocket for implantable defibrillator	3.09	090	
	33224	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existing generator)	5.15	000	
+	33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (List separately in addition to code for primary procedure)	4.59	ZZZ	
	33226	Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator)	4.96	000	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	3.20	090	
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system	3.33	090	
33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system	3.47	090	
33230	Insertion of implantable defibrillator pulse generator only; with existing dual leads	3.61	090	
33231	Insertion of implantable defibrillator pulse generator only; with existing multiple leads	3.74	090	
33233	Removal of permanent pacemaker pulse generator only	2.81	090	
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular	2.90	090	
33235	Removal of transvenous pacemaker electrode(s); dual lead system	2.90	090	
33236	Removal of permanent epicardial pacemaker and electrodes by thoracotomy; single lead system, atrial or ventricular	10.77	090	
33237	Removal of permanent epicardial pacemaker and electrodes by thoracotomy; dual lead system	10.77	090	
33238	Removal of permanent transvenous electrode(s) by thoracotomy	11.24	090	
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	4.12	090	
33241	Removal of implantable defibrillator pulse generator only	2.15	090	
33243	Removal of single or dual chamber implantable defibrillator electrode(s); by thoracotomy	9.08	090	
33244	Removal of single or dual chamber implantable defibrillator electrode(s); by transvenous extraction	3.18	090	
33249	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber	9.27	090	
33250	Operative ablation of supraventricular arrhythmogenic focus or pathway (eg, Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci); without cardiopulmonary bypass	10.86	090	
33251	Operative ablation of supraventricular arrhythmogenic focus or pathway (eg, Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci); with cardiopulmonary bypass	14.33	090	
33254	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	11.14	090	
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	13.39	090	
33256	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass	16.01	090	
+	33257 Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to code for primary procedure)	5.15	ZZZ	
+	33258 Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in addition to code for primary procedure)	5.81	ZZZ	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	33259	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure)	7.59	ZZZ	
	33261	Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary bypass	13.39	090	
	33262	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system	3.47	090	
	33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system	3.61	090	
	33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system	3.75	090	
	33265	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass	11.14	090	
	33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	15.27	090	
■	33267	Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	10.57	090	
■ +	33268	Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (List separately in addition to code for primary procedure)	1.30	ZZZ	
■	33269	Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	8.42	090	
	33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed	5.54	090	
	33271	Insertion of subcutaneous implantable defibrillator electrode	4.45	090	
	33272	Removal of subcutaneous implantable defibrillator electrode	3.41	090	
	33273	Repositioning of previously implanted subcutaneous implantable defibrillator electrode	3.92	090	
■	33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed	4.81	090	
■	33275	Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed	5.09	090	
■	33276	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed	5.85	090	
■ +	33277	Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)	2.79	ZZZ	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	33278	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s)	5.81	090	
■	33279	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only	3.49	090	
■	33280	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only	2.11	090	
■	33281	Repositioning of phrenic nerve stimulator transvenous lead(s)	3.71	090	
■	33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	33.19	000	
■	33286	Removal, subcutaneous cardiac rhythm monitor	1.08	000	
■	33287	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator	3.94	090	
■	33288	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s)	4.99	090	
■	33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed	3.35	000	
	33300	Repair of cardiac wound; without bypass	10.30	090	
	33305	Repair of cardiac wound; with cardiopulmonary bypass	15.45	090	
	33310	Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); without bypass	11.24	090	
	33315	Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); with cardiopulmonary bypass	18.73	090	
	33320	Suture repair of aorta or great vessels; without shunt or cardiopulmonary bypass	10.58	090	
	33321	Suture repair of aorta or great vessels; with shunt bypass	12.92	090	
	33322	Suture repair of aorta or great vessels; with cardiopulmonary bypass	14.42	090	
	33330	Insertion of graft, aorta or great vessels; without shunt, or cardiopulmonary bypass	15.45	090	
	33335	Insertion of graft, aorta or great vessels; with cardiopulmonary bypass	19.11	090	
	33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	7.75	000	
	33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	13.24	000	
	33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	14.46	000	
	33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	14.99	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	15.79	000	
	33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	17.37	000	
	33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	18.79	000	
+	33367	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)	6.13	ZZZ	
+	33368	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)	7.28	ZZZ	
+	33369	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)	9.61	ZZZ	
■ +	33370	Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging, and radiological supervision and interpretation, percutaneous (List separately in addition to code for primary procedure)	1.34	ZZZ	
	33390	Valvuloplasty, aortic valve, open, with cardiopulmonary bypass; simple (ie, valvotomy, debridement, debulking, and/or simple commissural resuspension)	18.44	090	
	33391	Valvuloplasty, aortic valve, open, with cardiopulmonary bypass; complex (eg, leaflet extension, leaflet resection, leaflet reconstruction, or annuloplasty)	21.88	090	
	33404	Construction of apical-aortic conduit	23.41	090	
	33405	Replacement, aortic valve, open, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	22.01	090	
	33406	Replacement, aortic valve, open, with cardiopulmonary bypass; with allograft valve (freehand)	22.01	090	
	33410	Replacement, aortic valve, open, with cardiopulmonary bypass; with stentless tissue valve	22.01	090	
	33411	Replacement, aortic valve; with aortic annulus enlargement, noncoronary sinus	23.41	090	
	33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	23.41	090	
	33413	Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)	29.27	090	
	33414	Repair of left ventricular outflow tract obstruction by patch enlargement of the outflow tract	22.94	090	
	33415	Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis	18.73	090	
	33416	Ventriculomyotomy (-myectomy) for idiopathic hypertrophic subaortic stenosis (eg, asymmetric septal hypertrophy)	21.07	090	
	33417	Aortoplasty (gusset) for supravalvular stenosis	21.07	090	
	33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	17.56	090	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
+	33419	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure)	4.15	ZZZ	
	33420	Valvotomy, mitral valve; closed heart	14.98	090	
	33422	Valvotomy, mitral valve; open heart, with cardiopulmonary bypass	20.60	090	
	33425	Valvuloplasty, mitral valve, with cardiopulmonary bypass;	19.48	090	
	33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	21.35	090	
	33427	Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring	24.31	090	
	33430	Replacement, mitral valve, with cardiopulmonary bypass	21.07	090	
■	33440	Replacement, aortic valve; by translocation of autologous pulmonary valve and transventricular aortic annulus enlargement of the left ventricular outflow tract with valved conduit replacement of pulmonary valve (Ross-Konno procedure)	34.06	090	
	33460	Valvectomy, tricuspid valve, with cardiopulmonary bypass	18.73	090	
	33463	Valvuloplasty, tricuspid valve; without ring insertion	21.35	090	
	33464	Valvuloplasty, tricuspid valve; with ring insertion	21.91	090	
	33465	Replacement, tricuspid valve, with cardiopulmonary bypass	20.14	090	
	33468	Tricuspid valve repositioning and plication for Ebstein anomaly	25.29	090	
■	33471	Valvotomy, pulmonary valve, closed heart, via pulmonary artery	14.98	090	
	33474	Valvotomy, pulmonary valve, open heart, with cardiopulmonary bypass	21.07	090	
	33475	Replacement, pulmonary valve	23.23	090	
	33476	Right ventricular resection for infundibular stenosis, with or without commissurotomy	20.60	090	
	33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed	13.31	000	
	33478	Outflow tract augmentation (gusset), with or without commissurotomy or infundibular resection	22.48	090	
	33496	Repair of non-structural prosthetic valve dysfunction with cardiopulmonary bypass (separate procedure)	20.44	090	
	33500	Repair of coronary arteriovenous or arteriocardiac chamber fistula; with cardiopulmonary bypass	19.95	090	
	33501	Repair of coronary arteriovenous or arteriocardiac chamber fistula; without cardiopulmonary bypass	13.30	090	
	33502	Repair of anomalous coronary artery from pulmonary artery origin; by ligation	10.30	090	
	33503	Repair of anomalous coronary artery from pulmonary artery origin; by graft, without cardiopulmonary bypass	11.24	090	
	33504	Repair of anomalous coronary artery from pulmonary artery origin; by graft, with cardiopulmonary bypass	16.20	090	
	33505	Repair of anomalous coronary artery from pulmonary artery origin; with construction of intrapulmonary artery tunnel (Takeuchi procedure)	17.04	090	
	33506	Repair of anomalous coronary artery from pulmonary artery origin; by translocation from pulmonary artery to aorta	18.92	090	
	33507	Repair of anomalous (eg, intramural) aortic origin of coronary artery by unroofing or translocation	17.79	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	33508	Endoscopy, surgical, including video-assisted harvest of vein(s) for coronary artery bypass procedure (List separately in addition to code for primary procedure)	4.59	ZZZ	
■ ⊖	33509	Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, endoscopic	1.74	ZZZ	
	33510	Coronary artery bypass, vein only; single coronary venous graft	18.36	090	
	33511	Coronary artery bypass, vein only; 2 coronary venous grafts	20.60	090	
	33512	Coronary artery bypass, vein only; 3 coronary venous grafts	22.94	090	
	33513	Coronary artery bypass, vein only; 4 coronary venous grafts	24.26	090	
	33514	Coronary artery bypass, vein only; 5 coronary venous grafts	25.75	090	
	33516	Coronary artery bypass, vein only; 6 or more coronary venous grafts	26.28	090	
+	33517	Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (List separately in addition to code for primary procedure)	4.50	ZZZ	
+	33518	Coronary artery bypass, using venous graft(s) and arterial graft(s); 2 venous grafts (List separately in addition to code for primary procedure)	6.84	ZZZ	
+	33519	Coronary artery bypass, using venous graft(s) and arterial graft(s); 3 venous grafts (List separately in addition to code for primary procedure)	9.18	ZZZ	
+	33521	Coronary artery bypass, using venous graft(s) and arterial graft(s); 4 venous grafts (List separately in addition to code for primary procedure)	11.52	ZZZ	
+	33522	Coronary artery bypass, using venous graft(s) and arterial graft(s); 5 venous grafts (List separately in addition to code for primary procedure)	13.86	ZZZ	
+	33523	Coronary artery bypass, using venous graft(s) and arterial graft(s); 6 or more venous grafts (List separately in addition to code for primary procedure)	10.35	ZZZ	
+	33530	Reoperation, coronary artery bypass procedure or valve procedure, more than 1 month after original operation (List separately in addition to code for primary procedure)	4.44	ZZZ	
	33533	Coronary artery bypass, using arterial graft(s); single arterial graft	20.09	090	
	33534	Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts	22.48	090	
	33535	Coronary artery bypass, using arterial graft(s); 3 coronary arterial grafts	25.01	090	
	33536	Coronary artery bypass, using arterial graft(s); 4 or more coronary arterial grafts	24.99	090	
	33542	Myocardial resection (eg, ventricular aneurysmectomy)	17.79	090	
	33545	Repair of postinfarction ventricular septal defect, with or without myocardial resection	24.35	090	
	33548	Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)	26.22	090	
+	33572	Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel (List separately in addition to primary procedure)	10.16	ZZZ	
	33600	Closure of atrioventricular valve (mitral or tricuspid) by suture or patch	21.35	090	
	33602	Closure of semilunar valve (aortic or pulmonary) by suture or patch	21.35	090	
	33606	Anastomosis of pulmonary artery to aorta (Damus-Kaye-Stansel procedure)	13.11	090	
	33608	Repair of complex cardiac anomaly other than pulmonary atresia with ventricular septal defect by construction or replacement of conduit from right or left ventricle to pulmonary artery	25.94	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
33610	Repair of complex cardiac anomalies (eg, single ventricle with subaortic obstruction) by surgical enlargement of ventricular septal defect	25.66	090	
33611	Repair of double outlet right ventricle with intraventricular tunnel repair;	27.07	090	
33612	Repair of double outlet right ventricle with intraventricular tunnel repair; with repair of right ventricular outflow tract obstruction	26.60	090	
33615	Repair of complex cardiac anomalies (eg, tricuspid atresia) by closure of atrial septal defect and anastomosis of atria or vena cava to pulmonary artery (simple Fontan procedure)	26.13	090	
33617	Repair of complex cardiac anomalies (eg, single ventricle) by modified Fontan procedure	26.69	090	
33619	Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure)	29.88	090	
33620	Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)	17.33	090	
33621	Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)	9.18	090	
33622	Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)	35.78	090	
33641	Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch	14.98	090	
33645	Direct or patch closure, sinus venosus, with or without anomalous pulmonary venous drainage	17.79	090	
33647	Repair of atrial septal defect and ventricular septal defect, with direct or patch closure	23.41	090	
33660	Repair of incomplete or partial atrioventricular canal (ostium primum atrial septal defect), with or without atrioventricular valve repair	20.14	090	
33665	Repair of intermediate or transitional atrioventricular canal, with or without atrioventricular valve repair	21.54	090	
33670	Repair of complete atrioventricular canal, with or without prosthetic valve	25.29	090	
33675	Closure of multiple ventricular septal defects;	24.35	090	
33676	Closure of multiple ventricular septal defects; with pulmonary valvotomy or infundibular resection (acyanotic)	25.10	090	
33677	Closure of multiple ventricular septal defects; with removal of pulmonary artery band, with or without gusset	26.13	090	
33681	Closure of single ventricular septal defect, with or without patch;	21.35	090	
33684	Closure of single ventricular septal defect, with or without patch; with pulmonary valvotomy or infundibular resection (acyanotic)	21.54	090	
33688	Closure of single ventricular septal defect, with or without patch; with removal of pulmonary artery band, with or without gusset	21.54	090	
33690	Banding of pulmonary artery	8.90	090	
33692	Complete repair tetralogy of Fallot without pulmonary atresia;	20.60	090	
33694	Complete repair tetralogy of Fallot without pulmonary atresia; with transannular patch	22.94	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
33697	Complete repair tetralogy of Fallot with pulmonary atresia including construction of conduit from right ventricle to pulmonary artery and closure of ventricular septal defect	23.98	090	
33702	Repair sinus of Valsalva fistula, with cardiopulmonary bypass;	18.73	090	
33710	Repair sinus of Valsalva fistula, with cardiopulmonary bypass; with repair of ventricular septal defect	24.35	090	
33720	Repair sinus of Valsalva aneurysm, with cardiopulmonary bypass	22.01	090	
33724	Repair of isolated partial anomalous pulmonary venous return (eg, Scimitar Syndrome)	18.26	090	
33726	Repair of pulmonary venous stenosis	21.35	090	
33730	Complete repair of anomalous pulmonary venous return (supracardiac, intracardiac, or infracardiac types)	22.01	090	
33732	Repair of cor triatriatum or supravalvular mitral ring by resection of left atrial membrane	21.73	090	
33735	Atrial septectomy or septostomy; closed heart (Blalock-Hanlon type operation)	14.05	090	
33736	Atrial septectomy or septostomy; open heart with cardiopulmonary bypass	17.70	090	
33737	Atrial septectomy or septostomy; open heart, with inflow occlusion	15.92	090	
■	33741 Transcatheter atrial septostomy (TAS) for congenital cardiac anomalies to create effective atrial flow, including all imaging guidance by the proceduralist, when performed, any method (eg, Rashkind, Sang-Park, balloon, cutting balloon, blade)	7.51	000	
■	33745 Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt	10.73	000	
■ +	33746 Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure)	4.29	ZZZ	
	33750 Shunt; subclavian to pulmonary artery (Blalock-Taussig type operation)	11.71	090	
	33755 Shunt; ascending aorta to pulmonary artery (Waterston type operation)	13.11	090	
	33762 Shunt; descending aorta to pulmonary artery (Potts-Smith type operation)	11.71	090	
	33764 Shunt; central, with prosthetic graft	14.05	090	
	33766 Shunt; superior vena cava to pulmonary artery for flow to 1 lung (classical Glenn procedure)	10.86	090	
	33767 Shunt; superior vena cava to pulmonary artery for flow to both lungs (bidirectional Glenn procedure)	13.77	090	
+	33768 Anastomosis, cavopulmonary, second superior vena cava (List separately in addition to primary procedure)	4.68	ZZZ	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
33770	Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; without surgical enlargement of ventricular septal defect	26.60	090	
33771	Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; with surgical enlargement of ventricular septal defect	26.97	090	
33774	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass;	23.41	090	
33775	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with removal of pulmonary band	27.16	090	
33776	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with closure of ventricular septal defect	28.10	090	
33777	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with repair of subpulmonic obstruction	28.10	090	
33778	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type);	28.10	090	
33779	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with removal of pulmonary band	29.03	090	
33780	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with closure of ventricular septal defect	33.72	090	
33781	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with repair of subpulmonic obstruction	33.72	090	
33782	Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); without coronary ostium reimplantation	44.02	090	
33783	Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); with reimplantation of 1 or both coronary ostia	47.76	090	
33786	Total repair, truncus arteriosus (Rastelli type operation)	25.57	090	
33788	Reimplantation of an anomalous pulmonary artery	15.45	090	
33800	Aortic suspension (aortopexy) for tracheal decompression (eg, for tracheomalacia) (separate procedure)	10.86	090	
33802	Division of aberrant vessel (vascular ring);	10.30	090	
33803	Division of aberrant vessel (vascular ring); with reanastomosis	13.11	090	
33813	Obliteration of aortopulmonary septal defect; without cardiopulmonary bypass	15.64	090	
33814	Obliteration of aortopulmonary septal defect; with cardiopulmonary bypass	20.51	090	
33820	Repair of patent ductus arteriosus; by ligation	9.37	090	
33822	Repair of patent ductus arteriosus; by division, younger than 18 years	11.24	090	
33824	Repair of patent ductus arteriosus; by division, 18 years and older	13.11	090	
33840	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with direct anastomosis	13.11	090	
33845	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with graft	18.73	090	
33851	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; repair using either left subclavian artery or prosthetic material as gusset for enlargement	20.60	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	33852	Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; without cardiopulmonary bypass	17.33	090	
	33853	Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; with cardiopulmonary bypass	23.04	090	
■	33858	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic dissection	34.05	090	
■	33859	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic disease other than dissection (eg, aneurysm)	24.48	090	
	33863	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)	25.75	090	
	33864	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure)	24.82	090	
■ +	33866	Aortic hemiarch graft including isolation and control of the arch vessels, beveled open distal aortic anastomosis extending under one or more of the arch vessels, and total circulatory arrest or isolated cerebral perfusion (List separately in addition to code for primary procedure)	9.21	ZZZ	
■	33871	Transverse aortic arch graft, with cardiopulmonary bypass, with profound hypothermia, total circulatory arrest and isolated cerebral perfusion with reimplantation of arch vessel(s) (eg, island pedicle or individual arch vessel reimplantation)	32.63	090	
	33875	Descending thoracic aorta graft, with or without bypass	18.73	090	
	33877	Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass	30.55	090	
	33880	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin	19.20	090	
	33881	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin	16.58	090	
	33883	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension	12.27	090	
+	33884	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (List separately in addition to code for primary procedure)	4.68	ZZZ	
	33886	Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta	10.49	090	
	33889	Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral	9.08	000	
	33891	Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision	11.61	000	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	33894	Endovascular stent repair of coarctation of the ascending, transverse, or descending thoracic or abdominal aorta, involving stent placement; across major side branches	9.81	000	
■	33895	Endovascular stent repair of coarctation of the ascending, transverse, or descending thoracic or abdominal aorta, involving stent placement; not crossing major side branches	7.80	000	
■	33897	Percutaneous transluminal angioplasty of native or recurrent coarctation of the aorta	5.80	000	
■	33900	Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, unilateral	5.92	000	
■	33901	Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, bilateral	7.78	000	
■	33902	Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, unilateral	7.51	000	
■	33903	Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, bilateral	8.85	000	
■ +	33904	Percutaneous pulmonary artery revascularization by stent placement, each additional vessel or separate lesion, normal or abnormal connections (List separately in addition to code for primary procedure)	2.97	ZZZ	
	33910	Pulmonary artery embolectomy; with cardiopulmonary bypass	16.86	090	
	33915	Pulmonary artery embolectomy; without cardiopulmonary bypass	12.64	090	
	33916	Pulmonary endarterectomy, with or without embolectomy, with cardiopulmonary bypass	16.86	090	
	33917	Repair of pulmonary artery stenosis by reconstruction with patch or graft	21.07	090	
	33920	Repair of pulmonary atresia with ventricular septal defect, by construction or replacement of conduit from right or left ventricle to pulmonary artery	13.11	090	
	33922	Transection of pulmonary artery with cardiopulmonary bypass	14.05	090	
+	33924	Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to code for primary procedure)	2.34	ZZZ	
	33925	Repair of pulmonary artery arborization anomalies by unifocalization; without cardiopulmonary bypass	22.01	090	
	33926	Repair of pulmonary artery arborization anomalies by unifocalization; with cardiopulmonary bypass	29.50	090	
	33927	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	24.78	XXX	
	33928	Removal and replacement of total replacement heart system (artificial heart)	29.48	XXX	
+	33929	Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)	11.03	ZZZ	
	33930	Donor cardiectomy-pneumonectomy (including cold preservation)	BR	XXX	
	33933	Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, and trachea for implantation	BR	XXX	
	33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy	47.63	090	
	33940	Donor cardiectomy (including cold preservation)	BR	XXX	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
33944	Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation	BR	XXX	
33945	Heart transplant, with or without recipient cardiectomy	29.99	090	
33946	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous	3.01	XXX	
33947	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-arterial	3.35	XXX	
33948	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-venous	2.33	XXX	
33949	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-arterial	2.26	XXX	
33952	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)	4.17	000	
33954	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	4.66	000	
33956	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older	8.12	000	
33958	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)	1.81	000	
33962	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)	2.30	000	
33964	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)	4.84	000	
33966	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older	2.31	000	
33967	Insertion of intra-aortic balloon assist device, percutaneous	1.83	000	
33968	Removal of intra-aortic balloon assist device, percutaneous	0.23	000	
33970	Insertion of intra-aortic balloon assist device through the femoral artery, open approach	6.09	000	
33971	Removal of intra-aortic balloon assist device including repair of femoral artery, with or without graft	7.02	090	
33973	Insertion of intra-aortic balloon assist device through the ascending aorta	6.23	000	
33974	Removal of intra-aortic balloon assist device from the ascending aorta, including repair of the ascending aorta, with or without graft	6.56	090	
33975	Insertion of ventricular assist device; extracorporeal, single ventricle	12.36	XXX	
33976	Insertion of ventricular assist device; extracorporeal, biventricular	14.84	XXX	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	33977	Removal of ventricular assist device; extracorporeal, single ventricle	10.86	XXX	
	33978	Removal of ventricular assist device; extracorporeal, biventricular	13.02	XXX	
	33979	Insertion of ventricular assist device, implantable intracorporeal, single ventricle	14.84	XXX	
	33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle	13.02	XXX	
	33981	Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump	8.09	XXX	
	33982	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass	18.92	XXX	
	33983	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass	22.22	XXX	
	33984	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	2.78	000	
	33986	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older	5.09	000	
+	33987	Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)	2.04	ZZZ	
	33988	Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	7.62	000	
	33989	Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	4.84	000	
■	33990	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, arterial access only	4.16	000	
■	33991	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, both arterial and venous access, with transeptal puncture	6.13	000	
■	33992	Removal of percutaneous left heart ventricular assist device, arterial or arterial and venous cannula(s), at separate and distinct session from insertion	1.95	000	
■	33993	Repositioning of percutaneous right or left heart ventricular assist device with imaging guidance at separate and distinct session from insertion	1.71	000	
■	33995	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only	3.54	000	
■	33997	Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion	1.61	000	
	33999	Unlisted procedure, cardiac surgery	BR	YYY	
	34001	Embolectomy or thrombectomy, with or without catheter; carotid, subclavian or innominate artery, by neck incision	6.56	090	
	34051	Embolectomy or thrombectomy, with or without catheter; innominate, subclavian artery, by thoracic incision	7.49	090	
	34101	Embolectomy or thrombectomy, with or without catheter; axillary, brachial, innominate, subclavian artery, by arm incision	5.62	090	
	34111	Embolectomy or thrombectomy, with or without catheter; radial or ulnar artery, by arm incision	11.24	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
34151	Embolectomy or thrombectomy, with or without catheter; renal, celiac, mesentery, aortoiliac artery, by abdominal incision	11.24	090	
34201	Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision	9.37	090	
34203	Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision	8.43	090	
34401	Thrombectomy, direct or with catheter; vena cava, iliac vein, by abdominal incision	8.43	090	
34421	Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by leg incision	6.37	090	
34451	Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by abdominal and leg incision	10.77	090	
34471	Thrombectomy, direct or with catheter; subclavian vein, by neck incision	6.56	090	
34490	Thrombectomy, direct or with catheter; axillary and subclavian vein, by arm incision	6.56	090	
34501	Valvuloplasty, femoral vein	6.09	090	
34502	Reconstruction of vena cava, any method	16.30	090	
34510	Venous valve transposition, any vein donor	7.40	090	
34520	Cross-over vein graft to venous system	7.77	090	
34530	Saphenopopliteal vein anastomosis	7.49	090	
34701	Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)	11.99	090	
34702	Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	17.91	090	
34703	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)	13.51	090	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split	
34704	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	22.47	090		
34705	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)	14.88	090		
34706	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	22.40	090		
34707	Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation)	11.18	090		
34708	Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)	17.99	090		
+	34709	Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)	3.15	ZZZ	
	34710	Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; initial vessel treated	7.80	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	34711	Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; each additional vessel treated (List separately in addition to code for primary procedure)	2.91	ZZZ	
	34712	Transcatheter delivery of enhanced fixation device(s) to the endograft (eg, anchor, screw, tack) and all associated radiological supervision and interpretation	6.67	090	
+	34713	Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)	1.26	ZZZ	
+	34714	Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)	2.63	ZZZ	
+	34715	Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)	2.94	ZZZ	
+	34716	Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)	3.65	ZZZ	
■ +	34717	Endovascular repair of iliac artery at the time of aorto-iliac artery endograft placement by deployment of an iliac branched endograft including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for rupture or other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer, traumatic disruption), unilateral (List separately in addition to code for primary procedure)	4.40	ZZZ	
■	34718	Endovascular repair of iliac artery, not associated with placement of an aorto-iliac artery endograft at the same session, by deployment of an iliac branched endograft, including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer), unilateral	12.34	090	
+	34808	Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure)	3.37	ZZZ	
+	34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	2.46	ZZZ	
+	34813	Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to code for primary procedure)	3.37	ZZZ	
+	34820	Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)	4.16	ZZZ	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	34830	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis	15.45	090	
	34831	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bi-iliac prosthesis	17.33	090	
	34832	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bifemoral prosthesis	17.33	090	
+	34833	Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)	3.84	ZZZ	
+	34834	Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (List separately in addition to code for primary procedure)	1.92	ZZZ	
	34839	Physician planning of a patient-specific fenestrated visceral aortic endograft requiring a minimum of 90 minutes of physician time	BR	YYY	
	34841	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)	13.02	YYY	
	34842	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	15.10	YYY	
	34843	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	16.85	YYY	
	34844	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	18.67	YYY	
	34845	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)	16.30	YYY	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
34846	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including two visceral artery endoprotheses (superior mesenteric, celiac and/or renal artery[s])	18.28	YYY	
34847	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including three visceral artery endoprotheses (superior mesenteric, celiac and/or renal artery[s])	20.13	YYY	
34848	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including four or more visceral artery endoprotheses (superior mesenteric, celiac and/or renal artery[s])	21.95	YYY	
35001	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, carotid, subclavian artery, by neck incision	12.64	090	
35002	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, carotid, subclavian artery, by neck incision	12.64	090	
35005	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, vertebral artery	12.64	090	
35011	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision	9.74	090	
35013	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, axillary-brachial artery, by arm incision	10.30	090	
35021	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, innominate, subclavian artery, by thoracic incision	13.11	090	
35022	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, innominate, subclavian artery, by thoracic incision	11.71	090	
35045	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery	8.43	090	
35081	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta	14.98	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
35082	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta	15.45	090	
35091	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)	17.23	090	
35092	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)	18.73	090	
35102	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)	15.92	090	
35103	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)	15.45	090	
35111	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, splenic artery	10.49	090	
35112	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, splenic artery	10.77	090	
35121	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, hepatic, celiac, renal, or mesenteric artery	13.49	090	
35122	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, hepatic, celiac, renal, or mesenteric artery	12.64	090	
35131	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, iliac artery (common, hypogastric, external)	12.64	090	
35132	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, iliac artery (common, hypogastric, external)	13.11	090	
35141	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral)	10.77	090	
35142	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, common femoral artery (profunda femoris, superficial femoral)	10.77	090	
35151	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, popliteal artery	10.77	090	
35152	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, popliteal artery	10.77	090	
35180	Repair, congenital arteriovenous fistula; head and neck	11.24	090	
35182	Repair, congenital arteriovenous fistula; thorax and abdomen	10.30	090	
35184	Repair, congenital arteriovenous fistula; extremities	11.24	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
35188	Repair, acquired or traumatic arteriovenous fistula; head and neck	11.24	090	
35189	Repair, acquired or traumatic arteriovenous fistula; thorax and abdomen	10.30	090	
35190	Repair, acquired or traumatic arteriovenous fistula; extremities	11.24	090	
35201	Repair blood vessel, direct; neck	11.24	090	
35206	Repair blood vessel, direct; upper extremity	9.08	090	
35207	Repair blood vessel, direct; hand, finger	9.65	090	
35211	Repair blood vessel, direct; intrathoracic, with bypass	15.45	090	
35216	Repair blood vessel, direct; intrathoracic, without bypass	13.11	090	
35221	Repair blood vessel, direct; intra-abdominal	13.11	090	
35226	Repair blood vessel, direct; lower extremity	8.62	090	
35231	Repair blood vessel with vein graft; neck	12.17	090	
35236	Repair blood vessel with vein graft; upper extremity	12.17	090	
35241	Repair blood vessel with vein graft; intrathoracic, with bypass	17.33	090	
35246	Repair blood vessel with vein graft; intrathoracic, without bypass	12.64	090	
35251	Repair blood vessel with vein graft; intra-abdominal	12.64	090	
35256	Repair blood vessel with vein graft; lower extremity	12.17	090	
35261	Repair blood vessel with graft other than vein; neck	12.17	090	
35266	Repair blood vessel with graft other than vein; upper extremity	12.17	090	
35271	Repair blood vessel with graft other than vein; intrathoracic, with bypass	17.33	090	
35276	Repair blood vessel with graft other than vein; intrathoracic, without bypass	12.64	090	
35281	Repair blood vessel with graft other than vein; intra-abdominal	12.64	090	
35286	Repair blood vessel with graft other than vein; lower extremity	12.17	090	
35301	Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision	12.17	090	
35302	Thromboendarterectomy, including patch graft, if performed; superficial femoral artery	9.83	090	
35303	Thromboendarterectomy, including patch graft, if performed; popliteal artery	10.30	090	
35304	Thromboendarterectomy, including patch graft, if performed; tibioperoneal trunk artery	10.40	090	
35305	Thromboendarterectomy, including patch graft, if performed; tibial or peroneal artery, initial vessel	10.30	090	
+	35306	Thromboendarterectomy, including patch graft, if performed; each additional tibial or peroneal artery (List separately in addition to code for primary procedure)	4.31	ZZZ
	35311	Thromboendarterectomy, including patch graft, if performed; subclavian, innominate, by thoracic incision	12.17	090
	35321	Thromboendarterectomy, including patch graft, if performed; axillary-brachial	12.17	090
	35331	Thromboendarterectomy, including patch graft, if performed; abdominal aorta	13.58	090
	35341	Thromboendarterectomy, including patch graft, if performed; mesenteric, celiac, or renal	11.24	090
	35351	Thromboendarterectomy, including patch graft, if performed; iliac	11.24	090
	35355	Thromboendarterectomy, including patch graft, if performed; iliofemoral	12.17	090
	35361	Thromboendarterectomy, including patch graft, if performed; combined aortoiliac	13.58	090

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	35363	Thromboendarterectomy, including patch graft, if performed; combined aortoiliofemoral	14.98	090	
	35371	Thromboendarterectomy, including patch graft, if performed; common femoral	9.37	090	
	35372	Thromboendarterectomy, including patch graft, if performed; deep (profunda) femoral	9.37	090	
+	35390	Reoperation, carotid, thromboendarterectomy, more than 1 month after original operation (List separately in addition to code for primary procedure)	2.42	ZZZ	
+	35400	Angioscopy (noncoronary vessels or grafts) during therapeutic intervention (List separately in addition to code for primary procedure)	1.47	ZZZ	
+	35500	Harvest of upper extremity vein, 1 segment, for lower extremity or coronary artery bypass procedure (List separately in addition to code for primary procedure)	2.81	ZZZ	
	35501	Bypass graft, with vein; common carotid-ipsilateral internal carotid	11.24	090	
	35506	Bypass graft, with vein; carotid-subclavian or subclavian-carotid	11.24	090	
	35508	Bypass graft, with vein; carotid-vertebral	12.64	090	
	35509	Bypass graft, with vein; carotid-contralateral carotid	11.24	090	
	35510	Bypass graft, with vein; carotid-brachial	12.18	090	
	35511	Bypass graft, with vein; subclavian-subclavian	11.24	090	
	35512	Bypass graft, with vein; subclavian-brachial	12.18	090	
	35515	Bypass graft, with vein; subclavian-vertebral	12.64	090	
	35516	Bypass graft, with vein; subclavian-axillary	11.24	090	
	35518	Bypass graft, with vein; axillary-axillary	13.11	090	
	35521	Bypass graft, with vein; axillary-femoral	11.24	090	
	35522	Bypass graft, with vein; axillary-brachial	11.24	090	
	35523	Bypass graft, with vein; brachial-ulnar or -radial	11.24	090	
	35525	Bypass graft, with vein; brachial-brachial	11.24	090	
	35526	Bypass graft, with vein; aortosubclavian, aortoinnominate, or aortocarotid	12.46	090	
	35531	Bypass graft, with vein; aortoceliac or aortomesenteric	12.92	090	
	35533	Bypass graft, with vein; axillary-femoral-femoral	16.39	090	
	35535	Bypass graft, with vein; hepatorenal	12.92	090	
	35536	Bypass graft, with vein; splenorenal	12.46	090	
	35537	Bypass graft, with vein; aortoiliac	14.05	090	
	35538	Bypass graft, with vein; aortobi-iliac	17.33	090	
	35539	Bypass graft, with vein; aortofemoral	16.39	090	
	35540	Bypass graft, with vein; aortobifemoral	18.73	090	
	35556	Bypass graft, with vein; femoral-popliteal	12.17	090	
	35558	Bypass graft, with vein; femoral-femoral	11.24	090	
	35560	Bypass graft, with vein; aortorenal	14.05	090	
	35563	Bypass graft, with vein; ilioiliac	11.71	090	
	35565	Bypass graft, with vein; iliofemoral	11.71	090	
	35566	Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels	14.05	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	35570	Bypass graft, with vein; tibial-tibial, peroneal-tibial, or tibial/peroneal trunk-tibial	11.52	090	
	35571	Bypass graft, with vein; popliteal-tibial, -peroneal artery or other distal vessels	14.05	090	
+	35572	Harvest of femoropopliteal vein, 1 segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery) (List separately in addition to code for primary procedure)	4.59	ZZZ	
	35583	In-situ vein bypass; femoral-popliteal	12.83	090	
	35585	In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery	14.70	090	
	35587	In-situ vein bypass; popliteal-tibial, peroneal	11.71	090	
■ ⊖	35600	Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, open	5.06	ZZZ	
	35601	Bypass graft, with other than vein; common carotid-ipsilateral internal carotid	10.77	090	
	35606	Bypass graft, with other than vein; carotid-subclavian	10.77	090	
	35612	Bypass graft, with other than vein; subclavian-subclavian	10.77	090	
	35616	Bypass graft, with other than vein; subclavian-axillary	10.77	090	
	35621	Bypass graft, with other than vein; axillary-femoral	11.24	090	
	35623	Bypass graft, with other than vein; axillary-popliteal or -tibial	14.61	090	
	35626	Bypass graft, with other than vein; aortosubclavian, aortoinnominate, or aortocarotid	11.52	090	
	35631	Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal	11.99	090	
	35632	Bypass graft, with other than vein; ilio-celiac	12.74	090	
	35633	Bypass graft, with other than vein; ilio-mesenteric	13.58	090	
	35634	Bypass graft, with other than vein; iliorenal	12.55	090	
	35636	Bypass graft, with other than vein; splenorenal (splenic to renal arterial anastomosis)	11.52	090	
	35637	Bypass graft, with other than vein; aortoiliac	12.17	090	
	35638	Bypass graft, with other than vein; aortobi-iliac	12.36	090	
	35642	Bypass graft, with other than vein; carotid-vertebral	11.71	090	
	35645	Bypass graft, with other than vein; subclavian-vertebral	11.71	090	
	35646	Bypass graft, with other than vein; aortobifemoral	17.51	090	
	35647	Bypass graft, with other than vein; aortofemoral	13.39	090	
	35650	Bypass graft, with other than vein; axillary-axillary	11.71	090	
	35654	Bypass graft, with other than vein; axillary-femoral-femoral	16.39	090	
	35656	Bypass graft, with other than vein; femoral-popliteal	11.71	090	
	35661	Bypass graft, with other than vein; femoral-femoral	11.24	090	
	35663	Bypass graft, with other than vein; ilioiliac	11.89	090	
	35665	Bypass graft, with other than vein; iliofemoral	11.71	090	
	35666	Bypass graft, with other than vein; femoral-anterior tibial, posterior tibial, or peroneal artery	11.71	090	
	35671	Bypass graft, with other than vein; popliteal-tibial or -peroneal artery	14.05	090	
+	35681	Bypass graft; composite, prosthetic and vein (List separately in addition to code for primary procedure)	0.79	ZZZ	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
+	35682	Bypass graft; autogenous composite, 2 segments of veins from 2 locations (List separately in addition to code for primary procedure)	3.52	ZZZ	
+	35683	Bypass graft; autogenous composite, 3 or more segments of vein from 2 or more locations (List separately in addition to code for primary procedure)	4.09	ZZZ	
+	35685	Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (List separately in addition to code for primary procedure)	2.81	ZZZ	
+	35686	Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis) (List separately in addition to code for primary procedure)	2.90	ZZZ	
	35691	Transposition and/or reimplantation; vertebral to carotid artery	11.24	090	
	35693	Transposition and/or reimplantation; vertebral to subclavian artery	11.24	090	
	35694	Transposition and/or reimplantation; subclavian to carotid artery	11.24	090	
	35695	Transposition and/or reimplantation; carotid to subclavian artery	11.24	090	
+	35697	Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery (List separately in addition to code for primary procedure)	5.62	ZZZ	
+	35700	Reoperation, femoral-popliteal or femoral (popliteal)-anterior tibial, posterior tibial, peroneal artery, or other distal vessels, more than 1 month after original operation (List separately in addition to code for primary procedure)	2.34	ZZZ	
■	35701	Exploration not followed by surgical repair, artery; neck (eg, carotid, subclavian)	5.34	090	
■	35702	Exploration not followed by surgical repair, artery; upper extremity (eg, axillary, brachial, radial, ulnar)	4.16	090	
■	35703	Exploration not followed by surgical repair, artery; lower extremity (eg, common femoral, deep femoral, superficial femoral, popliteal, tibial, peroneal)	4.22	090	
	35800	Exploration for postoperative hemorrhage, thrombosis or infection; neck	5.15	090	
	35820	Exploration for postoperative hemorrhage, thrombosis or infection; chest	7.02	090	
	35840	Exploration for postoperative hemorrhage, thrombosis or infection; abdomen	6.09	090	
	35860	Exploration for postoperative hemorrhage, thrombosis or infection; extremity	4.96	090	
	35870	Repair of graft-enteric fistula	16.86	090	
	35875	Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula);	5.95	090	
	35876	Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula); with revision of arterial or venous graft	7.02	090	
	35879	Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplasty	14.05	090	
	35881	Revision, lower extremity arterial bypass, without thrombectomy, open; with segmental vein interposition	14.61	090	
■	35883	Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium)	10.49	090	
	35884	Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with autogenous vein patch graft	11.14	090	
	35901	Excision of infected graft; neck	5.62	090	
	35903	Excision of infected graft; extremity	5.62	090	
	35905	Excision of infected graft; thorax	7.02	090	
	35907	Excision of infected graft; abdomen	6.74	090	
	36000	Introduction of needle or intracatheter, vein	0.33	XXX	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	36002	Injection procedures (eg, thrombin) for percutaneous treatment of extremity pseudoaneurysm	1.12	000	
	36005	Injection procedure for extremity venography (including introduction of needle or intracatheter)	0.66	000	
	36010	Introduction of catheter, superior or inferior vena cava	1.69	XXX	
	36011	Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein)	1.87	XXX	
	36012	Selective catheter placement, venous system; second order, or more selective, branch (eg, left adrenal vein, petrosal sinus)	2.25	XXX	
	36013	Introduction of catheter, right heart or main pulmonary artery	1.87	XXX	
	36014	Selective catheter placement, left or right pulmonary artery	2.25	XXX	
	36015	Selective catheter placement, segmental or subsegmental pulmonary artery	2.62	XXX	
	36100	Introduction of needle or intracatheter, carotid or vertebral artery	2.06	XXX	
	36140	Introduction of needle or intracatheter, upper or lower extremity artery	1.40	XXX	
	36160	Introduction of needle or intracatheter, aortic, translumbar	2.34	XXX	
	36200	Introduction of catheter, aorta	2.11	000	
	36215	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	2.25	000	
	36216	Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family	2.90	000	
	36217	Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	3.40	000	
+	36218	Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	0.75	ZZZ	
	36221	Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	8.27	000	
	36222	Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	9.74	000	
	36223	Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed	12.20	000	
	36224	Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed	15.50	000	
	36225	Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	11.74	000	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	36226	Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	15.03	000	
+	36227	Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	2.08	ZZZ	
+	36228	Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)	10.67	ZZZ	
	36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	2.34	XXX	
	36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	2.62	000	
	36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	3.28	000	
+	36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	0.61	ZZZ	
	36251	Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral	2.64	000	
	36252	Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral	3.44	000	
	36253	Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral	3.68	000	
	36254	Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral	3.97	000	
	36260	Insertion of implantable intra-arterial infusion pump (eg, for chemotherapy of liver)	5.62	090	
	36261	Revision of implanted intra-arterial infusion pump	2.81	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	36262	Removal of implanted intra-arterial infusion pump	2.34	090	
	36299	Unlisted procedure, vascular injection	BR	YYY	
	36410	Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)	0.19	XXX	
	36415	Collection of venous blood by venipuncture	0.04	XXX	
	36416	Collection of capillary blood specimen (eg, finger, heel, ear stick)	0.04	XXX	
	36425	Venipuncture, cutdown; age 1 or over	0.42	XXX	
	36430	Transfusion, blood or blood components	0.37	XXX	
	36450	Exchange transfusion, blood; newborn	2.34	XXX	
	36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	12.82	000	
	36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	13.39	000	
	36468	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk	BR	000	
	36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)	0.37	000	
	36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	0.84	000	
	36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	12.17	000	
+	36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	2.24	ZZZ	
	36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	18.73	000	
+	36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	3.99	ZZZ	
	36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	18.73	000	
+	36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	4.03	ZZZ	
	36481	Percutaneous portal vein catheterization by any method	4.12	000	
	36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	17.06	000	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
+	36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	1.16	ZZZ	
	36500	Venous catheterization for selective organ blood sampling	1.50	000	
	36510	Catheterization of umbilical vein for diagnosis or therapy, newborn	0.70	000	
	36511	Therapeutic apheresis; for white blood cells	1.59	000	
	36512	Therapeutic apheresis; for red blood cells	1.59	000	
	36513	Therapeutic apheresis; for platelets	1.59	000	
	36514	Therapeutic apheresis; for plasma pheresis	1.59	000	
	36516	Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion	1.59	000	
	36522	Photopheresis, extracorporeal	1.78	000	
	36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age	3.28	000	
	36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	2.81	000	
	36557	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; younger than 5 years of age	6.09	010	
	36558	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older	5.62	010	
	36560	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age	11.71	010	
	36561	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older	11.24	010	
	36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump	11.71	010	
	36565	Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; without subcutaneous port or pump (eg, Tesio type catheter)	9.37	010	
	36566	Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; with subcutaneous port(s)	10.77	010	
■	36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age	2.81	000	
■	36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; age 5 years or older	2.34	000	
	36570	Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age	10.77	010	
	36571	Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older	10.30	010	
■	36573	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older	3.10	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	36575	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site	1.41	000	
	36576	Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	2.34	010	
	36578	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	4.68	010	
	36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	2.34	000	
	36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	4.68	010	
	36582	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access	10.30	010	
	36583	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access	10.30	010	
■	36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the replacement	1.87	000	
	36585	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access	9.37	010	
	36589	Removal of tunneled central venous catheter, without subcutaneous port or pump	1.41	010	
	36590	Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion	2.34	010	
	36591	Collection of blood specimen from a completely implantable venous access device	0.14	XXX	
	36592	Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified	0.19	XXX	
	36593	Declotting by thrombolytic agent of implanted vascular access device or catheter	0.56	XXX	
	36595	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access	7.02	000	
	36596	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen	1.41	000	
	36597	Repositioning of previously placed central venous catheter under fluoroscopic guidance	1.12	000	
	36598	Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report	0.84	000	
	36600	Arterial puncture, withdrawal of blood for diagnosis	0.23	XXX	
■	36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous	0.80	000	
	36625	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); cutdown	0.80	000	
	36640	Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown	1.40	000	
	36660	Catheterization, umbilical artery, newborn, for diagnosis or therapy	0.94	000	
	36680	Placement of needle for intraosseous infusion	0.91	000	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
36800	Insertion of cannula for hemodialysis, other purpose (separate procedure); vein to vein	1.59	000	
36810	Insertion of cannula for hemodialysis, other purpose (separate procedure); arteriovenous, external (Scribner type)	3.75	000	
36815	Insertion of cannula for hemodialysis, other purpose (separate procedure); arteriovenous, external revision, or closure	2.62	000	
36818	Arteriovenous anastomosis, open; by upper arm cephalic vein transposition	6.28	090	
36819	Arteriovenous anastomosis, open; by upper arm basilic vein transposition	6.65	090	
36820	Arteriovenous anastomosis, open; by forearm vein transposition	6.65	090	
36821	Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)	5.81	090	
36823	Insertion of arterial and venous cannula(s) for isolated extracorporeal circulation including regional chemotherapy perfusion to an extremity, with or without hyperthermia, with removal of cannula(s) and repair of arteriotomy and venotomy sites	12.68	090	
36825	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft	7.49	090	
36830	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)	7.54	090	
36831	Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)	5.34	090	
36832	Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	6.32	090	
36833	Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	5.95	090	
36835	Insertion of Thomas shunt (separate procedure)	9.37	090	
■ 36836	Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation	64.40	000	
■ 36837	Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation	76.48	000	
36838	Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)	11.24	090	
36860	External cannula dec clotting (separate procedure); without balloon catheter	1.40	000	
36861	External cannula dec clotting (separate procedure); with balloon catheter	2.15	000	
36901	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report;	4.82	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
36902	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	10.04	000	
36903	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment	45.18	000	
36904	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s);	14.59	000	
36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	18.49	000	
36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit	54.84	000	
+	36907 Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)	6.08	ZZZ	
+	36908 Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)	21.80	ZZZ	
+	36909 Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	15.85	ZZZ	
37140	Venous anastomosis, open; portocaval	14.52	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	37145	Venous anastomosis, open; renoportal	14.52	090	
	37160	Venous anastomosis, open; caval-mesenteric	14.52	090	
	37180	Venous anastomosis, open; splenorenal, proximal	14.52	090	
	37181	Venous anastomosis, open; splenorenal, distal (selective decompression of esophagogastric varices, any technique)	14.52	090	
	37182	Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)	7.99	000	
	37183	Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated imaging guidance and documentation)	3.77	000	
	37184	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	37.55	000	
+	37185	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, 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)	12.17	ZZZ	
+	37186	Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, 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)	25.38	ZZZ	
	37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	36.52	000	
	37188	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	31.56	000	
	37191	Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	2.25	000	
	37192	Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	3.49	000	
	37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	3.49	000	
	37195	Thrombolysis, cerebral, by intravenous infusion	2.41	XXX	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	37197	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed	11.69	000	
	37200	Transcatheter biopsy	3.37	000	
	37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	3.76	000	
	37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	3.30	000	
	37213	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;	2.28	000	
	37214	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method	1.19	000	
	37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection	13.86	090	
	37216	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection	13.30	090	
	37217	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation	10.58	090	
	37218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation	7.93	090	
	37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	4.21	000	
	37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	5.24	000	
+	37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	1.97	ZZZ	
+	37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	2.62	ZZZ	
	37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	4.68	000	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	6.27	000	
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	5.34	000	
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	7.77	000	
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	5.71	000	
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	7.40	000	
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	7.21	000	
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	7.96	000	
+	37232 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	2.25	ZZZ	
+	37233 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	3.09	ZZZ	
+	37234 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	2.81	ZZZ	
+	37235 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	4.03	ZZZ	
37236	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery	30.96	000	
+	37237 Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)	19.48	ZZZ	
37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein	33.54	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	37239	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein (List separately in addition to code for primary procedure)	16.24	ZZZ	
	37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)	38.12	000	
	37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	58.98	000	
	37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	25.29	000	
	37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	54.46	000	
	37246	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery	17.22	000	
+	37247	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)	6.96	ZZZ	
	37248	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein	11.95	000	
+	37249	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure)	5.11	ZZZ	
+	37252	Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)	1.31	ZZZ	
+	37253	Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)	1.03	ZZZ	
	37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	5.71	090	
	37501	Unlisted vascular endoscopy procedure	BR	YYY	
	37565	Ligation, internal jugular vein	4.68	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	37600	Ligation; external carotid artery	4.21	090	
	37605	Ligation; internal or common carotid artery	4.21	090	
	37606	Ligation; internal or common carotid artery, with gradual occlusion, as with Selverstone or Crutchfield clamp	4.68	090	
	37607	Ligation or banding of angioaccess arteriovenous fistula	1.87	090	
	37609	Ligation or biopsy, temporal artery	1.87	010	
	37615	Ligation, major artery (eg, post-traumatic, rupture); neck	3.75	090	
	37616	Ligation, major artery (eg, post-traumatic, rupture); chest	7.02	090	
	37617	Ligation, major artery (eg, post-traumatic, rupture); abdomen	5.62	090	
	37618	Ligation, major artery (eg, post-traumatic, rupture); extremity	4.68	090	
	37619	Ligation of inferior vena cava	15.54	090	
	37650	Ligation of femoral vein	2.81	090	
	37660	Ligation of common iliac vein	2.81	090	
	37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	3.65	090	
	37718	Ligation, division, and stripping, short saphenous vein	3.09	090	
	37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	3.65	090	
	37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia	8.19	090	
	37760	Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open, 1 leg	5.71	090	
	37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	4.31	090	
■	37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	4.21	010	
■	37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions	5.15	010	
	37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)	0.94	090	
	37785	Ligation, division, and/or excision of varicose vein cluster(s), 1 leg	2.34	090	
	37788	Penile revascularization, artery, with or without vein graft	12.92	090	
	37790	Penile venous occlusive procedure	4.87	090	
	37799	Unlisted procedure, vascular surgery	BR	YYY	
	38100	Splenectomy; total (separate procedure)	8.43	090	
	38101	Splenectomy; partial (separate procedure)	8.43	090	
+	38102	Splenectomy; total, en bloc for extensive disease, in conjunction with other procedure (List in addition to code for primary procedure)	4.21	ZZZ	
	38115	Repair of ruptured spleen (splenorrhaphy) with or without partial splenectomy	7.96	090	
	38120	Laparoscopy, surgical, splenectomy	8.43	090	
	38129	Unlisted laparoscopy procedure, spleen	BR	YYY	
	38200	Injection procedure for splenoportography	1.59	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
38204	Management of recipient hematopoietic progenitor cell donor search and cell acquisition	0.94	XXX	
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic	1.59	000	
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous	1.59	000	
38207	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage	0.54	XXX	
38208	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor	0.59	XXX	
38209	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor	0.52	XXX	
38210	Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion	0.56	XXX	
38211	Transplant preparation of hematopoietic progenitor cells; tumor cell depletion	0.56	XXX	
38212	Transplant preparation of hematopoietic progenitor cells; red blood cell removal	0.56	XXX	
38213	Transplant preparation of hematopoietic progenitor cells; platelet depletion	0.56	XXX	
38214	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion	0.47	XXX	
38215	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer	0.56	XXX	
38220	Diagnostic bone marrow; aspiration(s)	0.59	XXX	
38221	Diagnostic bone marrow; biopsy(ies)	0.63	XXX	
38222	Diagnostic bone marrow; biopsy(ies) and aspiration(s)	1.38	XXX	
38230	Bone marrow harvesting for transplantation; allogeneic	3.32	000	
38232	Bone marrow harvesting for transplantation; autologous	1.74	000	
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	2.41	XXX	
38241	Hematopoietic progenitor cell (HPC); autologous transplantation	2.18	XXX	
38242	Allogeneic lymphocyte infusions	2.41	000	
38243	Hematopoietic progenitor cell (HPC); HPC boost	1.04	000	
38300	Drainage of lymph node abscess or lymphadenitis; simple	0.47	010	
38305	Drainage of lymph node abscess or lymphadenitis; extensive	0.94	090	
38308	Lymphangiectomy or other operations on lymphatic channels	1.87	090	
38380	Suture and/or ligation of thoracic duct; cervical approach	4.68	090	
38381	Suture and/or ligation of thoracic duct; thoracic approach	9.37	090	
38382	Suture and/or ligation of thoracic duct; abdominal approach	7.96	090	
38500	Biopsy or excision of lymph node(s); open, superficial	1.69	010	
38505	Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)	0.94	000	
38510	Biopsy or excision of lymph node(s); open, deep cervical node(s)	2.81	010	
38520	Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad	2.34	090	
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)	2.81	090	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	38530	Biopsy or excision of lymph node(s); open, internal mammary node(s)	3.28	090	
■	38531	Biopsy or excision of lymph node(s); open, inguofemoral node(s)	4.64	090	
	38542	Dissection, deep jugular node(s)	3.56	090	
	38550	Excision of cystic hygroma, axillary or cervical; without deep neurovascular dissection	2.81	090	
	38555	Excision of cystic hygroma, axillary or cervical; with deep neurovascular dissection	7.49	090	
	38562	Limited lymphadenectomy for staging (separate procedure); pelvic and para-aortic	7.02	090	
	38564	Limited lymphadenectomy for staging (separate procedure); retroperitoneal (aortic and/or splenic)	7.96	090	
	38570	Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple	7.96	010	
	38571	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy	8.52	010	
	38572	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple	8.90	010	
	38573	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling, peritoneal washings, peritoneal biopsy(ies), omentectomy, and diaphragmatic washings, including diaphragmatic and other serosal biopsy(ies), when performed	11.27	010	
	38589	Unlisted laparoscopy procedure, lymphatic system	BR	YYY	
	38700	Suprahyoid lymphadenectomy	5.62	090	
	38720	Cervical lymphadenectomy (complete)	10.77	090	
	38724	Cervical lymphadenectomy (modified radical neck dissection)	11.24	090	
	38740	Axillary lymphadenectomy; superficial	3.75	090	
	38745	Axillary lymphadenectomy; complete	7.96	090	
+	38746	Thoracic lymphadenectomy by thoracotomy, mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)	2.39	ZZZ	
+	38747	Abdominal lymphadenectomy, regional, including celiac, gastric, portal, peripancreatic, with or without para-aortic and vena caval nodes (List separately in addition to code for primary procedure)	2.67	ZZZ	
	38760	Inguofemoral lymphadenectomy, superficial, including Cloquet's node (separate procedure)	4.68	090	
	38765	Inguofemoral lymphadenectomy, superficial, in continuity with pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)	9.83	090	
	38770	Pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)	8.52	090	
	38780	Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure)	14.05	090	
	38790	Injection procedure; lymphangiography	1.59	000	
	38792	Injection procedure; radioactive tracer for identification of sentinel node	1.40	000	
	38794	Cannulation, thoracic duct	1.40	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)	1.12	ZZZ	
	38999	Unlisted procedure, hemic or lymphatic system	BR	YYY	
	39000	Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; cervical approach	4.03	090	
	39010	Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; transthoracic approach, including either transthoracic or median sternotomy	8.34	090	
	39200	Resection of mediastinal cyst	9.37	090	
	39220	Resection of mediastinal tumor	10.30	090	
	39401	Mediastinoscopy; includes biopsy(ies) of mediastinal mass (eg, lymphoma), when performed	3.02	000	
	39402	Mediastinoscopy; with lymph node biopsy(ies) (eg, lung cancer staging)	3.94	000	
	39499	Unlisted procedure, mediastinum	BR	YYY	
	39501	Repair, laceration of diaphragm, any approach	8.43	090	
	39503	Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia	10.30	090	
	39540	Repair, diaphragmatic hernia (other than neonatal), traumatic; acute	10.68	090	
	39541	Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic	8.05	090	
	39545	Imbrication of diaphragm for eventration, transthoracic or transabdominal, paralytic or nonparalytic	10.30	090	
	39560	Resection, diaphragm; with simple repair (eg, primary suture)	7.49	090	
	39561	Resection, diaphragm; with complex repair (eg, prosthetic material, local muscle flap)	11.24	090	
	39599	Unlisted procedure, diaphragm	BR	YYY	
	40490	Biopsy of lip	0.64	000	
	40500	Vermilionectomy (lip shave), with mucosal advancement	5.66	090	
	40510	Excision of lip; transverse wedge excision with primary closure	5.84	090	
	40520	Excision of lip; V-excision with primary direct linear closure	4.67	090	
	40525	Excision of lip; full thickness, reconstruction with local flap (eg, Estlander or fan)	9.34	090	
	40527	Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)	10.98	090	
	40530	Resection of lip, more than one-fourth, without reconstruction	4.67	090	
	40650	Repair lip, full thickness; vermilion only	2.92	090	
	40652	Repair lip, full thickness; up to half vertical height	3.85	090	
	40654	Repair lip, full thickness; over one-half vertical height, or complex	5.49	090	
	40700	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral	12.85	090	
	40701	Plastic repair of cleft lip/nasal deformity; primary bilateral, 1-stage procedure	14.77	090	
	40702	Plastic repair of cleft lip/nasal deformity; primary bilateral, 1 of 2 stages	12.85	090	
	40720	Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure	10.92	090	
	40761	Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle	15.42	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
40799	Unlisted procedure, lips	BR	YYY	
40800	Drainage of abscess, cyst, hematoma, vestibule of mouth; simple	0.61	010	
40801	Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated	3.15	010	
40804	Removal of embedded foreign body, vestibule of mouth; simple	0.93	010	
40805	Removal of embedded foreign body, vestibule of mouth; complicated	2.80	010	
40806	Incision of labial frenum (frenotomy)	1.40	000	
40808	Biopsy, vestibule of mouth	0.93	010	
40810	Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair	1.17	010	
40812	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair	1.46	010	
40814	Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair	3.50	090	
40816	Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle	4.55	090	
40818	Excision of mucosa of vestibule of mouth as donor graft	1.93	090	
40819	Excision of frenum, labial or buccal (frenulectomy, frenulectomy, frenectomy)	1.64	090	
40820	Destruction of lesion or scar of vestibule of mouth by physical methods (eg, laser, thermal, cryo, chemical)	1.40	010	
40830	Closure of laceration, vestibule of mouth; 2.5 cm or less	0.93	010	
40831	Closure of laceration, vestibule of mouth; over 2.5 cm or complex	2.34	010	
40840	Vestibuloplasty; anterior	4.67	090	
40842	Vestibuloplasty; posterior, unilateral	3.62	090	
40843	Vestibuloplasty; posterior, bilateral	5.14	090	
40844	Vestibuloplasty; entire arch	8.18	090	
40845	Vestibuloplasty; complex (including ridge extension, muscle repositioning)	9.93	090	
40899	Unlisted procedure, vestibule of mouth	BR	YYY	
41000	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual	0.93	010	
41005	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, superficial	1.05	010	
41006	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, deep, supramylohyoid	2.92	090	
41007	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submental space	2.92	090	
41008	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space	2.92	090	
41009	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; masticator space	2.92	090	
41010	Incision of lingual frenum (frenotomy)	1.40	010	
41015	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual	3.04	090	
41016	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submental	2.34	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
41017	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submandibular	3.04	090	
41018	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space	3.04	090	
41019	Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application	3.85	000	
41100	Biopsy of tongue; anterior two-thirds	0.93	010	
41105	Biopsy of tongue; posterior one-third	1.17	010	
41108	Biopsy of floor of mouth	0.82	010	
41110	Excision of lesion of tongue without closure	1.05	010	
41112	Excision of lesion of tongue with closure; anterior two-thirds	2.57	090	
41113	Excision of lesion of tongue with closure; posterior one-third	3.04	090	
41114	Excision of lesion of tongue with closure; with local tongue flap	2.80	090	
41115	Excision of lingual frenum (frenectomy)	1.87	010	
41116	Excision, lesion of floor of mouth	3.50	090	
41120	Glossectomy; less than one-half tongue	6.31	090	
41130	Glossectomy; hemiglossectomy	9.81	090	
41135	Glossectomy; partial, with unilateral radical neck dissection	17.52	090	
41140	Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection	11.45	090	
41145	Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection	19.85	090	
41150	Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection	18.10	090	
41153	Glossectomy; composite procedure with resection floor of mouth, with suprahyoid neck dissection	19.85	090	
41155	Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)	23.94	090	
41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue	1.05	010	
41251	Repair of laceration 2.5 cm or less; posterior one-third of tongue	0.93	010	
41252	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex	4.20	010	
41510	Suture of tongue to lip for micrognathia (Douglas type procedure)	4.20	090	
41512	Tongue base suspension, permanent suture technique	3.97	090	
41520	Frenoplasty (surgical revision of frenum, eg, with Z-plasty)	2.80	090	
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	24.64	000	
41599	Unlisted procedure, tongue, floor of mouth	BR	YYY	
41800	Drainage of abscess, cyst, hematoma from dentoalveolar structures	0.93	010	
41805	Removal of embedded foreign body from dentoalveolar structures; soft tissues	1.05	010	
41806	Removal of embedded foreign body from dentoalveolar structures; bone	1.17	010	
41820	Gingivectomy, excision gingiva, each quadrant	2.34	000	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
41821	Operculectomy, excision pericoronal tissues	0.53	000	
41822	Excision of fibrous tuberosities, dentoalveolar structures	1.17	010	
41823	Excision of osseous tuberosities, dentoalveolar structures	2.69	090	
41825	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair	1.17	010	
41826	Excision of lesion or tumor (except listed above), dentoalveolar structures; with simple repair	2.04	010	
41827	Excision of lesion or tumor (except listed above), dentoalveolar structures; with complex repair	3.21	090	
41828	Excision of hyperplastic alveolar mucosa, each quadrant (specify)	3.39	010	
41830	Alveolectomy, including curettage of osteitis or sequestrectomy	2.80	010	
41850	Destruction of lesion (except excision), dentoalveolar structures	1.17	000	
41870	Periodontal mucosal grafting	2.92	000	
41872	Gingivoplasty, each quadrant (specify)	3.50	090	
41874	Alveoloplasty, each quadrant (specify)	2.45	090	
41899	Unlisted procedure, dentoalveolar structures	BR	YYY	
42000	Drainage of abscess of palate, uvula	1.05	010	
42100	Biopsy of palate, uvula	1.17	010	
42104	Excision, lesion of palate, uvula; without closure	1.69	010	
42106	Excision, lesion of palate, uvula; with simple primary closure	2.16	010	
42107	Excision, lesion of palate, uvula; with local flap closure	3.85	090	
42120	Resection of palate or extensive resection of lesion	6.19	090	
42140	Uvulectomy, excision of uvula	2.45	090	
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	10.57	090	
42160	Destruction of lesion, palate or uvula (thermal, cryo or chemical)	0.70	010	
42180	Repair, laceration of palate; up to 2 cm	1.28	010	
42182	Repair, laceration of palate; over 2 cm or complex	3.15	010	
42200	Palatoplasty for cleft palate, soft and/or hard palate only	13.66	090	
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only	14.37	090	
42210	Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)	18.10	090	
42215	Palatoplasty for cleft palate; major revision	17.52	090	
42220	Palatoplasty for cleft palate; secondary lengthening procedure	13.43	090	
42225	Palatoplasty for cleft palate; attachment pharyngeal flap	11.68	090	
42226	Lengthening of palate, and pharyngeal flap	14.60	090	
42227	Lengthening of palate, with island flap	14.60	090	
42235	Repair of anterior palate, including vomer flap	10.63	090	
42260	Repair of nasolabial fistula	5.84	090	
42280	Maxillary impression for palatal prosthesis	1.05	010	
42281	Insertion of pin-retained palatal prosthesis	2.10	010	
42299	Unlisted procedure, palate, uvula	BR	YYY	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
42300	Drainage of abscess; parotid, simple	0.82	010	
42305	Drainage of abscess; parotid, complicated	1.75	090	
42310	Drainage of abscess; submaxillary or sublingual, intraoral	1.05	010	
42320	Drainage of abscess; submaxillary, external	1.17	010	
42330	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral	1.75	010	
42335	Sialolithotomy; submandibular (submaxillary), complicated, intraoral	3.85	090	
42340	Sialolithotomy; parotid, extraoral or complicated intraoral	5.84	090	
42400	Biopsy of salivary gland; needle	0.70	000	
42405	Biopsy of salivary gland; incisional	1.46	010	
42408	Excision of sublingual salivary cyst (ranula)	2.92	090	
42409	Marsupialization of sublingual salivary cyst (ranula)	2.92	090	
42410	Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection	4.79	090	
42415	Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve	11.10	090	
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	12.26	090	
42425	Excision of parotid tumor or parotid gland; total, en bloc removal with sacrifice of facial nerve	8.18	090	
42426	Excision of parotid tumor or parotid gland; total, with unilateral radical neck dissection	18.10	090	
42440	Excision of submandibular (submaxillary) gland	8.93	090	
42450	Excision of sublingual gland	4.09	090	
42500	Plastic repair of salivary duct, sialodochoplasty; primary or simple	4.67	090	
42505	Plastic repair of salivary duct, sialodochoplasty; secondary or complicated	7.01	090	
42507	Parotid duct diversion, bilateral (Wilke type procedure);	7.59	090	
42509	Parotid duct diversion, bilateral (Wilke type procedure); with excision of both submandibular glands	11.10	090	
42510	Parotid duct diversion, bilateral (Wilke type procedure); with ligation of both submandibular (Wharton's) ducts	9.34	090	
42550	Injection procedure for sialography	0.50	000	
42600	Closure salivary fistula	5.84	090	
42650	Dilation salivary duct	0.35	000	
42660	Dilation and catheterization of salivary duct, with or without injection	0.53	000	
42665	Ligation salivary duct, intraoral	0.70	090	
42699	Unlisted procedure, salivary glands or ducts	BR	YYY	
42700	Incision and drainage abscess; peritonsillar	1.23	010	
42720	Incision and drainage abscess; retropharyngeal or parapharyngeal, intraoral approach	1.99	010	
42725	Incision and drainage abscess; retropharyngeal or parapharyngeal, external approach	3.50	090	
42800	Biopsy; oropharynx	0.82	010	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
42804	Biopsy; nasopharynx, visible lesion, simple	0.82	010	
42806	Biopsy; nasopharynx, survey for unknown primary lesion	1.64	010	
42808	Excision or destruction of lesion of pharynx, any method	2.10	010	
42809	Removal of foreign body from pharynx	1.17	010	
42810	Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues	2.69	090	
42815	Excision branchial cleft cyst, vestige, or fistula, extending beneath subcutaneous tissues and/or into pharynx	6.66	090	
42820	Tonsillectomy and adenoidectomy; younger than age 12	3.39	090	
42821	Tonsillectomy and adenoidectomy; age 12 or over	3.62	090	
42825	Tonsillectomy, primary or secondary; younger than age 12	3.27	090	
42826	Tonsillectomy, primary or secondary; age 12 or over	3.45	090	
42830	Adenoidectomy, primary; younger than age 12	2.45	090	
42831	Adenoidectomy, primary; age 12 or over	2.57	090	
42835	Adenoidectomy, secondary; younger than age 12	2.07	090	
42836	Adenoidectomy, secondary; age 12 or over	2.45	090	
42842	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure	15.77	090	
42844	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with local flap (eg, tongue, buccal)	21.02	090	
42845	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap	21.02	090	
42860	Excision of tonsil tags	2.10	090	
42870	Excision or destruction lingual tonsil, any method (separate procedure)	3.50	090	
42890	Limited pharyngectomy	8.18	090	
42892	Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and posterior pharyngeal walls	10.16	090	
42894	Resection of pharyngeal wall requiring closure with myocutaneous or fasciocutaneous flap or free muscle, skin, or fascial flap with microvascular anastomosis	18.69	090	
42900	Suture pharynx for wound or injury	3.27	010	
42950	Pharyngoplasty (plastic or reconstructive operation on pharynx)	8.18	090	
42953	Pharyngoesophageal repair	10.28	090	
42955	Pharyngostomy (fistulization of pharynx, external for feeding)	2.69	090	
42960	Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy); simple	1.28	010	
42961	Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy); complicated, requiring hospitalization	2.04	090	
42962	Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy); with secondary surgical intervention	2.45	090	
42970	Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); simple, with posterior nasal packs, with or without anterior packs and/or cautery	1.75	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
42971	Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); complicated, requiring hospitalization	2.28	090	
42972	Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); with secondary surgical intervention	2.57	090	
■ 42975	Drug-induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep-disordered breathing, flexible, diagnostic	0.87	000	
42999	Unlisted procedure, pharynx, adenoids, or tonsils	BR	YYY	
43020	Esophagotomy, cervical approach, with removal of foreign body	8.18	090	
43030	Cricopharyngeal myotomy	8.18	090	
43045	Esophagotomy, thoracic approach, with removal of foreign body	11.45	090	
43100	Excision of lesion, esophagus, with primary repair; cervical approach	11.10	090	
43101	Excision of lesion, esophagus, with primary repair; thoracic or abdominal approach	14.01	090	
43107	Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastronomy, with or without pyloroplasty (transhiatal)	11.68	090	
43108	Total or near total esophagectomy, without thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es)	23.94	090	
43112	Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastronomy, with or without pyloroplasty (ie, McKeown esophagectomy or tri-incisional esophagectomy)	16.00	090	
43113	Total or near total esophagectomy, with thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	24.53	090	
43116	Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction	28.03	090	
43117	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastronomy, with or without pyloroplasty (Ivor Lewis)	20.32	090	
43118	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	26.16	090	
43121	Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastronomy, with or without pyloroplasty	18.69	090	
43122	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastronomy, with or without pyloroplasty	20.32	090	
43123	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	25.52	090	
43124	Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagotomy	8.76	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
43130	Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach	8.18	090	
43135	Diverticulectomy of hypopharynx or esophagus, with or without myotomy; thoracic approach	11.68	090	
43180	Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed	4.72	090	
43191	Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)	1.34	000	
43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance	1.46	000	
43193	Esophagoscopy, rigid, transoral; with biopsy, single or multiple	1.47	000	
43194	Esophagoscopy, rigid, transoral; with removal of foreign body(s)	1.68	000	
43195	Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)	1.60	000	
43196	Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire	1.71	000	
43197	Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	1.54	000	
43198	Esophagoscopy, flexible, transnasal; with biopsy, single or multiple	1.70	000	
43200	Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	2.57	000	
43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance	3.85	000	
43202	Esophagoscopy, flexible, transoral; with biopsy, single or multiple	2.80	000	
43204	Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices	3.85	000	
43205	Esophagoscopy, flexible, transoral; with band ligation of esophageal varices	3.85	000	
43206	Esophagoscopy, flexible, transoral; with optical endomicroscopy	2.15	000	
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	3.92	000	
43211	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection	2.08	000	
43212	Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	3.50	000	
43213	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)	2.34	000	
43214	Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	1.70	000	
43215	Esophagoscopy, flexible, transoral; with removal of foreign body(s)	3.74	000	
43216	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	4.09	000	
43217	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.09	000	
43220	Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter)	3.15	000	
43226	Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire	2.80	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
43227	Esophagoscopy, flexible, transoral; with control of bleeding, any method	3.85	000	
43229	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	3.50	000	
43231	Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination	3.09	000	
43232	Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)	3.62	000	
43233	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	2.02	000	
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	2.57	000	
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	4.20	000	
43237	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures	3.10	000	
43238	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)	3.62	000	
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	2.98	000	
43240	Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)	3.85	000	
43241	Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or catheter	3.27	000	
43242	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	3.62	000	
43243	Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices	4.20	000	
43244	Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices	3.97	000	
43245	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)	3.50	000	
43246	Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube	5.14	000	
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	3.50	000	
43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire	3.09	000	
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	3.39	000	
43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	3.85	000	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	3.85	000	
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	2.45	000	
43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	2.33	000	
43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection	2.39	000	
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	4.09	000	
43257	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease	5.61	000	
43259	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis	3.10	000	
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	4.32	000	
43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	4.85	000	
43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	6.77	000	
43263	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi	5.84	000	
43264	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)	7.36	000	
43265	Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)	6.89	000	
43266	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	3.85	000	
43270	Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	4.26	000	
+	43273 Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)	1.64	ZZZ	
	43274 Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent	4.10	000	
	43275 Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	3.34	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	43276	Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged	4.27	000	
	43277	Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct	6.31	000	
	43278	Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed	4.91	000	
	43279	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed	9.34	090	
	43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)	11.56	090	
	43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	12.26	090	
	43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	14.01	090	
+	43283	Laparoscopy, surgical, esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)	1.40	ZZZ	
	43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	5.67	090	
	43285	Removal of esophageal sphincter augmentation device	5.43	090	
	43286	Esophagectomy, total or near total, with laparoscopic mobilization of the abdominal and mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy or esophagogastrostomy (ie, laparoscopic transhiatal esophagectomy)	27.41	090	
	43287	Esophagectomy, distal two-thirds, with laparoscopic mobilization of the abdominal and lower mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with separate thoracoscopic mobilization of the middle and upper mediastinal esophagus and thoracic esophagogastrostomy (ie, laparoscopic thoracoscopic esophagectomy, Ivor Lewis esophagectomy)	31.30	090	
	43288	Esophagectomy, total or near total, with thoracoscopic mobilization of the upper, middle, and lower mediastinal esophagus, with separate laparoscopic proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy or esophagogastrostomy (ie, thoracoscopic, laparoscopic and cervical incision esophagectomy, McKeown esophagectomy, tri-incisional esophagectomy)	32.66	090	
	43289	Unlisted laparoscopy procedure, esophagus	BR	YYY	
■	43290	Esophagogastrroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon	19.45	000	
■	43291	Esophagogastrroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	3.62	000	
	43300	Esophagoplasty (plastic repair or reconstruction), cervical approach; without repair of tracheoesophageal fistula	8.76	090	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
43305	Esophagoplasty (plastic repair or reconstruction), cervical approach; with repair of tracheoesophageal fistula	12.85	090	
43310	Esophagoplasty (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula	14.60	090	
43312	Esophagoplasty (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula	16.58	090	
43313	Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula	17.52	090	
43314	Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; with repair of congenital tracheoesophageal fistula	19.91	090	
43320	Esophagogastrostomy (cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach	11.68	090	
43325	Esophagogastric fundoplasty, with fundic patch (Thal-Nissen procedure)	13.43	090	
43327	Esophagogastric fundoplasty partial or complete; laparotomy	6.31	090	
43328	Esophagogastric fundoplasty partial or complete; thoracotomy	9.23	090	
43330	Esophagomyotomy (Heller type); abdominal approach	10.22	090	
43331	Esophagomyotomy (Heller type); thoracic approach	11.10	090	
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	8.99	090	
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis	9.81	090	
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	9.93	090	
43335	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis	10.74	090	
43336	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis	11.68	090	
43337	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis	12.85	090	
+	43338 Esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)	1.05	ZZZ	
43340	Esophagojejunostomy (without total gastrectomy); abdominal approach	13.43	090	
43341	Esophagojejunostomy (without total gastrectomy); thoracic approach	15.18	090	
43351	Esophagostomy, fistulization of esophagus, external; thoracic approach	9.34	090	
43352	Esophagostomy, fistulization of esophagus, external; cervical approach	7.01	090	
43360	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty	19.04	090	
43361	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	23.71	090	
43400	Ligation, direct, esophageal varices	11.68	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	43405	Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation	6.42	090	
	43410	Suture of esophageal wound or injury; cervical approach	6.77	090	
	43415	Suture of esophageal wound or injury; transthoracic or transabdominal approach	11.21	090	
	43420	Closure of esophagostomy or fistula; cervical approach	7.01	090	
	43425	Closure of esophagostomy or fistula; transthoracic or transabdominal approach	9.46	090	
	43450	Dilation of esophagus, by unguided sound or bougie, single or multiple passes	0.82	000	
	43453	Dilation of esophagus, over guide wire	1.52	000	
	43460	Esophagogastric tamponade, with balloon (Sengstaken type)	2.45	000	
	43496	Free jejunum transfer with microvascular anastomosis	BR	090	
■	43497	Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])	7.06	090	
	43499	Unlisted procedure, esophagus	BR	YYY	
	43500	Gastrotomy; with exploration or foreign body removal	7.01	090	
	43501	Gastrotomy; with suture repair of bleeding ulcer	9.69	090	
	43502	Gastrotomy; with suture repair of pre-existing esophagogastric laceration (eg, Mallory-Weiss)	9.69	090	
	43510	Gastrotomy; with esophageal dilation and insertion of permanent intraluminal tube (eg, Celestin or Mousseaux-Barbin)	6.19	090	
	43520	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)	7.01	090	
	43605	Biopsy of stomach, by laparotomy	8.18	090	
	43610	Excision, local; ulcer or benign tumor of stomach	8.99	090	
	43611	Excision, local; malignant tumor of stomach	10.34	090	
	43620	Gastrectomy, total; with esophagoenterostomy	16.35	090	
	43621	Gastrectomy, total; with Roux-en-Y reconstruction	21.61	090	
	43622	Gastrectomy, total; with formation of intestinal pouch, any type	23.65	090	
	43631	Gastrectomy, partial, distal; with gastroduodenostomy	11.68	090	
	43632	Gastrectomy, partial, distal; with gastrojejunostomy	11.68	090	
	43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	15.42	090	
	43634	Gastrectomy, partial, distal; with formation of intestinal pouch	18.98	090	
+	43635	Vagotomy when performed with partial distal gastrectomy (List separately in addition to code[s] for primary procedure)	4.38	ZZZ	
	43640	Vagotomy including pyloroplasty, with or without gastrotomy; truncal or selective	11.27	090	
	43641	Vagotomy including pyloroplasty, with or without gastrotomy; parietal cell (highly selective)	13.43	090	
	43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	19.62	090	
	43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	21.14	090	
	43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	BR	YYY	
	43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	BR	YYY	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
43651	Laparoscopy, surgical; transection of vagus nerves, truncal	8.18	090	
43652	Laparoscopy, surgical; transection of vagus nerves, selective or highly selective	12.85	090	
43653	Laparoscopy, surgical; gastrostomy, without construction of gastric tube (eg, Stamm procedure) (separate procedure)	7.12	090	
43659	Unlisted laparoscopy procedure, stomach	BR	YYY	
43752	Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)	0.70	000	
43753	Gastric intubation and aspiration(s) therapeutic, necessitating physician's skill (eg, for gastrointestinal hemorrhage), including lavage if performed	0.18	000	
43754	Gastric intubation and aspiration, diagnostic; single specimen (eg, acid analysis)	0.23	000	
43755	Gastric intubation and aspiration, diagnostic; collection of multiple fractional specimens with gastric stimulation, single or double lumen tube (gastric secretory study) (eg, histamine, insulin, pentagastrin, calcium, secretin), includes drug administration	0.64	000	
43756	Duodenal intubation and aspiration, diagnostic, includes image guidance; single specimen (eg, bile study for crystals or afferent loop culture)	0.58	000	
43757	Duodenal intubation and aspiration, diagnostic, includes image guidance; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube, includes drug administration	0.88	000	
43761	Repositioning of a naso- or oro-gastric feeding tube, through the duodenum for enteric nutrition	1.17	000	
■ 43762	Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract	1.76	000	
■ 43763	Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; requiring revision of gastrostomy tract	2.60	000	
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)	10.74	090	
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	12.26	090	
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	9.40	090	
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	12.38	090	
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	9.46	090	
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	11.68	090	
43800	Pyloroplasty	8.18	090	
43810	Gastroduodenostomy	8.76	090	
43820	Gastrojejunostomy; without vagotomy	8.82	090	
43825	Gastrojejunostomy; with vagotomy, any type	10.51	090	
43830	Gastrostomy, open; without construction of gastric tube (eg, Stamm procedure) (separate procedure)	7.12	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	43831	Gastrostomy, open; neonatal, for feeding	7.12	090	
	43832	Gastrostomy, open; with construction of gastric tube (eg, Janeway procedure)	8.18	090	
	43840	Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury	8.76	090	
	43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	16.12	090	
	43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	18.10	090	
	43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	20.44	090	
	43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	20.32	090	
	43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	20.32	090	
	43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	19.85	090	
	43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy	11.68	090	
	43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy	13.43	090	
	43870	Closure of gastrostomy, surgical	5.84	090	
	43880	Closure of gastrocolic fistula	8.76	090	
	43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	BR	YYY	
	43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	BR	YYY	
	43886	Gastric restrictive procedure, open; revision of subcutaneous port component only	3.04	090	
	43887	Gastric restrictive procedure, open; removal of subcutaneous port component only	2.92	090	
	43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	4.09	090	
	43999	Unlisted procedure, stomach	BR	YYY	
	44005	Enterolysis (freeing of intestinal adhesion) (separate procedure)	8.76	090	
	44010	Duodenotomy, for exploration, biopsy(s), or foreign body removal	8.76	090	
+	44015	Tube or needle catheter jejunostomy for enteral alimentation, intraoperative, any method (List separately in addition to primary procedure)	4.03	ZZZ	
	44020	Enterotomy, small intestine, other than duodenum; for exploration, biopsy(s), or foreign body removal	8.76	090	
	44021	Enterotomy, small intestine, other than duodenum; for decompression (eg, Baker tube)	7.59	090	
	44025	Colotomy, for exploration, biopsy(s), or foreign body removal	8.76	090	
	44050	Reduction of volvulus, intussusception, internal hernia, by laparotomy	7.59	090	
	44055	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (eg, Ladd procedure)	10.28	090	
	44100	Biopsy of intestine by capsule, tube, peroral (1 or more specimens)	1.28	000	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	44110	Excision of 1 or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; single enterotomy	7.71	090	
	44111	Excision of 1 or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; multiple enterotomies	11.68	090	
	44120	Enterectomy, resection of small intestine; single resection and anastomosis	10.74	090	
+	44121	Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)	5.37	ZZZ	
	44125	Enterectomy, resection of small intestine; with enterostomy	11.33	090	
	44126	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; without tapering	12.91	090	
	44127	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; with tapering	12.91	090	
+	44128	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)	6.45	ZZZ	
	44130	Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure)	10.28	090	
	44132	Donor enterectomy (including cold preservation), open; from cadaver donor	BR	XXX	
	44133	Donor enterectomy (including cold preservation), open; partial, from living donor	BR	XXX	
	44135	Intestinal allotransplantation; from cadaver donor	BR	XXX	
	44136	Intestinal allotransplantation; from living donor	BR	XXX	
	44137	Removal of transplanted intestinal allograft, complete	BR	XXX	
+	44139	Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)	0.76	ZZZ	
	44140	Colectomy, partial; with anastomosis	11.68	090	
	44141	Colectomy, partial; with skin level cecostomy or colostomy	12.26	090	
	44143	Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)	12.26	090	
	44144	Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula	12.85	090	
	44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)	12.85	090	
	44146	Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy	14.60	090	
	44147	Colectomy, partial; abdominal and transanal approach	16.93	090	
	44150	Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy	14.60	090	
	44151	Colectomy, total, abdominal, without proctectomy; with continent ileostomy	20.44	090	
	44155	Colectomy, total, abdominal, with proctectomy; with ileostomy	18.69	090	
	44156	Colectomy, total, abdominal, with proctectomy; with continent ileostomy	25.69	090	
	44157	Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy, when performed	18.57	090	
	44158	Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, creation of ileal reservoir (S or J), includes loop ileostomy, and rectal mucosectomy, when performed	19.15	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	44160	Colectomy, partial, with removal of terminal ileum with ileocolostomy	12.85	090	
	44180	Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)	7.01	090	
	44186	Laparoscopy, surgical; jejunostomy (eg, for decompression or feeding)	5.49	090	
	44187	Laparoscopy, surgical; ileostomy or jejunostomy, non-tube	8.41	090	
	44188	Laparoscopy, surgical, colostomy or skin level cecostomy	9.34	090	
	44202	Laparoscopy, surgical; enterectomy, resection of small intestine, single resection and anastomosis	10.74	090	
+	44203	Laparoscopy, surgical; each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure)	5.37	ZZZ	
	44204	Laparoscopy, surgical; colectomy, partial, with anastomosis	11.68	090	
	44205	Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy	12.85	090	
	44206	Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)	12.26	090	
	44207	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)	12.85	090	
	44208	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy	14.60	090	
	44210	Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy	14.60	090	
	44211	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, includes rectal mucosectomy, when performed	22.77	090	
	44212	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy	18.69	090	
+	44213	Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)	1.75	ZZZ	
	44227	Laparoscopy, surgical, closure of enterostomy, large or small intestine, with resection and anastomosis	12.96	090	
	44238	Unlisted laparoscopy procedure, intestine (except rectum)	BR	YYY	
	44300	Placement, enterostomy or cecostomy, tube open (eg, for feeding or decompression) (separate procedure)	6.77	090	
	44310	Ileostomy or jejunostomy, non-tube	8.76	090	
	44312	Revision of ileostomy; simple (release of superficial scar) (separate procedure)	3.04	090	
	44314	Revision of ileostomy; complicated (reconstruction in-depth) (separate procedure)	9.34	090	
	44316	Continent ileostomy (Kock procedure) (separate procedure)	14.60	090	
	44320	Colostomy or skin level cecostomy;	6.77	090	
	44322	Colostomy or skin level cecostomy; with multiple biopsies (eg, for congenital megacolon) (separate procedure)	7.94	090	
	44340	Revision of colostomy; simple (release of superficial scar) (separate procedure)	2.98	090	
	44345	Revision of colostomy; complicated (reconstruction in-depth) (separate procedure)	6.77	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
44346	Revision of colostomy; with repair of paracolostomy hernia (separate procedure)	7.94	090	
44360	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	3.27	000	
44361	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple	3.50	000	
44363	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body(s)	3.50	000	
44364	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	3.97	000	
44365	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	3.97	000	
44366	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	4.67	000	
44369	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	3.97	000	
44370	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with transendoscopic stent placement (includes predilation)	4.91	000	
44372	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with placement of percutaneous jejunostomy tube	3.27	000	
44373	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube	3.27	000	
44376	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	3.62	000	
44377	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with biopsy, single or multiple	3.97	000	
44378	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	5.49	000	
44379	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with transendoscopic stent placement (includes predilation)	5.43	000	
44380	Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	2.57	000	
44381	Ileoscopy, through stoma; with transendoscopic balloon dilation	7.45	000	
44382	Ileoscopy, through stoma; with biopsy, single or multiple	3.39	000	
44384	Ileoscopy, through stoma; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	3.85	000	
44385	Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	3.09	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
44386	Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); with biopsy, single or multiple	3.62	000	
44388	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	3.50	000	
44389	Colonoscopy through stoma; with biopsy, single or multiple	4.09	000	
44390	Colonoscopy through stoma; with removal of foreign body(s)	4.09	000	
44391	Colonoscopy through stoma; with control of bleeding, any method	5.61	000	
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	4.79	000	
44394	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.79	000	
44401	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)	4.79	000	
44402	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)	5.26	000	
44403	Colonoscopy through stoma; with endoscopic mucosal resection	2.69	000	
44404	Colonoscopy through stoma; with directed submucosal injection(s), any substance	2.94	000	
44405	Colonoscopy through stoma; with transendoscopic balloon dilation	4.34	000	
44406	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	2.03	000	
44407	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	2.44	000	
44408	Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed	2.05	000	
⊖ 44500	Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)	0.49	000	
44602	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; single perforation	8.76	090	
44603	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; multiple perforations	10.22	090	
44604	Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); without colostomy	8.76	090	
44605	Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); with colostomy	9.93	090	
44615	Intestinal stricturoplasty (enterotomy and enterorrhaphy) with or without dilation, for intestinal obstruction	10.51	090	
44620	Closure of enterostomy, large or small intestine;	6.42	090	
44625	Closure of enterostomy, large or small intestine; with resection and anastomosis other than colorectal	9.11	090	
44626	Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)	10.01	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	44640	Closure of intestinal cutaneous fistula	6.77	090	
	44650	Closure of enteroenteric or enterocolic fistula	8.18	090	
	44660	Closure of enterovesical fistula; without intestinal or bladder resection	8.18	090	
	44661	Closure of enterovesical fistula; with intestine and/or bladder resection	12.85	090	
	44680	Intestinal plication (separate procedure)	10.51	090	
	44700	Exclusion of small intestine from pelvis by mesh or other prosthesis, or native tissue (eg, bladder or omentum)	7.74	090	
+	44701	Intraoperative colonic lavage (List separately in addition to code for primary procedure)	1.17	ZZZ	
	44705	Preparation of fecal microbiota for instillation, including assessment of donor specimen	0.93	XXX	
	44715	Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, including mobilization and fashioning of the superior mesenteric artery and vein	BR	XXX	
	44720	Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; venous anastomosis, each	2.17	XXX	
	44721	Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; arterial anastomosis, each	3.38	XXX	
	44799	Unlisted procedure, small intestine	BR	YYY	
	44800	Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct	7.01	090	
	44820	Excision of lesion of mesentery (separate procedure)	5.84	090	
	44850	Suture of mesentery (separate procedure)	7.01	090	
	44899	Unlisted procedure, Meckel's diverticulum and the mesentery	BR	YYY	
	44900	Incision and drainage of appendiceal abscess, open	4.91	090	
	44950	Appendectomy;	5.61	090	
+	44955	Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure)	3.04	ZZZ	
	44960	Appendectomy; for ruptured appendix with abscess or generalized peritonitis	7.01	090	
	44970	Laparoscopy, surgical, appendectomy	5.61	090	
	44979	Unlisted laparoscopy procedure, appendix	BR	YYY	
	45000	Transrectal drainage of pelvic abscess	2.04	090	
	45005	Incision and drainage of submucosal abscess, rectum	1.64	010	
	45020	Incision and drainage of deep supralelevator, pelvirectal, or retrorectal abscess	2.63	090	
	45100	Biopsy of anorectal wall, anal approach (eg, congenital megacolon)	2.34	090	
	45108	Anorectal myomectomy	5.84	090	
	45110	Proctectomy; complete, combined abdominoperineal, with colostomy	15.18	090	
	45111	Proctectomy; partial resection of rectum, transabdominal approach	12.26	090	
	45112	Proctectomy, combined abdominoperineal, pull-through procedure (eg, colo-anal anastomosis)	15.18	090	
	45113	Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy	18.69	090	
	45114	Proctectomy, partial, with anastomosis; abdominal and transsacral approach	17.52	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
45116	Proctectomy, partial, with anastomosis; transsacral approach only (Kraske type)	12.26	090	
45119	Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy when performed	16.35	090	
45120	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull-through procedure and anastomosis (eg, Swenson, Duhamel, or Soave type operation)	17.52	090	
45121	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with subtotal or total colectomy, with multiple biopsies	15.18	090	
45123	Proctectomy, partial, without anastomosis, perineal approach	9.93	090	
45126	Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), or any combination thereof	28.91	090	
45130	Excision of rectal procidentia, with anastomosis; perineal approach	9.69	090	
45135	Excision of rectal procidentia, with anastomosis; abdominal and perineal approach	16.35	090	
45136	Excision of ileoanal reservoir with ileostomy	10.51	090	
45150	Division of stricture of rectum	4.09	090	
45160	Excision of rectal tumor by proctotomy, transsacral or transcoccygeal approach	10.51	090	
45171	Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)	4.67	090	
45172	Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness)	6.42	090	
45190	Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach	2.34	090	
45300	Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	0.50	000	
45303	Proctosigmoidoscopy, rigid; with dilation (eg, balloon, guide wire, bougie)	0.64	000	
45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple	0.82	000	
45307	Proctosigmoidoscopy, rigid; with removal of foreign body	1.17	000	
45308	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	1.17	000	
45309	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique	1.17	000	
45315	Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique	1.87	000	
45317	Proctosigmoidoscopy, rigid; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	1.75	000	
45320	Proctosigmoidoscopy, rigid; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (eg, laser)	1.87	000	
45321	Proctosigmoidoscopy, rigid; with decompression of volvulus	1.52	000	
45327	Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation)	0.76	000	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	0.96	000	
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	1.40	000	
45332	Sigmoidoscopy, flexible; with removal of foreign body(s)	1.75	000	
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	3.04	000	
45334	Sigmoidoscopy, flexible; with control of bleeding, any method	2.63	000	
45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance	2.63	000	
45337	Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed	2.45	000	
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	3.04	000	
45340	Sigmoidoscopy, flexible; with transendoscopic balloon dilation	1.17	000	
45341	Sigmoidoscopy, flexible; with endoscopic ultrasound examination	1.17	000	
45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)	1.34	000	
45346	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	3.04	000	
45347	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	1.46	000	
45349	Sigmoidoscopy, flexible; with endoscopic mucosal resection	1.76	000	
45350	Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)	4.26	000	
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	3.50	000	
45379	Colonoscopy, flexible; with removal of foreign body(s)	4.09	000	
45380	Colonoscopy, flexible; with biopsy, single or multiple	3.85	000	
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	4.67	000	
45382	Colonoscopy, flexible; with control of bleeding, any method	4.67	000	
45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	4.96	000	
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.96	000	
45386	Colonoscopy, flexible; with transendoscopic balloon dilation	4.32	000	
45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	4.96	000	
45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)	5.26	000	
45390	Colonoscopy, flexible; with endoscopic mucosal resection	2.95	000	
45391	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	2.69	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
45392	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	3.39	000	
45393	Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed	2.24	000	
45395	Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy	18.92	090	
45397	Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy, when performed	20.56	090	
45398	Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)	5.52	000	
45399	Unlisted procedure, colon	1.87	YYY	
45400	Laparoscopy, surgical; proctopexy (for prolapse)	11.10	090	
45402	Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resection	14.95	090	
45499	Unlisted laparoscopy procedure, rectum	BR	YYY	
45500	Proctoplasty; for stenosis	6.42	090	
45505	Proctoplasty; for prolapse of mucous membrane	6.42	090	
45520	Perirectal injection of sclerosing solution for prolapse	0.47	000	
45540	Proctopexy (eg, for prolapse); abdominal approach	10.16	090	
45541	Proctopexy (eg, for prolapse); perineal approach	9.69	090	
45550	Proctopexy (eg, for prolapse); with sigmoid resection, abdominal approach	12.26	090	
45560	Repair of rectocele (separate procedure)	3.97	090	
45562	Exploration, repair, and presacral drainage for rectal injury;	11.10	090	
45563	Exploration, repair, and presacral drainage for rectal injury; with colostomy	12.26	090	
45800	Closure of rectovesical fistula;	11.10	090	
45805	Closure of rectovesical fistula; with colostomy	12.26	090	
45820	Closure of rectourethral fistula;	11.10	090	
45825	Closure of rectourethral fistula; with colostomy	12.26	090	
45900	Reduction of procidentia (separate procedure) under anesthesia	0.70	010	
45905	Dilation of anal sphincter (separate procedure) under anesthesia other than local	1.05	010	
45910	Dilation of rectal stricture (separate procedure) under anesthesia other than local	1.99	010	
45915	Removal of fecal impaction or foreign body (separate procedure) under anesthesia	1.99	010	
45990	Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic	1.05	000	
45999	Unlisted procedure, rectum	BR	YYY	
■ 46020	Placement of seton	0.58	000	
■ 46030	Removal of anal seton, other marker	0.58	000	
46040	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)	2.22	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
46045	Incision and drainage of intramural, intramuscular, or submucosal abscess, transanal, under anesthesia	2.48	090	
46050	Incision and drainage, perianal abscess, superficial	0.93	010	
46060	Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton	5.61	090	
46070	Incision, anal septum (infant)	0.93	090	
46080	Sphincterotomy, anal, division of sphincter (separate procedure)	2.45	010	
46083	Incision of thrombosed hemorrhoid, external	0.67	010	
46200	Fissurectomy, including sphincterotomy, when performed	3.62	090	
46220	Excision of single external papilla or tag, anus	0.70	010	
46221	Hemorrhoidectomy, internal, by rubber band ligation(s)	1.05	010	
46230	Excision of multiple external papillae or tags, anus	0.88	010	
46250	Hemorrhoidectomy, external, 2 or more columns/groups	3.50	090	
46255	Hemorrhoidectomy, internal and external, single column/group;	4.67	090	
46257	Hemorrhoidectomy, internal and external, single column/group; with fissurectomy	4.96	090	
46258	Hemorrhoidectomy, internal and external, single column/group; with fistulectomy, including fissurectomy, when performed	5.26	090	
46260	Hemorrhoidectomy, internal and external, 2 or more columns/groups;	5.84	090	
46261	Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fissurectomy	6.13	090	
46262	Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed	6.42	090	
46270	Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous	3.50	090	
46275	Surgical treatment of anal fistula (fistulectomy/fistulotomy); intersphincteric	5.14	090	
46280	Surgical treatment of anal fistula (fistulectomy/fistulotomy); transsphincteric, suprasphincteric, extrasphincteric or multiple, including placement of seton, when performed	5.96	090	
46285	Surgical treatment of anal fistula (fistulectomy/fistulotomy); second stage	1.87	090	
46288	Closure of anal fistula with rectal advancement flap	5.84	090	
46320	Excision of thrombosed hemorrhoid, external	0.88	010	
46500	Injection of sclerosing solution, hemorrhoids	0.32	010	
46505	Chemodenervation of internal anal sphincter	2.69	010	
46600	Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	0.27	000	
46601	Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed	1.10	000	
46604	Anoscopy; with dilation (eg, balloon, guide wire, bougie)	0.53	000	
46606	Anoscopy; with biopsy, single or multiple	0.53	000	
46607	Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple	1.55	000	
46608	Anoscopy; with removal of foreign body	0.53	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
46610	Anoscopy; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	1.05	000	
46611	Anoscopy; with removal of single tumor, polyp, or other lesion by snare technique	1.05	000	
46612	Anoscopy; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique	1.23	000	
46614	Anoscopy; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	1.17	000	
46615	Anoscopy; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	1.23	000	
46700	Anoplasty, plastic operation for stricture; adult	4.79	090	
46705	Anoplasty, plastic operation for stricture; infant	5.37	090	
46706	Repair of anal fistula with fibrin glue	1.87	010	
46707	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	3.50	090	
46710	Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach	7.59	090	
46712	Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; combined transperineal and transabdominal approach	15.88	090	
46715	Repair of low imperforate anus; with anoperineal fistula (cut-back procedure)	4.67	090	
46716	Repair of low imperforate anus; with transposition of anoperineal or anovestibular fistula	5.84	090	
46730	Repair of high imperforate anus without fistula; perineal or sacroperineal approach	11.68	090	
46735	Repair of high imperforate anus without fistula; combined transabdominal and sacroperineal approaches	12.85	090	
46740	Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach	14.01	090	
46742	Repair of high imperforate anus with rectourethral or rectovaginal fistula; combined transabdominal and sacroperineal approaches	15.42	090	
46744	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach	19.04	090	
46746	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach;	20.96	090	
46748	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach; with vaginal lengthening by intestinal graft or pedicle flaps	23.18	090	
46750	Sphincteroplasty, anal, for incontinence or prolapse; adult	6.42	090	
46751	Sphincteroplasty, anal, for incontinence or prolapse; child	5.84	090	
46753	Graft (Thiersch operation) for rectal incontinence and/or prolapse	4.09	090	
46754	Removal of Thiersch wire or suture, anal canal	0.93	010	
46760	Sphincteroplasty, anal, for incontinence, adult; muscle transplant	8.18	090	
46761	Sphincteroplasty, anal, for incontinence, adult; levator muscle imbrication (Park posterior anal repair)	11.68	090	
46900	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical	0.47	010	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	46910	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation	0.88	010	
	46916	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery	1.05	010	
	46917	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery	2.34	010	
	46922	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision	1.58	010	
	46924	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	3.50	010	
	46930	Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)	0.82	090	
	46940	Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); initial	0.58	010	
	46942	Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); subsequent	0.58	010	
■	46945	Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group, without imaging guidance	0.93	090	
■	46946	Hemorrhoidectomy, internal, by ligation other than rubber band; 2 or more hemorrhoid columns/groups, without imaging guidance	1.40	090	
	46947	Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling	1.64	090	
■	46948	Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy, when performed	4.03	090	
	46999	Unlisted procedure, anus	BR	YYY	
	47000	Biopsy of liver, needle; percutaneous	1.52	000	
+	47001	Biopsy of liver, needle; when done for indicated purpose at time of other major procedure (List separately in addition to code for primary procedure)	0.82	ZZZ	
	47010	Hepatotomy, for open drainage of abscess or cyst, 1 or 2 stages	7.01	090	
	47015	Laparotomy, with aspiration and/or injection of hepatic parasitic (eg, amoebic or echinococcal) cyst(s) or abscess(es)	7.01	090	
	47100	Biopsy of liver, wedge	5.26	090	
	47120	Hepatectomy, resection of liver; partial lobectomy	12.50	090	
	47122	Hepatectomy, resection of liver; trisegmentectomy	17.52	090	
	47125	Hepatectomy, resection of liver; total left lobectomy	17.52	090	
	47130	Hepatectomy, resection of liver; total right lobectomy	17.52	090	
	47133	Donor hepatectomy (including cold preservation), from cadaver donor	BR	XXX	
	47135	Liver allotransplantation, orthotopic, partial or whole, from cadaver or living donor, any age	42.78	090	
	47140	Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III)	30.62	090	
	47141	Donor hepatectomy (including cold preservation), from living donor; total left lobectomy (segments II, III and IV)	34.19	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
47142	Donor hepatectomy (including cold preservation), from living donor; total right lobectomy (segments V, VI, VII and VIII)	41.05	090	
47143	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; without trisegment or lobe split	BR	XXX	
47144	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with trisegment split of whole liver graft into 2 partial liver grafts (ie, left lateral segment [segments II and III] and right trisegment [segments I and IV through VIII])	BR	090	
47145	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with lobe split of whole liver graft into 2 partial liver grafts (ie, left lobe [segments II, III, and IV] and right lobe [segments I and V through VIII])	BR	XXX	
47146	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each	2.89	XXX	
47147	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; arterial anastomosis, each	3.37	XXX	
47300	Marsupialization of cyst or abscess of liver	8.53	090	
47350	Management of liver hemorrhage; simple suture of liver wound or injury	8.53	090	
47360	Management of liver hemorrhage; complex suture of liver wound or injury, with or without hepatic artery ligation	11.68	090	
47361	Management of liver hemorrhage; exploration of hepatic wound, extensive debridement, coagulation and/or suture, with or without packing of liver	14.01	090	
47362	Management of liver hemorrhage; re-exploration of hepatic wound for removal of packing	7.01	090	
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	10.77	090	
47371	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical	11.01	090	
47379	Unlisted laparoscopic procedure, liver	BR	YYY	
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency	12.50	090	
47381	Ablation, open, of 1 or more liver tumor(s); cryosurgical	12.96	090	
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	6.92	010	
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	55.23	010	
47399	Unlisted procedure, liver	BR	YYY	
47400	Hepaticotomy or hepaticostomy with exploration, drainage, or removal of calculus	11.68	090	
47420	Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; without transduodenal sphincterotomy or sphincteroplasty	9.93	090	
47425	Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; with transduodenal sphincterotomy or sphincteroplasty	12.91	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
47460	Transduodenal sphincterotomy or sphincteroplasty, with or without transduodenal extraction of calculus (separate procedure)	9.93	090	
47480	Cholecystotomy or cholecystostomy, open, with exploration, drainage, or removal of calculus (separate procedure)	7.94	090	
47490	Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation	3.50	010	
47531	Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access	2.55	000	
47532	Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access (eg, percutaneous transhepatic cholangiogram)	6.41	000	
47533	Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; external	9.91	000	
47534	Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; internal-external	11.84	000	
47535	Conversion of external biliary drainage catheter to internal-external biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation	8.18	000	
47536	Exchange of biliary drainage catheter (eg, external, internal-external, or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation	5.55	000	
47537	Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (eg, with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation	2.95	000	
47538	Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; existing access	34.77	000	
47539	Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, without placement of separate biliary drainage catheter	38.53	000	
47540	Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, with placement of separate biliary drainage catheter (eg, external or internal-external)	39.37	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	47541	Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (eg, rendezvous procedure), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation, new access	9.44	000	
+	47542	Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty), percutaneous, including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, each duct (List separately in addition to code for primary procedure)	3.72	ZZZ	
+	47543	Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (eg, brush, forceps, and/or needle), including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, single or multiple (List separately in addition to code for primary procedure)	3.84	ZZZ	
+	47544	Removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous, including destruction of calculi by any method (eg, mechanical, electrohydraulic, lithotripsy) when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	8.65	ZZZ	
+	47550	Biliary endoscopy, intraoperative (choledochoscopy) (List separately in addition to code for primary procedure)	1.75	ZZZ	
	47552	Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic, with collection of specimen(s) by brushing and/or washing, when performed (separate procedure)	2.34	000	
	47553	Biliary endoscopy, percutaneous via T-tube or other tract; with biopsy, single or multiple	2.80	000	
	47554	Biliary endoscopy, percutaneous via T-tube or other tract; with removal of calculus/calculi	2.80	000	
	47555	Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) without stent	2.80	000	
	47556	Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) with stent	2.80	000	
	47562	Laparoscopy, surgical; cholecystectomy	8.76	090	
	47563	Laparoscopy, surgical; cholecystectomy with cholangiography	9.34	090	
	47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct	10.28	090	
	47570	Laparoscopy, surgical; cholecystoenterostomy	8.76	090	
	47579	Unlisted laparoscopy procedure, biliary tract	BR	YYY	
	47600	Cholecystectomy;	8.76	090	
	47605	Cholecystectomy; with cholangiography	9.81	090	
	47610	Cholecystectomy with exploration of common duct;	10.28	090	
	47612	Cholecystectomy with exploration of common duct; with choledchoenterostomy	15.77	090	
	47620	Cholecystectomy with exploration of common duct; with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography	11.68	090	
	47700	Exploration for congenital atresia of bile ducts, without repair, with or without liver biopsy, with or without cholangiography	8.76	090	
	47701	Portoenterostomy (eg, Kasai procedure)	16.12	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
47711	Excision of bile duct tumor, with or without primary repair of bile duct; extrahepatic	14.13	090	
47712	Excision of bile duct tumor, with or without primary repair of bile duct; intrahepatic	15.30	090	
47715	Excision of choledochal cyst	10.39	090	
47720	Cholecystoenterostomy; direct	8.76	090	
47721	Cholecystoenterostomy; with gastroenterostomy	11.10	090	
47740	Cholecystoenterostomy; Roux-en-Y	9.93	090	
47741	Cholecystoenterostomy; Roux-en-Y with gastroenterostomy	12.26	090	
47760	Anastomosis, of extrahepatic biliary ducts and gastrointestinal tract	12.26	090	
47765	Anastomosis, of intrahepatic ducts and gastrointestinal tract	13.43	090	
47780	Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract	15.77	090	
47785	Anastomosis, Roux-en-Y, of intrahepatic biliary ducts and gastrointestinal tract	17.52	090	
47800	Reconstruction, plastic, of extrahepatic biliary ducts with end-to-end anastomosis	12.85	090	
47801	Placement of choledochal stent	7.71	090	
47802	U-tube hepaticoenterostomy	13.43	090	
47900	Suture of extrahepatic biliary duct for pre-existing injury (separate procedure)	7.59	090	
47999	Unlisted procedure, biliary tract	BR	YYY	
48000	Placement of drains, peripancreatic, for acute pancreatitis;	7.59	090	
48001	Placement of drains, peripancreatic, for acute pancreatitis; with cholecystostomy, gastrostomy, and jejunostomy	19.15	090	
48020	Removal of pancreatic calculus	10.51	090	
48100	Biopsy of pancreas, open (eg, fine needle aspiration, needle core biopsy, wedge biopsy)	8.18	090	
48102	Biopsy of pancreas, percutaneous needle	1.99	010	
48105	Resection or debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis	20.09	090	
48120	Excision of lesion of pancreas (eg, cyst, adenoma)	10.51	090	
48140	Pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostomy	12.26	090	
48145	Pancreatectomy, distal subtotal, with or without splenectomy; with pancreaticojejunostomy	14.01	090	
48146	Pancreatectomy, distal, near-total with preservation of duodenum (Child-type procedure)	16.35	090	
48148	Excision of ampulla of Vater	14.01	090	
48150	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreaticojejunostomy	23.36	090	
48152	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); without pancreaticojejunostomy	21.61	090	
48153	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreaticojejunostomy	23.36	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	48154	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); without pancreatojejunostomy	21.61	090	
	48155	Pancreatectomy, total	19.85	090	
	48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells	23.94	XXX	
+	48400	Injection procedure for intraoperative pancreatography (List separately in addition to code for primary procedure)	1.87	ZZZ	
	48500	Marsupialization of pancreatic cyst	8.76	090	
	48510	External drainage, pseudocyst of pancreas, open	11.68	090	
	48520	Internal anastomosis of pancreatic cyst to gastrointestinal tract; direct	9.93	090	
	48540	Internal anastomosis of pancreatic cyst to gastrointestinal tract; Roux-en-Y	11.68	090	
	48545	Pancreatorrhaphy for injury	10.28	090	
	48547	Duodenal exclusion with gastrojejunostomy for pancreatic injury	21.02	090	
	48548	Pancreaticojejunostomy, side-to-side anastomosis (Puestow-type operation)	14.72	090	
	48550	Donor pancreatectomy (including cold preservation), with or without duodenal segment for transplantation	BR	XXX	
	48551	Backbench standard preparation of cadaver donor pancreas allograft prior to transplantation, including dissection of allograft from surrounding soft tissues, splenectomy, duodenotomy, ligation of bile duct, ligation of mesenteric vessels, and Y-graft arterial anastomoses from iliac artery to superior mesenteric artery and to splenic artery	BR	XXX	
	48552	Backbench reconstruction of cadaver donor pancreas allograft prior to transplantation, venous anastomosis, each	2.07	XXX	
	48554	Transplantation of pancreatic allograft	22.34	090	
	48556	Removal of transplanted pancreatic allograft	12.35	090	
	48999	Unlisted procedure, pancreas	BR	YYY	
	49000	Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)	7.01	090	
	49002	Reopening of recent laparotomy	7.01	090	
	49010	Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)	7.01	090	
■	49013	Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration	4.08	000	
■	49014	Re-exploration of pelvic wound with removal of preperitoneal pelvic packing, including repacking, when performed	3.40	000	
	49020	Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess, open	6.42	090	
	49040	Drainage of subdiaphragmatic or subphrenic abscess, open	7.94	090	
	49060	Drainage of retroperitoneal abscess, open	7.59	090	
	49062	Drainage of extraperitoneal lymphocele to peritoneal cavity, open	5.84	090	
	49082	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance	0.61	000	
	49083	Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance	0.95	000	
	49084	Peritoneal lavage, including imaging guidance, when performed	0.87	000	
	49180	Biopsy, abdominal or retroperitoneal mass, percutaneous needle	1.75	000	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	49185	Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed	7.62	000	
	49203	Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less	9.34	090	
	49204	Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5.1-10.0 cm diameter	11.68	090	
	49205	Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor greater than 10.0 cm diameter	14.01	090	
	49215	Excision of presacral or sacrococcygeal tumor	13.20	090	
	49250	Umbilectomy, omphalectomy, excision of umbilicus (separate procedure)	4.09	090	
	49255	Omentectomy, epiploectomy, resection of omentum (separate procedure)	5.84	090	
	49320	Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	5.02	010	
	49321	Laparoscopy, surgical; with biopsy (single or multiple)	5.61	010	
	49322	Laparoscopy, surgical; with aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple)	5.61	010	
	49323	Laparoscopy, surgical; with drainage of lymphocele to peritoneal cavity	5.84	090	
	49324	Laparoscopy, surgical; with insertion of tunneled intraperitoneal catheter	3.85	010	
	49325	Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed	3.97	010	
+	49326	Laparoscopy, surgical; with omentopexy (omental tacking procedure) (List separately in addition to code for primary procedure)	2.10	ZZZ	
+	49327	Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	1.28	ZZZ	
	49329	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum	BR	YYY	
	49400	Injection of air or contrast into peritoneal cavity (separate procedure)	0.82	000	
	49402	Removal of peritoneal foreign body from peritoneal cavity	7.01	090	
	49405	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous	6.50	000	
	49406	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous	6.50	000	
	49407	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal	1.17	000	
	49411	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple	1.99	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	49412	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	1.05	ZZZ	
	49418	Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous	3.27	000	
	49419	Insertion of tunneled intraperitoneal catheter, with subcutaneous port (ie, totally implantable)	4.67	090	
	49421	Insertion of tunneled intraperitoneal catheter for dialysis, open	4.67	000	
■	49422	Removal of tunneled intraperitoneal catheter	3.50	000	
	49423	Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)	1.75	000	
	49424	Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube (separate procedure)	0.88	000	
	49425	Insertion of peritoneal-venous shunt	7.36	090	
	49426	Revision of peritoneal-venous shunt	7.36	090	
	49427	Injection procedure (eg, contrast media) for evaluation of previously placed peritoneal-venous shunt	0.76	000	
	49428	Ligation of peritoneal-venous shunt	2.34	010	
	49429	Removal of peritoneal-venous shunt	5.96	010	
+	49435	Insertion of subcutaneous extension to intraperitoneal cannula or catheter with remote chest exit site (List separately in addition to code for primary procedure)	1.17	ZZZ	
	49436	Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter	1.64	010	
	49440	Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	9.34	010	
	49441	Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	10.51	010	
	49442	Insertion of cecostomy or other colonic tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	8.99	010	
	49446	Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	9.11	000	
	49450	Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	6.66	000	
	49451	Replacement of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	7.01	000	
	49452	Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	8.18	000	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
49460	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	7.01	000	
49465	Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including image documentation and report	1.64	000	
49491	Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; reducible	6.42	090	
49492	Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; incarcerated or strangulated	7.33	090	
49495	Repair, initial inguinal hernia, full term infant younger than age 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; reducible	5.84	090	
49496	Repair, initial inguinal hernia, full term infant younger than age 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; incarcerated or strangulated	6.66	090	
49500	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducible	5.26	090	
49501	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; incarcerated or strangulated	6.07	090	
49505	Repair initial inguinal hernia, age 5 years or older; reducible	5.61	090	
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	6.42	090	
49520	Repair recurrent inguinal hernia, any age; reducible	6.42	090	
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	7.36	090	
49525	Repair inguinal hernia, sliding, any age	6.07	090	
49540	Repair lumbar hernia	6.07	090	
49550	Repair initial femoral hernia, any age; reducible	5.26	090	
49553	Repair initial femoral hernia, any age; incarcerated or strangulated	6.07	090	
49555	Repair recurrent femoral hernia; reducible	5.72	090	
49557	Repair recurrent femoral hernia; incarcerated or strangulated	6.54	090	
■ 49591	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible	3.09	000	
■ 49592	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated	4.29	000	
■ 49593	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible	5.16	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
■	49594	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated	6.72	000	
■	49595	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible	6.96	000	
■	49596	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated	9.25	000	
	49600	Repair of small omphalocele, with primary closure	6.42	090	
	49605	Repair of large omphalocele or gastroschisis; with or without prosthesis	10.51	090	
	49606	Repair of large omphalocele or gastroschisis; with removal of prosthesis, final reduction and closure, in operating room	7.88	090	
	49610	Repair of omphalocele (Gross type operation); first stage	6.42	090	
	49611	Repair of omphalocele (Gross type operation); second stage	6.42	090	
■	49613	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible	3.80	000	
■	49614	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated	5.15	000	
■	49615	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible	5.76	000	
■	49616	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated	7.73	000	
■	49617	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible	8.00	000	
■	49618	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated	11.21	000	
■	49621	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; reducible	6.78	000	
■ +	49622	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; incarcerated or strangulated	8.43	000	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■ +	49623	Removal of total or near total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach (ie, open, laparoscopic, robotic) (List separately in addition to code for primary procedure)	1.82	ZZZ	
	49650	Laparoscopy, surgical; repair initial inguinal hernia	5.61	090	
	49651	Laparoscopy, surgical; repair recurrent inguinal hernia	6.42	090	
	49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	BR	YYY	
	49900	Suture, secondary, of abdominal wall for evisceration or dehiscence	5.84	090	
	49904	Omental flap, extra-abdominal (eg, for reconstruction of sternal and chest wall defects)	5.84	090	
+	49905	Omental flap, intra-abdominal (List separately in addition to code for primary procedure)	4.67	ZZZ	
	49906	Free omental flap with microvascular anastomosis	BR	090	
	49999	Unlisted procedure, abdomen, peritoneum and omentum	BR	YYY	
	50010	Renal exploration, not necessitating other specific procedures	7.02	090	
	50020	Drainage of perirenal or renal abscess, open	6.27	090	
	50040	Nephrostomy, nephrotomy with drainage	8.43	090	
	50045	Nephrotomy, with exploration	8.43	090	
	50060	Nephrolithotomy; removal of calculus	8.90	090	
	50065	Nephrolithotomy; secondary surgical operation for calculus	11.24	090	
	50070	Nephrolithotomy; complicated by congenital kidney abnormality	10.86	090	
	50075	Nephrolithotomy; removal of large staghorn calculus filling renal pelvis and calyces (including anatomic pyelolithotomy)	11.52	090	
■	50080	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (eg, stone[s] up to 2 cm in single location of kidney or renal pelvis, nonbranching stones)	9.08	090	
■	50081	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; complex (eg, stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy)	10.44	090	
	50100	Transection or repositioning of aberrant renal vessels (separate procedure)	5.62	090	
	50120	Pyelotomy; with exploration	8.43	090	
	50125	Pyelotomy; with drainage, pyelostomy	8.43	090	
	50130	Pyelotomy; with removal of calculus (pyelolithotomy, pyelolithotomy, including coagulum pyelolithotomy)	8.43	090	
	50135	Pyelotomy; complicated (eg, secondary operation, congenital kidney abnormality)	10.30	090	
	50200	Renal biopsy; percutaneous, by trocar or needle	1.69	000	
	50205	Renal biopsy; by surgical exposure of kidney	4.21	090	
	50220	Nephrectomy, including partial ureterectomy, any open approach including rib resection;	8.43	090	
	50225	Nephrectomy, including partial ureterectomy, any open approach including rib resection; complicated because of previous surgery on same kidney	10.11	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
50230	Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy	12.78	090	
50234	Nephrectomy with total ureterectomy and bladder cuff; through same incision	10.30	090	
50236	Nephrectomy with total ureterectomy and bladder cuff; through separate incision	10.77	090	
50240	Nephrectomy, partial	10.30	090	
50250	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed	9.93	090	
50280	Excision or unroofing of cyst(s) of kidney	7.49	090	
50290	Excision of perinephric cyst	7.49	090	
50300	Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral	BR	XXX	
50320	Donor nephrectomy (including cold preservation); open, from living donor	12.69	090	
50323	Backbench standard preparation of cadaver donor renal allograft prior to transplantation, including dissection and removal of perinephric fat, diaphragmatic and retroperitoneal attachments, excision of adrenal gland, and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary	BR	XXX	
50325	Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation, including dissection and removal of perinephric fat and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary	BR	XXX	
50327	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; venous anastomosis, each	1.91	XXX	
50328	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; arterial anastomosis, each	1.67	XXX	
50329	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; ureteral anastomosis, each	1.56	XXX	
50340	Recipient nephrectomy (separate procedure)	8.43	090	
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy	22.61	090	
50365	Renal allotransplantation, implantation of graft; with recipient nephrectomy	22.76	090	
50370	Removal of transplanted renal allograft	7.49	090	
50380	Renal autotransplantation, reimplantation of kidney	14.98	090	
50382	Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation	14.52	000	
50384	Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation	14.05	000	
50385	Removal (via snare/capture) and replacement of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation	2.90	000	
50386	Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation	2.43	000	
50387	Removal and replacement of externally accessible nephroureteral catheter (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation	7.02	000	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
50389	Removal of nephrostomy tube, requiring fluoroscopic guidance (eg, with concurrent indwelling ureteral stent)	4.87	000	
50390	Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous	1.31	000	
50391	Instillation(s) of therapeutic agent into renal pelvis and/or ureter through established nephrostomy, pyelostomy or ureterostomy tube (eg, anticarcinogenic or antifungal agent)	1.22	000	
50396	Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral catheter	0.47	000	
50400	Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; simple	9.37	090	
50405	Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; complicated (congenital kidney abnormality, secondary pyeloplasty, solitary kidney, calycolasty)	11.24	090	
50430	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access	3.79	000	
50431	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access	1.35	000	
50432	Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	6.37	000	
50433	Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access	8.72	000	
50434	Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract	6.83	000	
50435	Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	0.42	000	
■ 50436	Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed	1.36	000	
■ 50437	Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed; including new access into the renal collecting system	2.27	000	
50500	Nephrorrhaphy, suture of kidney wound or injury	8.43	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
50520	Closure of nephrocutaneous or pyelocutaneous fistula	8.43	090	
50525	Closure of nephrovisceral fistula (eg, renocolic), including visceral repair; abdominal approach	10.30	090	
50526	Closure of nephrovisceral fistula (eg, renocolic), including visceral repair; thoracic approach	10.30	090	
50540	Symphysiotomy for horseshoe kidney with or without pyeloplasty and/or other plastic procedure, unilateral or bilateral (1 operation)	13.11	090	
50541	Laparoscopy, surgical; ablation of renal cysts	7.49	090	
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	8.43	090	
50543	Laparoscopy, surgical; partial nephrectomy	10.30	090	
50544	Laparoscopy, surgical; pyeloplasty	9.37	090	
50545	Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)	13.39	090	
50546	Laparoscopy, surgical; nephrectomy, including partial ureterectomy	8.43	090	
50547	Laparoscopy, surgical; donor nephrectomy (including cold preservation), from living donor	14.98	090	
50548	Laparoscopy, surgical; nephrectomy with total ureterectomy	10.30	090	
50549	Unlisted laparoscopy procedure, renal	BR	YYY	
50551	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	0.94	000	
50553	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter	1.97	000	
50555	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	2.15	000	
50557	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy	2.53	000	
50561	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	3.00	000	
50562	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with resection of tumor	3.61	090	
50570	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	1.12	000	
50572	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter	2.15	000	
50574	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	2.25	000	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	50575	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with endopyelotomy (includes cystoscopy, ureteroscopy, dilation of ureter and ureteral pelvic junction, incision of ureteral pelvic junction and insertion of endopyelotomy stent)	3.75	000	
	50576	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy	2.72	000	
	50580	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	3.18	000	
	50590	Lithotripsy, extracorporeal shock wave	9.37	090	
	50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	46.83	010	
	50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	6.09	010	
	50600	Ureterotomy with exploration or drainage (separate procedure)	7.49	090	
	50605	Ureterotomy for insertion of indwelling stent, all types	4.68	090	
+	50606	Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	5.79	ZZZ	
	50610	Ureterolithotomy; upper one-third of ureter	7.96	090	
	50620	Ureterolithotomy; middle one-third of ureter	7.49	090	
	50630	Ureterolithotomy; lower one-third of ureter	7.96	090	
	50650	Ureterectomy, with bladder cuff (separate procedure)	8.43	090	
	50660	Ureterectomy, total, ectopic ureter, combination abdominal, vaginal and/or perineal approach	9.83	090	
	50684	Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter	0.30	000	
	50686	Manometric studies through ureterostomy or indwelling ureteral catheter	0.37	000	
	50688	Change of ureterostomy tube or externally accessible ureteral stent via ileal conduit	0.33	010	
	50690	Injection procedure for visualization of ileal conduit and/or ureteropyelography, exclusive of radiologic service	0.37	000	
	50693	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract	8.15	000	
	50694	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter	8.95	000	
	50695	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter	10.99	000	
	50700	Ureteroplasty, plastic operation on ureter (eg, stricture)	8.43	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	50705	Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	15.94	ZZZ	
+	50706	Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	8.15	ZZZ	
	50715	Ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis	8.43	090	
	50722	Ureterolysis for ovarian vein syndrome	6.56	090	
	50725	Ureterolysis for retrocaval ureter, with reanastomosis of upper urinary tract or vena cava	11.24	090	
	50727	Revision of urinary-cutaneous anastomosis (any type urostomy);	5.62	090	
	50728	Revision of urinary-cutaneous anastomosis (any type urostomy); with repair of fascial defect and hernia	7.49	090	
	50740	Ureteropyelostomy, anastomosis of ureter and renal pelvis	9.83	090	
	50750	Ureterocalycostomy, anastomosis of ureter to renal calyx	10.30	090	
	50760	Ureteroureterostomy	9.83	090	
	50770	Transureteroureterostomy, anastomosis of ureter to contralateral ureter	10.30	090	
	50780	Ureteroneocystostomy; anastomosis of single ureter to bladder	9.83	090	
	50782	Ureteroneocystostomy; anastomosis of duplicated ureter to bladder	10.77	090	
	50783	Ureteroneocystostomy; with extensive ureteral tailoring	11.24	090	
	50785	Ureteroneocystostomy; with vesico-psoas hitch or bladder flap	11.71	090	
	50800	Ureteroenterostomy, direct anastomosis of ureter to intestine	9.83	090	
	50810	Ureterosigmoidostomy, with creation of sigmoid bladder and establishment of abdominal or perineal colostomy, including intestine anastomosis	14.98	090	
	50815	Ureterocolon conduit, including intestine anastomosis	14.98	090	
	50820	Ureteroileal conduit (ileal bladder), including intestine anastomosis (Bricker operation)	14.98	090	
	50825	Continent diversion, including intestine anastomosis using any segment of small and/or large intestine (Kock pouch or Camey enterocystoplasty)	16.39	090	
	50830	Urinary undiversion (eg, taking down of ureteroileal conduit, ureterosigmoidostomy or ureteroenterostomy with ureteroureterostomy or ureteroneocystostomy)	9.37	090	
	50840	Replacement of all or part of ureter by intestine segment, including intestine anastomosis	14.98	090	
	50845	Cutaneous appendico-vesicostomy	10.68	090	
	50860	Ureterostomy, transplantation of ureter to skin	7.49	090	
	50900	Ureterorrhaphy, suture of ureter (separate procedure)	8.43	090	
	50920	Closure of ureterocutaneous fistula	8.43	090	
	50930	Closure of ureterovisceral fistula (including visceral repair)	10.30	090	
	50940	Deligation of ureter	8.43	090	
	50945	Laparoscopy, surgical; ureterolithotomy	7.49	090	
	50947	Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placement	11.10	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
50948	Laparoscopy, surgical; ureteroneocystostomy without cystoscopy and ureteral stent placement	9.83	090	
50949	Unlisted laparoscopy procedure, ureter	BR	YYY	
50951	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	0.84	000	
50953	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter	1.87	000	
50955	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	2.06	000	
50957	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy	2.43	000	
50961	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	2.90	000	
50970	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	1.03	000	
50972	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter	2.06	000	
50974	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	2.25	000	
50976	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy	2.62	000	
50980	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	3.09	000	
51020	Cystotomy or cystostomy; with fulguration and/or insertion of radioactive material	5.62	090	
51030	Cystotomy or cystostomy; with cryosurgical destruction of intravesical lesion	5.62	090	
51040	Cystostomy, cystostomy with drainage	4.68	090	
51045	Cystotomy, with insertion of ureteral catheter or stent (separate procedure)	5.15	090	
51050	Cystolithotomy, cystostomy with removal of calculus, without vesical neck resection	5.62	090	
51060	Transvesical ureterolithotomy	7.49	090	
51065	Cystotomy, with calculus basket extraction and/or ultrasonic or electrohydraulic fragmentation of ureteral calculus	6.56	090	
51080	Drainage of perivesical or prevesical space abscess	4.21	090	
51100	Aspiration of bladder; by needle	0.35	000	
51101	Aspiration of bladder; by trocar or intracatheter	0.37	000	
51102	Aspiration of bladder; with insertion of suprapubic catheter	0.84	000	
51500	Excision of urachal cyst or sinus, with or without umbilical hernia repair	6.09	090	
51520	Cystotomy; for simple excision of vesical neck (separate procedure)	6.56	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
51525	Cystotomy; for excision of bladder diverticulum, single or multiple (separate procedure)	8.43	090	
51530	Cystotomy; for excision of bladder tumor	6.56	090	
51535	Cystotomy for excision, incision, or repair of ureterocele	6.56	090	
51550	Cystectomy, partial; simple	6.56	090	
51555	Cystectomy, partial; complicated (eg, postradiation, previous surgery, difficult location)	8.43	090	
51565	Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy)	10.30	090	
51570	Cystectomy, complete; (separate procedure)	11.24	090	
51575	Cystectomy, complete; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	16.86	090	
51580	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations;	16.58	090	
51585	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	20.60	090	
51590	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis;	21.35	090	
51595	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	24.54	090	
51596	Cystectomy, complete, with continent diversion, any open technique, using any segment of small and/or large intestine to construct neobladder	23.41	090	
51597	Pelvic exenteration, complete, for vesical, prostatic or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof	26.69	090	
51600	Injection procedure for cystography or voiding urethrocystography	0.28	000	
51605	Injection procedure and placement of chain for contrast and/or chain urethrocystography	0.37	000	
51610	Injection procedure for retrograde urethrocystography	0.42	000	
51700	Bladder irrigation, simple, lavage and/or instillation	0.19	000	
51701	Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)	0.18	000	
51702	Insertion of temporary indwelling bladder catheter; simple (eg, Foley)	0.18	000	
51703	Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)	0.33	000	
51705	Change of cystostomy tube; simple	0.28	000	
51710	Change of cystostomy tube; complicated	1.12	000	
51715	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck	2.25	000	
51720	Bladder instillation of anticarcinogenic agent (including retention time)	0.37	000	
51725	Simple cystometrogram (CMG) (eg, spinal manometer)	0.61	000	85/15
51726	Complex cystometrogram (ie, calibrated electronic equipment);	0.70	000	85/15

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
51727	Complex cystometrogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique	1.24	000	37/63
51728	Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique	1.24	000	37/63
51729	Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique	1.26	000	37/63
51736	Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)	0.30	XXX	85/15
51741	Complex uroflowmetry (eg, calibrated electronic equipment)	0.37	XXX	85/15
51784	Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique	0.66	XXX	85/15
51785	Needle electromyography studies (EMG) of anal or urethral sphincter, any technique	0.66	XXX	85/15
51792	Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)	0.66	000	85/15
+	51797 Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)	0.70	ZZZ	85/15
51798	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	0.70	XXX	85/15
51800	Cystoplasty or cystourethroplasty, plastic operation on bladder and/or vesical neck (anterior Y-plasty, vesical fundus resection), any procedure, with or without wedge resection of posterior vesical neck	9.37	090	
51820	Cystourethroplasty with unilateral or bilateral ureteroneocystostomy	13.58	090	
51840	Anterior vesicourethropey, or urethropey (eg, Marshall-Marchetti-Krantz, Burch); simple	7.30	090	
51841	Anterior vesicourethropey, or urethropey (eg, Marshall-Marchetti-Krantz, Burch); complicated (eg, secondary repair)	8.24	090	
51845	Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, Stamey, Raz, modified Pereyra)	7.02	090	
51860	Cystorrhaphy, suture of bladder wound, injury or rupture; simple	6.56	090	
51865	Cystorrhaphy, suture of bladder wound, injury or rupture; complicated	8.43	090	
51880	Closure of cystostomy (separate procedure)	4.21	090	
51900	Closure of vesicovaginal fistula, abdominal approach	9.83	090	
51920	Closure of vesicouterine fistula;	8.43	090	
51925	Closure of vesicouterine fistula; with hysterectomy	9.83	090	
51940	Closure, exstrophy of bladder	5.62	090	
51960	Enterocystoplasty, including intestinal anastomosis	14.98	090	
51980	Cutaneous vesicostomy	8.43	090	
51990	Laparoscopy, surgical; urethral suspension for stress incontinence	7.30	090	
51992	Laparoscopy, surgical; sling operation for stress incontinence (eg, fascia or synthetic)	7.21	090	
51999	Unlisted laparoscopy procedure, bladder	BR	YYY	
52000	Cystourethroscopy (separate procedure)	1.03	000	
52001	Cystourethroscopy with irrigation and evacuation of multiple obstructing clots	1.55	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	1.69	000	
52007	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis	1.87	000	
52010	Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service	1.78	000	
52204	Cystourethroscopy, with biopsy(s)	1.78	000	
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	1.78	000	
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	1.87	000	
52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)	2.81	000	
52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)	4.68	000	
52240	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)	6.56	000	
52250	Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration	2.15	000	
52260	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	1.69	000	
52265	Cystourethroscopy, with dilation of bladder for interstitial cystitis; local anesthesia	1.78	000	
52270	Cystourethroscopy, with internal urethrotomy; female	2.06	000	
52275	Cystourethroscopy, with internal urethrotomy; male	2.53	000	
52276	Cystourethroscopy with direct vision internal urethrotomy	3.47	000	
52277	Cystourethroscopy, with resection of external sphincter (sphincterotomy)	2.62	000	
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female	1.69	000	
52282	Cystourethroscopy, with insertion of permanent urethral stent	1.78	000	
52283	Cystourethroscopy, with steroid injection into stricture	1.64	000	
■ 52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed	20.98	000	
52285	Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone	2.11	000	
52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder	2.60	000	
52290	Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral	1.87	000	
52300	Cystourethroscopy; with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral	2.53	000	
52301	Cystourethroscopy; with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral	2.53	000	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
52305	Cystourethroscopy; with incision or resection of orifice of bladder diverticulum, single or multiple	2.53	000	
52310	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple	1.87	000	
52315	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated	3.09	000	
52317	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)	3.84	000	
52318	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; complicated or large (over 2.5 cm)	5.15	000	
52320	Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus	3.51	000	
52325	Cystourethroscopy (including ureteral catheterization); with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique)	6.09	000	
52327	Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material	3.75	000	
52330	Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus	2.62	000	
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	2.53	000	
52334	Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde	2.34	000	
52341	Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	3.84	000	
52342	Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	4.21	000	
52343	Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	4.64	000	
52344	Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	4.21	000	
52345	Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	4.64	000	
52346	Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	5.10	000	
52351	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic	4.21	000	
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)	7.49	000	
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	9.37	000	
52354	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion	5.06	000	
52355	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor	5.99	000	
52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	3.80	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	52400	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds	4.21	090	
	52402	Cystourethroscopy with transurethral resection or incision of ejaculatory ducts	2.81	000	
	52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	10.38	000	
+	52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	7.95	ZZZ	
	52450	Transurethral incision of prostate	3.65	090	
	52500	Transurethral resection of bladder neck (separate procedure)	4.68	090	
	52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	7.77	090	
	52630	Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	8.43	090	
	52640	Transurethral resection; of postoperative bladder neck contracture	4.50	090	
	52647	Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)	7.46	090	
	52648	Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	8.10	090	
	52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	9.37	090	
	52700	Transurethral drainage of prostatic abscess	3.47	090	
	53000	Urethrotomy or urethrostomy, external (separate procedure); pendulous urethra	1.12	010	
	53010	Urethrotomy or urethrostomy, external (separate procedure); perineal urethra, external	2.34	090	
	53020	Meatotomy, cutting of meatus (separate procedure); except infant	0.94	000	
	53025	Meatotomy, cutting of meatus (separate procedure); infant	0.47	000	
	53040	Drainage of deep periurethral abscess	1.40	090	
	53060	Drainage of Skene's gland abscess or cyst	0.56	010	
	53080	Drainage of perineal urinary extravasation; uncomplicated (separate procedure)	1.40	090	
	53085	Drainage of perineal urinary extravasation; complicated	2.34	090	
	53200	Biopsy of urethra	0.94	000	
	53210	Urethrectomy, total, including cystostomy; female	6.09	090	
	53215	Urethrectomy, total, including cystostomy; male	7.49	090	
	53220	Excision or fulguration of carcinoma of urethra	4.68	090	
	53230	Excision of urethral diverticulum (separate procedure); female	5.62	090	
	53235	Excision of urethral diverticulum (separate procedure); male	5.62	090	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
53240	Marsupialization of urethral diverticulum, male or female	2.34	090	
53250	Excision of bulbourethral gland (Cowper's gland)	5.15	090	
53260	Excision or fulguration; urethral polyp(s), distal urethra	0.66	010	
53265	Excision or fulguration; urethral caruncle	1.40	010	
53270	Excision or fulguration; Skene's glands	1.40	010	
53275	Excision or fulguration; urethral prolapse	1.87	010	
53400	Urethroplasty; first stage, for fistula, diverticulum, or stricture (eg, Johanssen type)	4.68	090	
53405	Urethroplasty; second stage (formation of urethra), including urinary diversion	6.56	090	
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra	7.49	090	
53415	Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra	8.43	090	
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage	8.43	090	
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage	8.43	090	
53430	Urethroplasty, reconstruction of female urethra	6.56	090	
53431	Urethroplasty with tubularization of posterior urethra and/or lower bladder for incontinence (eg, Tenago, Leadbetter procedure)	8.43	090	
53440	Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)	8.43	090	
53442	Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic)	2.81	090	
53444	Insertion of tandem cuff (dual cuff)	6.13	090	
53445	Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff	7.21	090	
53446	Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff	5.90	090	
53447	Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff at the same operative session	6.56	090	
53448	Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue	9.11	090	
53449	Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff	4.68	090	
53450	Urethromeatoplasty, with mucosal advancement	1.87	090	
■ 53451	Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance	5.87	010	
■ 53452	Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance	3.87	010	
■ 53453	Periurethral transperineal adjustable balloon continence device; removal, each balloon	1.50	000	
■ 53454	Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume	0.45	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
53460	Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)	2.06	090	
53500	Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (eg, postsurgical obstruction, scarring)	5.53	090	
53502	Urethrorrhaphy, suture of urethral wound or injury, female	4.68	090	
53505	Urethrorrhaphy, suture of urethral wound or injury; penile	4.68	090	
53510	Urethrorrhaphy, suture of urethral wound or injury; perineal	6.09	090	
53515	Urethrorrhaphy, suture of urethral wound or injury; prostatomembranous	9.37	090	
53520	Closure of urethrostomy or urethrocuteaneous fistula, male (separate procedure)	3.28	090	
53600	Dilation of urethral stricture by passage of sound or urethral dilator, male; initial	0.28	000	
53601	Dilation of urethral stricture by passage of sound or urethral dilator, male; subsequent	0.21	000	
53605	Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia	0.66	000	
53620	Dilation of urethral stricture by passage of filiform and follower, male; initial	0.40	000	
53621	Dilation of urethral stricture by passage of filiform and follower, male; subsequent	0.32	000	
53660	Dilation of female urethra including suppository and/or instillation; initial	0.23	000	
53661	Dilation of female urethra including suppository and/or instillation; subsequent	0.19	000	
53665	Dilation of female urethra, general or conduction (spinal) anesthesia	0.54	000	
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	18.73	090	
53852	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy	17.79	090	
■ 53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	13.19	090	
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	5.81	000	
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	11.33	090	
53899	Unlisted procedure, urinary system	BR	YYY	
54000	Slitting of prepuce, dorsal or lateral (separate procedure); newborn	0.52	010	
54001	Slitting of prepuce, dorsal or lateral (separate procedure); except newborn	0.75	010	
54015	Incision and drainage of penis, deep	1.22	010	
54050	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical	0.33	010	
54055	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation	0.56	010	
54056	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery	0.59	010	
54057	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery	1.87	010	
54060	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision	1.22	010	
54065	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	2.53	010	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
54100	Biopsy of penis; (separate procedure)	0.56	000	
54105	Biopsy of penis; deep structures	1.03	010	
54110	Excision of penile plaque (Peyronie disease);	3.93	090	
54111	Excision of penile plaque (Peyronie disease); with graft to 5 cm in length	5.81	090	
54112	Excision of penile plaque (Peyronie disease); with graft greater than 5 cm in length	7.68	090	
54115	Removal foreign body from deep penile tissue (eg, plastic implant)	2.58	090	
54120	Amputation of penis; partial	4.68	090	
54125	Amputation of penis; complete	5.62	090	
54130	Amputation of penis, radical; with bilateral inguinofoveal lymphadenectomy	11.24	090	
54135	Amputation of penis, radical; in continuity with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	14.05	090	
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	0.54	000	
54160	Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days of age or less)	0.61	010	
54161	Circumcision, surgical excision other than clamp, device, or dorsal slit; older than 28 days of age	1.80	010	
54162	Lysis or excision of penile post-circumcision adhesions	0.61	010	
54163	Repair incomplete circumcision	0.61	010	
54164	Frenulotomy of penis	0.61	010	
54200	Injection procedure for Peyronie disease;	0.33	010	
54205	Injection procedure for Peyronie disease; with surgical exposure of plaque	3.28	090	
54220	Irrigation of corpora cavernosa for priapism	1.22	000	
54230	Injection procedure for corpora cavernosography	0.98	000	
54231	Dynamic cavernosometry, including intracavernosal injection of vasoactive drugs (eg, papaverine, phentolamine)	1.55	000	
54235	Injection of corpora cavernosa with pharmacologic agent(s) (eg, papaverine, phentolamine)	0.59	000	
54240	Penile plethysmography	0.75	000	85/15
54250	Nocturnal penile tumescence and/or rigidity test	0.94	000	85/15
54300	Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra	4.96	090	
54304	Plastic operation on penis for correction of chordee or for first stage hypospadias repair with or without transplantation of prepuce and/or skin flaps	6.09	090	
54308	Urethroplasty for second stage hypospadias repair (including urinary diversion); less than 3 cm	7.49	090	
54312	Urethroplasty for second stage hypospadias repair (including urinary diversion); greater than 3 cm	8.43	090	
54316	Urethroplasty for second stage hypospadias repair (including urinary diversion) with free skin graft obtained from site other than genitalia	9.37	090	
54318	Urethroplasty for third stage hypospadias repair to release penis from scrotum (eg, third stage Cecil repair)	4.68	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
54322	1-stage distal hypospadias repair (with or without chordee or circumcision); with simple meatal advancement (eg, Magpi, V-flap)	5.85	090	
54324	1-stage distal hypospadias repair (with or without chordee or circumcision); with urethroplasty by local skin flaps (eg, flip-flap, prepuccial flap)	7.96	090	
54326	1-stage distal hypospadias repair (with or without chordee or circumcision); with urethroplasty by local skin flaps and mobilization of urethra	8.99	090	
54328	1-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	10.58	090	
54332	1-stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap	9.74	090	
54336	1-stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap	11.19	090	
■ 54340	Repair of hypospadias complication(s) (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple	5.62	090	
■ 54344	Repair of hypospadias complication(s) (ie, fistula, stricture, diverticula); requiring mobilization of skin flaps and urethroplasty with flap or patch graft	7.49	090	
■ 54348	Repair of hypospadias complication(s) (ie, fistula, stricture, diverticula); requiring extensive dissection, and urethroplasty with flap, patch or tubed graft (including urinary diversion, when performed)	8.52	090	
■ 54352	Revision of prior hypospadias repair 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	12.64	090	
54360	Plastic operation on penis to correct angulation	6.18	090	
54380	Plastic operation on penis for epispadias distal to external sphincter;	5.62	090	
54385	Plastic operation on penis for epispadias distal to external sphincter; with incontinence	9.37	090	
54390	Plastic operation on penis for epispadias distal to external sphincter; with exstrophy of bladder	11.24	090	
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)	8.24	090	
54401	Insertion of penile prosthesis; inflatable (self-contained)	10.21	090	
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir	7.21	090	
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis	5.90	090	
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis	5.62	090	
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	6.56	090	
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue	9.11	090	
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis	4.68	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session	5.01	090	
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue	7.26	090	
54420	Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral	6.56	090	
54430	Corpora cavernosa-corpus spongiosum shunt (priapism operation), unilateral or bilateral	6.56	090	
54435	Corpora cavernosa-glans penis fistulization (eg, biopsy needle, Winter procedure, rongeur, or punch) for priapism	3.75	090	
54437	Repair of traumatic corporeal tear(s)	6.15	090	
54438	Replantation, penis, complete amputation including urethral repair	12.19	090	
54440	Plastic operation of penis for injury	5.15	090	
54450	Foreskin manipulation including lysis of preputial adhesions and stretching	0.61	000	
54500	Biopsy of testis, needle (separate procedure)	0.56	000	
54505	Biopsy of testis, incisional (separate procedure)	1.87	010	
54512	Excision of extraparenchymal lesion of testis	2.81	090	
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach	3.28	090	
54522	Orchiectomy, partial	3.28	090	
54530	Orchiectomy, radical, for tumor; inguinal approach	4.68	090	
54535	Orchiectomy, radical, for tumor; with abdominal exploration	5.34	090	
54550	Exploration for undescended testis (inguinal or scrotal area)	3.75	090	
54560	Exploration for undescended testis with abdominal exploration	5.34	090	
54600	Reduction of torsion of testis, surgical, with or without fixation of contralateral testis	4.21	090	
54620	Fixation of contralateral testis (separate procedure)	2.13	010	
■ 54640	Orchiopexy, inguinal or scrotal approach	5.34	090	
54650	Orchiopexy, abdominal approach, for intra-abdominal testis (eg, Fowler-Stephens)	5.71	090	
54660	Insertion of testicular prosthesis (separate procedure)	1.87	090	
54670	Suture or repair of testicular injury	3.68	090	
54680	Transplantation of testis(es) to thigh (because of scrotal destruction)	4.68	090	
54690	Laparoscopy, surgical; orchiectomy	5.34	090	
54692	Laparoscopy, surgical; orchiopexy for intra-abdominal testis	5.34	090	
54699	Unlisted laparoscopy procedure, testis	BR	YYY	
54700	Incision and drainage of epididymis, testis and/or scrotal space (eg, abscess or hematoma)	1.26	010	
54800	Biopsy of epididymis, needle	0.56	000	
54830	Excision of local lesion of epididymis	2.34	090	
54840	Excision of spermatocele, with or without epididymectomy	3.56	090	
54860	Epididymectomy; unilateral	3.75	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
54861	Epididymectomy; bilateral	5.64	090	
54865	Exploration of epididymis, with or without biopsy	0.94	090	
54900	Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral	4.68	090	
54901	Epididymovasostomy, anastomosis of epididymis to vas deferens; bilateral	6.86	090	
55000	Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication	0.44	000	
55040	Excision of hydrocele; unilateral	3.75	090	
55041	Excision of hydrocele; bilateral	5.81	090	
55060	Repair of tunica vaginalis hydrocele (Bottle type)	2.81	090	
55100	Drainage of scrotal wall abscess	0.54	010	
55110	Scrotal exploration	2.81	090	
55120	Removal of foreign body in scrotum	1.59	090	
55150	Resection of scrotum	4.68	090	
55175	Scrotoplasty; simple	3.75	090	
55180	Scrotoplasty; complicated	5.62	090	
55200	Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)	1.92	090	
55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)	1.87	090	
55300	Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral	2.06	000	
55400	Vasovasostomy, vasovasorrhaphy	7.96	090	
55500	Excision of hydrocele of spermatic cord, unilateral (separate procedure)	2.81	090	
55520	Excision of lesion of spermatic cord (separate procedure)	2.81	090	
55530	Excision of varicocele or ligation of spermatic veins for varicocele; (separate procedure)	4.40	090	
55535	Excision of varicocele or ligation of spermatic veins for varicocele; abdominal approach	4.68	090	
55540	Excision of varicocele or ligation of spermatic veins for varicocele; with hernia repair	4.45	090	
55550	Laparoscopy, surgical, with ligation of spermatic veins for varicocele	4.68	090	
55559	Unlisted laparoscopy procedure, spermatic cord	BR	YYY	
55600	Vesiculotomy;	3.75	090	
55605	Vesiculotomy; complicated	6.09	090	
55650	Vesiculectomy, any approach	9.37	090	
55680	Excision of Mullerian duct cyst	9.37	090	
55700	Biopsy, prostate; needle or punch, single or multiple, any approach	1.17	000	
55705	Biopsy, prostate; incisional, any approach	4.21	010	
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	3.75	010	
55720	Prostatotomy, external drainage of prostatic abscess, any approach; simple	4.21	090	
55725	Prostatotomy, external drainage of prostatic abscess, any approach; complicated	5.43	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
55801	Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)	8.43	090	
55810	Prostatectomy, perineal radical;	12.17	090	
55812	Prostatectomy, perineal radical; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	14.52	090	
55815	Prostatectomy, perineal radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	17.33	090	
55821	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages	9.37	090	
55831	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal	9.37	090	
55840	Prostatectomy, retropubic radical, with or without nerve sparing;	12.17	090	
55842	Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	12.17	090	
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	15.92	090	
55860	Exposure of prostate, any approach, for insertion of radioactive substance;	3.75	090	
55862	Exposure of prostate, any approach, for insertion of radioactive substance; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	6.37	090	
55865	Exposure of prostate, any approach, for insertion of radioactive substance; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	11.24	090	
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	12.17	090	
■ 55867	Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed	9.55	090	
55870	Electroejaculation	1.96	000	
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)	5.62	090	
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	30.62	000	
55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy	4.68	090	
55876	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple	0.84	000	
■ 55880	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance	8.94	090	
55899	Unlisted procedure, male genital system	BR	YYY	
55920	Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application	2.81	000	
55970	Intersex surgery; male to female	BR	YYY	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	55980	Intersex surgery; female to male	BR	YYY	
	56405	Incision and drainage of vulva or perineal abscess	0.70	010	
	56420	Incision and drainage of Bartholin's gland abscess	0.80	010	
	56440	Marsupialization of Bartholin's gland cyst	2.58	010	
	56441	Lysis of labial adhesions	0.52	010	
	56442	Hymenotomy, simple incision	0.47	000	
	56501	Destruction of lesion(s), vulva; simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	0.80	010	
	56515	Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	2.72	010	
	56605	Biopsy of vulva or perineum (separate procedure); 1 lesion	0.61	000	
+	56606	Biopsy of vulva or perineum (separate procedure); each separate additional lesion (List separately in addition to code for primary procedure)	0.30	ZZZ	
	56620	Vulvectomy simple; partial	5.43	090	
	56625	Vulvectomy simple; complete	7.30	090	
	56630	Vulvectomy, radical, partial;	9.37	090	
	56631	Vulvectomy, radical, partial; with unilateral inguinofemoral lymphadenectomy	11.71	090	
	56632	Vulvectomy, radical, partial; with bilateral inguinofemoral lymphadenectomy	14.05	090	
	56633	Vulvectomy, radical, complete;	11.71	090	
	56634	Vulvectomy, radical, complete; with unilateral inguinofemoral lymphadenectomy	14.61	090	
	56637	Vulvectomy, radical, complete; with bilateral inguinofemoral lymphadenectomy	16.06	090	
	56640	Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy	14.52	090	
	56700	Partial hymenectomy or revision of hymenal ring	1.87	010	
	56740	Excision of Bartholin's gland or cyst	2.43	010	
	56800	Plastic repair of introitus	2.81	010	
	56805	Clitoroplasty for intersex state	2.72	090	
	56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)	2.81	010	
	56820	Colposcopy of the vulva;	0.70	000	
	56821	Colposcopy of the vulva; with biopsy(s)	1.05	000	
	57000	Colpotomy; with exploration	2.34	010	
	57010	Colpotomy; with drainage of pelvic abscess	2.58	090	
	57020	Colpocentesis (separate procedure)	0.70	000	
	57022	Incision and drainage of vaginal hematoma; obstetrical/postpartum	0.94	010	
	57023	Incision and drainage of vaginal hematoma; non-obstetrical (eg, post-trauma, spontaneous bleeding)	0.94	010	
	57061	Destruction of vaginal lesion(s); simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	1.40	010	
	57065	Destruction of vaginal lesion(s); extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	2.81	010	
	57100	Biopsy of vaginal mucosa; simple (separate procedure)	0.56	000	
	57105	Biopsy of vaginal mucosa; extensive, requiring suture (including cysts)	1.38	010	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
57106	Vaginectomy, partial removal of vaginal wall;	4.87	090	
57107	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)	6.09	090	
57109	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)	8.66	090	
57110	Vaginectomy, complete removal of vaginal wall;	6.09	090	
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)	7.59	090	
57120	Colpocleisis (Le Fort type)	5.43	090	
57130	Excision of vaginal septum	2.43	010	
57135	Excision of vaginal cyst or tumor	1.87	010	
57150	Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease	0.16	000	
57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy	4.40	000	
57156	Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy	1.87	000	
57160	Fitting and insertion of pessary or other intravaginal support device	0.19	000	
57170	Diaphragm or cervical cap fitting with instructions	0.20	000	
57180	Introduction of any hemostatic agent or pack for spontaneous or traumatic nonobstetrical vaginal hemorrhage (separate procedure)	0.84	010	
57200	Colporrhaphy, suture of injury of vagina (nonobstetrical)	2.81	090	
57210	Colpoperineorrhaphy, suture of injury of vagina and/or perineum (nonobstetrical)	3.04	090	
57220	Plastic operation on urethral sphincter, vaginal approach (eg, Kelly urethral plication)	3.51	090	
57230	Plastic repair of urethrocele	3.28	090	
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed	4.21	090	
57250	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	4.03	090	
57260	Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed;	6.09	090	
57265	Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; with enterocele repair	7.02	090	
+	57267	Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)	2.62	ZZZ
	57268	Repair of enterocele, vaginal approach (separate procedure)	4.68	090
	57270	Repair of enterocele, abdominal approach (separate procedure)	5.24	090
	57280	Colpopexy, abdominal approach	6.56	090
	57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)	6.56	090
	57283	Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)	5.99	090
	57284	Paravaginal defect repair (including repair of cystocele, if performed); open abdominal approach	6.93	090
	57285	Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach	4.96	090

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
57287	Removal or revision of sling for stress incontinence (eg, fascia or synthetic)	5.15	090	
57288	Sling operation for stress incontinence (eg, fascia or synthetic)	7.21	090	
57289	Pereyra procedure, including anterior colporrhaphy	6.56	090	
57291	Construction of artificial vagina; without graft	5.62	090	
57292	Construction of artificial vagina; with graft	10.30	090	
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach	4.92	090	
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach	8.05	090	
57300	Closure of rectovaginal fistula; vaginal or transanal approach	5.62	090	
57305	Closure of rectovaginal fistula; abdominal approach	7.96	090	
57307	Closure of rectovaginal fistula; abdominal approach, with concomitant colostomy	8.43	090	
57308	Closure of rectovaginal fistula; transperineal approach, with perineal body reconstruction, with or without levator plication	7.02	090	
57310	Closure of urethrovaginal fistula;	6.79	090	
57311	Closure of urethrovaginal fistula; with bulbo cavernosus transplant	10.30	090	
57320	Closure of vesicovaginal fistula; vaginal approach	6.79	090	
57330	Closure of vesicovaginal fistula; transvesical and vaginal approach	7.49	090	
57335	Vaginoplasty for intersex state	4.21	090	
57400	Dilation of vagina under anesthesia (other than local)	1.17	000	
57410	Pelvic examination under anesthesia (other than local)	0.84	000	
57415	Removal of impacted vaginal foreign body (separate procedure) under anesthesia (other than local)	1.10	010	
57420	Colposcopy of the entire vagina, with cervix if present;	0.70	000	
57421	Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix	1.05	000	
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach	6.56	090	
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)	6.56	090	
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	5.99	090	
57452	Colposcopy of the cervix including upper/adjacent vagina;	0.70	000	
57454	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage	1.05	000	
57455	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix	0.49	000	
57456	Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage	0.56	000	
57460	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix	2.95	000	
57461	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix	2.95	000	
■ +	57465 Computer-aided mapping of cervix uteri during colposcopy, including optical dynamic spectral imaging and algorithmic quantification of the acetowhitening effect (List separately in addition to code for primary procedure)	0.45	ZZZ	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	0.94	000	
	57505	Endocervical curettage (not done as part of a dilation and curettage)	0.56	010	
	57510	Cautery of cervix; electro or thermal	0.84	010	
	57511	Cautery of cervix; cryocautery, initial or repeat	0.80	010	
	57513	Cautery of cervix; laser ablation	2.81	010	
	57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser	3.37	090	
	57522	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision	3.37	090	
	57530	Trachelectomy (cervicectomy), amputation of cervix (separate procedure)	2.67	090	
	57531	Radical trachelectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling biopsy, with or without removal of tube(s), with or without removal of ovary(s)	13.28	090	
	57540	Excision of cervical stump, abdominal approach;	5.62	090	
	57545	Excision of cervical stump, abdominal approach; with pelvic floor repair	7.02	090	
	57550	Excision of cervical stump, vaginal approach;	4.21	090	
	57555	Excision of cervical stump, vaginal approach; with anterior and/or posterior repair	6.56	090	
	57556	Excision of cervical stump, vaginal approach; with repair of enterocele	5.06	090	
	57558	Dilation and curettage of cervical stump	1.08	010	
	57700	Cerclage of uterine cervix, nonobstetrical	3.28	090	
	57720	Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach	2.76	090	
	57800	Dilation of cervical canal, instrumental (separate procedure)	0.49	000	
	58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	0.66	000	
+	58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)	0.52	ZZZ	
	58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	2.58	010	
	58140	Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; abdominal approach	6.70	090	
	58145	Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; vaginal approach	6.09	090	
	58146	Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g, abdominal approach	8.05	090	
	58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	9.13	090	
	58152	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)	11.71	090	
	58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	8.43	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
58200	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)	11.10	090	
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)	17.79	090	
58240	Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof	19.67	090	
58260	Vaginal hysterectomy, for uterus 250 g or less;	8.80	090	
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)	9.46	090	
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele	10.30	090	
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	11.24	090	
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele	9.74	090	
58275	Vaginal hysterectomy, with total or partial vaginectomy;	9.83	090	
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele	10.77	090	
58285	Vaginal hysterectomy, radical (Schauta type operation)	11.71	090	
58290	Vaginal hysterectomy, for uterus greater than 250 g;	10.58	090	
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	11.33	090	
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele	12.36	090	
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele	11.71	090	
58300	Insertion of intrauterine device (IUD)	0.75	XXX	
58301	Removal of intrauterine device (IUD)	0.28	000	
58321	Artificial insemination; intra-cervical	0.61	000	
58322	Artificial insemination; intra-uterine	0.70	000	
58323	Sperm washing for artificial insemination	0.52	000	
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography	0.84	000	
58345	Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography	2.43	010	
58346	Insertion of Heyman capsules for clinical brachytherapy	4.68	090	
58350	Chromotubation of oviduct, including materials	0.84	010	
58353	Endometrial ablation, thermal, without hysteroscopic guidance	4.40	010	
58356	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed	2.62	010	
58400	Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure)	5.53	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
58410	Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; with presacral sympathectomy	7.49	090	
58520	Hysterorrhaphy, repair of ruptured uterus (nonobstetrical)	4.68	090	
58540	Hysteroplasty, repair of uterine anomaly (Strassman type)	7.02	090	
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;	6.37	090	
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	7.02	090	
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;	7.12	090	
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	7.96	090	
58545	Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 g or less and/or removal of surface myomas	6.70	090	
58546	Laparoscopy, surgical, myomectomy, excision; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g	8.05	090	
58548	Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed	12.17	090	
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;	9.46	090	
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	8.80	090	
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;	10.58	090	
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	11.33	090	
58555	Hysteroscopy, diagnostic (separate procedure)	2.72	000	
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	4.40	000	
58559	Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)	5.24	000	
58560	Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)	5.71	000	
58561	Hysteroscopy, surgical; with removal of leiomyomata	6.74	000	
58562	Hysteroscopy, surgical; with removal of impacted foreign body	5.06	000	
58563	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	7.49	000	
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	6.56	090	
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	7.02	090	
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	7.87	090	
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;	8.43	090	
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	9.83	090	
58575	Laparoscopy, surgical, total hysterectomy for resection of malignancy (tumor debulking), with omentectomy including salpingo-oophorectomy, unilateral or bilateral, when performed	16.86	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	58578	Unlisted laparoscopy procedure, uterus	BR	YYY	
	58579	Unlisted hysteroscopy procedure, uterus	BR	YYY	
■	58580	Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency	22.12	010	
	58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	4.40	090	
	58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)	3.79	090	
+	58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)	2.11	ZZZ	
	58615	Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach	4.21	010	
	58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)	6.84	090	
	58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	6.56	010	
	58662	Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method	7.49	090	
	58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	4.21	090	
	58671	Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)	4.21	090	
	58672	Laparoscopy, surgical; with fimbrioplasty	10.77	090	
	58673	Laparoscopy, surgical; with salpingostomy (salpingoneostomy)	9.83	090	
	58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	7.22	090	
	58679	Unlisted laparoscopy procedure, oviduct, ovary	BR	YYY	
	58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)	5.62	090	
	58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	6.56	090	
	58740	Lysis of adhesions (salpingolysis, ovariolysis)	6.84	090	
	58750	Tubotubal anastomosis	11.24	090	
	58752	Tubouterine implantation	10.30	090	
	58760	Fimbrioplasty	10.77	090	
	58770	Salpingostomy (salpingoneostomy)	9.83	090	
	58800	Drainage of ovarian cyst(s), unilateral or bilateral (separate procedure); vaginal approach	3.47	090	
	58805	Drainage of ovarian cyst(s), unilateral or bilateral (separate procedure); abdominal approach	5.06	090	
	58820	Drainage of ovarian abscess; vaginal approach, open	4.26	090	
	58822	Drainage of ovarian abscess; abdominal approach	5.62	090	
	58825	Transposition, ovary(s)	5.62	090	
	58900	Biopsy of ovary, unilateral or bilateral (separate procedure)	5.06	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
58920	Wedge resection or bisection of ovary, unilateral or bilateral	5.62	090	
58925	Ovarian cystectomy, unilateral or bilateral	6.09	090	
58940	Oophorectomy, partial or total, unilateral or bilateral;	6.09	090	
58943	Oophorectomy, partial or total, unilateral or bilateral; for ovarian, tubal or primary peritoneal malignancy, with para-aortic and pelvic lymph node biopsies, peritoneal washings, peritoneal biopsies, diaphragmatic assessments, with or without salpingectomy(s), with or without omentectomy	10.02	090	
58950	Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy;	9.37	090	
58951	Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy	14.89	090	
58952	Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal or retroperitoneal tumors)	18.08	090	
58953	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;	22.66	090	
58954	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy	24.63	090	
58956	Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy	14.80	090	
58957	Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed;	15.55	090	
58958	Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy	17.23	090	
58960	Laparotomy, for staging or restaging of ovarian, tubal, or primary peritoneal malignancy (second look), with or without omentectomy, peritoneal washing, biopsy of abdominal and pelvic peritoneum, diaphragmatic assessment with pelvic and limited para-aortic lymphadenectomy	10.30	090	
58970	Follicle puncture for oocyte retrieval, any method	4.21	000	
58974	Embryo transfer, intrauterine	1.50	000	
58976	Gamete, zygote, or embryo intrafallopian transfer, any method	5.24	000	
58999	Unlisted procedure, female genital system (nonobstetrical)	BR	YYY	
59000	Amniocentesis; diagnostic	0.94	000	
59001	Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)	1.87	000	
59012	Cordocentesis (intrauterine), any method	2.15	000	
59015	Chorionic villus sampling, any method	1.19	000	
59020	Fetal contraction stress test	0.56	000	85/15
59025	Fetal non-stress test	0.47	000	85/15
59030	Fetal scalp blood sampling	0.56	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
59050	Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation	0.70	XXX	
59051	Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; interpretation only	0.28	XXX	
59070	Transabdominal amnioinfusion, including ultrasound guidance	3.93	000	
59072	Fetal umbilical cord occlusion, including ultrasound guidance	4.68	000	
59074	Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance	3.75	000	
59076	Fetal shunt placement, including ultrasound guidance	4.68	000	
59100	Hysterotomy, abdominal (eg, for hydatidiform mole, abortion)	6.18	090	
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach	7.02	090	
59121	Surgical treatment of ectopic pregnancy; tubal or ovarian, without salpingectomy and/or oophorectomy	6.84	090	
59130	Surgical treatment of ectopic pregnancy; abdominal pregnancy	6.56	090	
59136	Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy with partial resection of uterus	7.68	090	
59140	Surgical treatment of ectopic pregnancy; cervical, with evacuation	5.06	090	
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	6.84	090	
59151	Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy	7.77	090	
59160	Curettage, postpartum	2.43	010	
59200	Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)	0.82	000	
59300	Episiotomy or vaginal repair, by other than attending	1.76	000	
59320	Cerclage of cervix, during pregnancy; vaginal	3.28	000	
59325	Cerclage of cervix, during pregnancy; abdominal	4.68	000	
59350	Hysterorrhaphy of ruptured uterus	5.15	000	
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	8.43	MMM	
59409	Vaginal delivery only (with or without episiotomy and/or forceps);	4.40	MMM	
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	4.87	MMM	
59412	External cephalic version, with or without tocolysis	1.64	MMM	
59414	Delivery of placenta (separate procedure)	1.31	MMM	
59425	Antepartum care only; 4-6 visits	1.19	MMM	
59426	Antepartum care only; 7 or more visits	3.56	MMM	
59430	Postpartum care only (separate procedure)	0.47	MMM	
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	10.11	MMM	
59514	Cesarean delivery only;	6.04	MMM	
59515	Cesarean delivery only; including postpartum care	6.51	MMM	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
+	59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)	3.37	ZZZ	
	59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	9.30	MMM	
	59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);	4.85	MMM	
	59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	5.36	MMM	
	59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	11.17	MMM	
	59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;	6.67	MMM	
	59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care	7.19	MMM	
	59812	Treatment of incomplete abortion, any trimester, completed surgically	2.53	090	
	59820	Treatment of missed abortion, completed surgically; first trimester	2.62	090	
	59821	Treatment of missed abortion, completed surgically; second trimester	3.04	090	
	59830	Treatment of septic abortion, completed surgically	3.75	090	
	59840	Induced abortion, by dilation and curettage	3.00	010	
	59841	Induced abortion, by dilation and evacuation	3.18	010	
	59850	Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;	4.59	090	
	59851	Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation	4.87	090	
	59852	Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed intra-amniotic injection)	6.18	090	
	59855	Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines;	3.42	090	
	59856	Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation	3.70	090	
	59857	Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed medical evacuation)	6.18	090	
	59866	Multifetal pregnancy reduction(s) (MPR)	7.52	000	
	59870	Uterine evacuation and curettage for hydatidiform mole	3.00	090	
	59871	Removal of cerclage suture under anesthesia (other than local)	0.82	000	
	59897	Unlisted fetal invasive procedure, including ultrasound guidance, when performed	BR	YYY	
	59898	Unlisted laparoscopy procedure, maternity care and delivery	BR	YYY	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	59899	Unlisted procedure, maternity care and delivery	BR	YYY	
	60000	Incision and drainage of thyroglossal duct cyst, infected	0.56	010	
	60100	Biopsy thyroid, percutaneous core needle	0.75	000	
	60200	Excision of cyst or adenoma of thyroid, or transection of isthmus	5.15	090	
	60210	Partial thyroid lobectomy, unilateral; with or without isthmusectomy	7.02	090	
	60212	Partial thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy	7.96	090	
	60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	6.84	090	
	60225	Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy	8.52	090	
	60240	Thyroidectomy, total or complete	8.43	090	
	60252	Thyroidectomy, total or subtotal for malignancy; with limited neck dissection	12.17	090	
	60254	Thyroidectomy, total or subtotal for malignancy; with radical neck dissection	14.98	090	
	60260	Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid	7.77	090	
	60270	Thyroidectomy, including substernal thyroid; sternal split or transthoracic approach	9.83	090	
	60271	Thyroidectomy, including substernal thyroid; cervical approach	8.43	090	
	60280	Excision of thyroglossal duct cyst or sinus;	5.62	090	
	60281	Excision of thyroglossal duct cyst or sinus; recurrent	5.90	090	
	60300	Aspiration and/or injection, thyroid cyst	0.94	000	
	60500	Parathyroidectomy or exploration of parathyroid(s);	8.62	090	
	60502	Parathyroidectomy or exploration of parathyroid(s); re-exploration	9.46	090	
	60505	Parathyroidectomy or exploration of parathyroid(s); with mediastinal exploration, sternal split or transthoracic approach	11.24	090	
+	60512	Parathyroid autotransplantation (List separately in addition to code for primary procedure)	1.72	ZZZ	
	60520	Thymectomy, partial or total; transcervical approach (separate procedure)	9.65	090	
	60521	Thymectomy, partial or total; sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure)	9.83	090	
	60522	Thymectomy, partial or total; sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)	12.22	090	
	60540	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure);	9.13	090	
	60545	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure); with excision of adjacent retroperitoneal tumor	11.71	090	
	60600	Excision of carotid body tumor; without excision of carotid artery	9.37	090	
	60605	Excision of carotid body tumor; with excision of carotid artery	10.77	090	
	60650	Laparoscopy, surgical, with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal	8.86	090	
	60659	Unlisted laparoscopy procedure, endocrine system	BR	YYY	
	60699	Unlisted procedure, endocrine system	BR	YYY	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	61000	Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; initial	0.91	000	
	61001	Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; subsequent taps	0.64	000	
	61020	Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; without injection	1.00	000	
	61026	Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; with injection of medication or other substance for diagnosis or treatment	1.00	000	
	61050	Cisternal or lateral cervical (C1-C2) puncture; without injection (separate procedure)	0.91	000	
	61055	Cisternal or lateral cervical (C1-C2) puncture; with injection of medication or other substance for diagnosis or treatment	1.45	000	
	61070	Puncture of shunt tubing or reservoir for aspiration or injection procedure	0.82	000	
	61105	Twist drill hole for subdural or ventricular puncture	4.55	090	
⊖	61107	Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for implanting ventricular catheter, pressure recording device, or other intracerebral monitoring device	5.91	000	
	61108	Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for evacuation and/or drainage of subdural hematoma	9.09	090	
	61120	Burr hole(s) for ventricular puncture (including injection of gas, contrast media, dye, or radioactive material)	4.55	090	
	61140	Burr hole(s) or trephine; with biopsy of brain or intracranial lesion	10.00	090	
	61150	Burr hole(s) or trephine; with drainage of brain abscess or cyst	10.00	090	
	61151	Burr hole(s) or trephine; with subsequent tapping (aspiration) of intracranial abscess or cyst	1.36	090	
	61154	Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural	11.36	090	
	61156	Burr hole(s); with aspiration of hematoma or cyst, intracerebral	10.00	090	
	61210	Burr hole(s); for implanting ventricular catheter, reservoir, EEG electrode(s), pressure recording device, or other cerebral monitoring device (separate procedure)	6.09	000	
	61215	Insertion of subcutaneous reservoir, pump or continuous infusion system for connection to ventricular catheter	5.91	090	
	61250	Burr hole(s) or trephine, supratentorial, exploratory, not followed by other surgery	5.91	090	
	61253	Burr hole(s) or trephine, infratentorial, unilateral or bilateral	9.09	090	
	61304	Craniectomy or craniotomy, exploratory; supratentorial	13.27	090	
	61305	Craniectomy or craniotomy, exploratory; infratentorial (posterior fossa)	14.55	090	
	61312	Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural	15.46	090	
	61313	Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebral	16.36	090	
	61314	Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural	13.64	090	
	61315	Craniectomy or craniotomy for evacuation of hematoma, infratentorial; intracerebellar	15.46	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	61316	Incision and subcutaneous placement of cranial bone graft (List separately in addition to code for primary procedure)	3.45	ZZZ	
	61320	Craniectomy or craniotomy, drainage of intracranial abscess; supratentorial	15.91	090	
	61321	Craniectomy or craniotomy, drainage of intracranial abscess; infratentorial	14.55	090	
	61322	Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; without lobectomy	15.91	090	
	61323	Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; with lobectomy	19.09	090	
	61330	Decompression of orbit only, transcranial approach	12.46	090	
	61333	Exploration of orbit (transcranial approach); with removal of lesion	13.82	090	
	61340	Subtemporal cranial decompression (pseudotumor cerebri, slit ventricle syndrome)	9.18	090	
	61343	Craniectomy, suboccipital with cervical laminectomy for decompression of medulla and spinal cord, with or without dural graft (eg, Arnold-Chiari malformation)	23.09	090	
	61345	Other cranial decompression, posterior fossa	8.64	090	
	61450	Craniectomy, subtemporal, for section, compression, or decompression of sensory root of gasserian ganglion	14.55	090	
	61458	Craniectomy, suboccipital; for exploration or decompression of cranial nerves	18.27	090	
	61460	Craniectomy, suboccipital; for section of 1 or more cranial nerves	17.55	090	
	61500	Craniectomy; with excision of tumor or other bone lesion of skull	15.00	090	
	61501	Craniectomy; for osteomyelitis	11.82	090	
	61510	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	20.46	090	
	61512	Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial	20.46	090	
	61514	Craniectomy, trephination, bone flap craniotomy; for excision of brain abscess, supratentorial	17.27	090	
	61516	Craniectomy, trephination, bone flap craniotomy; for excision or fenestration of cyst, supratentorial	17.27	090	
+	61517	Implantation of brain intracavitary chemotherapy agent (List separately in addition to code for primary procedure)	0.91	ZZZ	
	61518	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull	20.46	090	
	61519	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; meningioma	21.18	090	
	61520	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; cerebellopontine angle tumor	21.18	090	
	61521	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; midline tumor at base of skull	22.91	090	
	61522	Craniectomy, infratentorial or posterior fossa; for excision of brain abscess	17.27	090	
	61524	Craniectomy, infratentorial or posterior fossa; for excision or fenestration of cyst	17.27	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
61526	Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor;	18.18	090	
61530	Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor; combined with middle/posterior fossa craniotomy/craniectomy	19.09	090	
61531	Subdural implantation of strip electrodes through 1 or more burr or trephine hole(s) for long-term seizure monitoring	11.09	090	
61533	Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long-term seizure monitoring	17.73	090	
61534	Craniotomy with elevation of bone flap; for excision of epileptogenic focus without electrocorticography during surgery	18.46	090	
61535	Craniotomy with elevation of bone flap; for removal of epidural or subdural electrode array, without excision of cerebral tissue (separate procedure)	11.82	090	
61536	Craniotomy with elevation of bone flap; for excision of cerebral epileptogenic focus, with electrocorticography during surgery (includes removal of electrode array)	18.18	090	
61537	Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, without electrocorticography during surgery	15.64	090	
61538	Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, with electrocorticography during surgery	16.82	090	
61539	Craniotomy with elevation of bone flap; for lobectomy, other than temporal lobe, partial or total, with electrocorticography during surgery	19.55	090	
61540	Craniotomy with elevation of bone flap; for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery	19.09	090	
61541	Craniotomy with elevation of bone flap; for transection of corpus callosum	22.73	090	
61543	Craniotomy with elevation of bone flap; for partial or subtotal (functional) hemispherectomy	18.18	090	
61544	Craniotomy with elevation of bone flap; for excision or coagulation of choroid plexus	15.91	090	
61545	Craniotomy with elevation of bone flap; for excision of craniopharyngioma	22.73	090	
61546	Craniotomy for hypophysectomy or excision of pituitary tumor, intracranial approach	19.55	090	
61548	Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic	18.64	090	
61550	Craniectomy for craniosynostosis; single cranial suture	11.36	090	
61552	Craniectomy for craniosynostosis; multiple cranial sutures	13.64	090	
61556	Craniotomy for craniosynostosis; frontal or parietal bone flap	13.27	090	
61557	Craniotomy for craniosynostosis; bifrontal bone flap	15.91	090	
61558	Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); not requiring bone grafts	16.36	090	
61559	Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); recontouring with multiple osteotomies and bone autografts (eg, barrel-stave procedure) (includes obtaining grafts)	19.55	090	
61563	Excision, intra and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); without optic nerve decompression	17.91	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
61564	Excision, intra and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); with optic nerve decompression	21.55	090	
61566	Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy	18.73	090	
61567	Craniotomy with elevation of bone flap; for multiple subpial transections, with electrocorticography during surgery	21.37	090	
61570	Craniectomy or craniotomy; with excision of foreign body from brain	20.37	090	
61571	Craniectomy or craniotomy; with treatment of penetrating wound of brain	20.37	090	
61575	Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion;	14.09	090	
61576	Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion; requiring splitting of tongue and/or mandible (including tracheostomy)	15.00	090	
61580	Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration	11.36	090	
61581	Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, orbital exenteration, ethmoidectomy, sphenoidectomy and/or maxillectomy	15.91	090	
61582	Craniofacial approach to anterior cranial fossa; extradural, including unilateral or bifrontal craniotomy, elevation of frontal lobe(s), osteotomy of base of anterior cranial fossa	16.36	090	
61583	Craniofacial approach to anterior cranial fossa; intradural, including unilateral or bifrontal craniotomy, elevation or resection of frontal lobe, osteotomy of base of anterior cranial fossa	17.27	090	
61584	Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); without orbital exenteration	11.36	090	
61585	Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); with orbital exenteration	15.91	090	
61586	Bicoronal, transzygomatic and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft	11.36	090	
61590	Infratemporal pre-auricular approach to middle cranial fossa (parapharyngeal space, infratemporal and midline skull base, nasopharynx), with or without disarticulation of the mandible, including parotidectomy, craniotomy, decompression and/or mobilization of the facial nerve and/or petrous carotid artery	36.15	090	
61591	Infratemporal post-auricular approach to middle cranial fossa (internal auditory meatus, petrous apex, tentorium, cavernous sinus, parasellar area, infratemporal fossa) including mastoidectomy, resection of sigmoid sinus, with or without decompression and/or mobilization of contents of auditory canal or petrous carotid artery	37.91	090	
61592	Orbitocranial zygomatic approach to middle cranial fossa (cavernous sinus and carotid artery, clivus, basilar artery or petrous apex) including osteotomy of zygoma, craniotomy, extra- or intradural elevation of temporal lobe	17.09	090	
61595	Transtemporal approach to posterior cranial fossa, jugular foramen or midline skull base, including mastoidectomy, decompression of sigmoid sinus and/or facial nerve, with or without mobilization	15.18	090	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
61596	Transcochlear approach to posterior cranial fossa, jugular foramen or midline skull base, including labyrinthectomy, decompression, with or without mobilization of facial nerve and/or petrous carotid artery	16.36	090	
61597	Transcondylar (far lateral) approach to posterior cranial fossa, jugular foramen or midline skull base, including occipital condylectomy, mastoidectomy, resection of C1-C3 vertebral body(s), decompression of vertebral artery, with or without mobilization	21.09	090	
61598	Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus	13.64	090	
61600	Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; extradural	15.09	090	
61601	Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; intradural, including dural repair, with or without graft	16.18	090	
61605	Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; extradural	17.09	090	
61606	Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; intradural, including dural repair, with or without graft	22.82	090	
61607	Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; extradural	21.37	090	
61608	Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; intradural, including dural repair, with or without graft	24.82	090	
+	61611	Transection or ligation, carotid artery in petrous canal; without repair (List separately in addition to code for primary procedure)	4.55	ZZZ
	61613	Obliteration of carotid aneurysm, arteriovenous malformation, or carotid-cavernous fistula by dissection within cavernous sinus	24.37	090
	61615	Resection or excision of neoplastic, vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or C1-C3 vertebral bodies; extradural	18.73	090
	61616	Resection or excision of neoplastic, vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or C1-C3 vertebral bodies; intradural, including dural repair, with or without graft	25.55	090
	61618	Secondary repair of dura for cerebrospinal fluid leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by free tissue graft (eg, pericranium, fascia, tensor fascia lata, adipose tissue, homologous or synthetic grafts)	13.64	090
	61619	Secondary repair of dura for cerebrospinal fluid leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by local or regionalized vascularized pedicle flap or myocutaneous flap (including galea, temporalis, frontalis or occipitalis muscle)	21.82	090
	61623	Endovascular temporary balloon arterial occlusion, head or neck (extracranial/ intracranial) including selective catheterization of vessel to be occluded, positioning and inflation of occlusion balloon, concomitant neurological monitoring, and radiologic supervision and interpretation of all angiography required for balloon occlusion and to exclude vascular injury post occlusion	7.55	000

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	61624	Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)	15.46	000	
	61626	Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; non-central nervous system, head or neck (extracranial, brachiocephalic branch)	10.64	000	
	61630	Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous	12.73	XXX	
	61635	Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed	14.55	XXX	
	61640	Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel	10.91	000	
■ +	61641	Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in same vascular territory (List separately in addition to code for primary procedure)	5.45	ZZZ	
■ +	61642	Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular territory (List separately in addition to code for primary procedure)	5.45	ZZZ	
	61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	6.93	000	
	61650	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory	4.51	000	
+	61651	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; each additional vascular territory (List separately in addition to code for primary procedure)	1.92	ZZZ	
	61680	Surgery of intracranial arteriovenous malformation; supratentorial, simple	20.46	090	
	61682	Surgery of intracranial arteriovenous malformation; supratentorial, complex	24.55	090	
	61684	Surgery of intracranial arteriovenous malformation; infratentorial, simple	24.55	090	
	61686	Surgery of intracranial arteriovenous malformation; infratentorial, complex	29.46	090	
	61690	Surgery of intracranial arteriovenous malformation; dural, simple	17.73	090	
	61692	Surgery of intracranial arteriovenous malformation; dural, complex	21.27	090	
	61697	Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation	36.12	090	
	61698	Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation	39.56	090	
	61700	Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation	23.64	090	
	61702	Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation	25.91	090	
	61703	Surgery of intracranial aneurysm, cervical approach by application of occluding clamp to cervical carotid artery (Selverstone-Crutchfield type)	12.27	090	
	61705	Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial and cervical occlusion of carotid artery	20.46	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	61708	Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial electrothrombosis	18.18	090	
	61710	Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intra-arterial embolization, injection procedure, or balloon catheter	7.27	090	
	61711	Anastomosis, arterial, extracranial-intracranial (eg, middle cerebral/cortical) arteries	19.09	090	
	61720	Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus	17.09	090	
	61735	Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; subcortical structure(s) other than globus pallidus or thalamus	17.09	090	
■	61736	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion	10.27	000	
■	61737	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)	12.19	000	
	61750	Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion;	16.36	090	
	61751	Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computed tomography and/or magnetic resonance guidance	17.09	090	
	61760	Stereotactic implantation of depth electrodes into the cerebrum for long-term seizure monitoring	16.36	090	
	61770	Stereotactic localization, including burr hole(s), with insertion of catheter(s) or probe(s) for placement of radiation source	16.36	090	
+	61781	Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)	2.73	ZZZ	
+	61782	Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)	2.18	ZZZ	
+	61783	Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)	2.27	ZZZ	
	61790	Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); gasserian ganglion	11.18	090	
	61791	Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); trigeminal medullary tract	11.18	090	
	61796	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion	12.36	090	
+	61797	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)	3.36	ZZZ	
	61798	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion	12.36	090	
+	61799	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)	4.73	ZZZ	
+	61800	Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure)	2.36	ZZZ	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical	9.73	090	
	61860	Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical	13.64	090	
	61863	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array	9.55	090	
+	61864	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	4.73	ZZZ	
	61867	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array	14.18	090	
+	61868	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	7.09	ZZZ	
	61880	Revision or removal of intracranial neurostimulator electrodes	15.27	090	
	61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	3.73	090	
	61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays	4.00	090	
	61888	Revision or removal of cranial neurostimulator pulse generator or receiver	2.55	010	
■	61889	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)	10.44	090	
■	61891	Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)	4.95	090	
■	61892	Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed	6.89	090	
	62000	Elevation of depressed skull fracture; simple, extradural	9.64	090	
	62005	Elevation of depressed skull fracture; compound or comminuted, extradural	12.73	090	
	62010	Elevation of depressed skull fracture; with repair of dura and/or debridement of brain	14.91	090	
	62100	Craniotomy for repair of dural/cerebrospinal fluid leak, including surgery for rhinorrhea/otorrhea	15.91	090	
	62115	Reduction of craniomegalic skull (eg, treated hydrocephalus); not requiring bone grafts or cranioplasty	18.52	090	
	62117	Reduction of craniomegalic skull (eg, treated hydrocephalus); requiring craniotomy and reconstruction with or without bone graft (includes obtaining grafts)	22.92	090	
	62120	Repair of encephalocele, skull vault, including cranioplasty	13.64	090	
	62121	Craniotomy for repair of encephalocele, skull base	13.64	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	62140	Cranioplasty for skull defect; up to 5 cm diameter	11.73	090	
	62141	Cranioplasty for skull defect; larger than 5 cm diameter	14.27	090	
	62142	Removal of bone flap or prosthetic plate of skull	8.18	090	
	62143	Replacement of bone flap or prosthetic plate of skull	10.91	090	
	62145	Cranioplasty for skull defect with reparative brain surgery	14.55	090	
	62146	Cranioplasty with autograft (includes obtaining bone grafts); up to 5 cm diameter	14.46	090	
	62147	Cranioplasty with autograft (includes obtaining bone grafts); larger than 5 cm diameter	17.73	090	
+	62148	Incision and retrieval of subcutaneous cranial bone graft for cranioplasty (List separately in addition to code for primary procedure)	1.27	ZZZ	
+	62160	Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage (List separately in addition to code for primary procedure)	1.63	ZZZ	
	62161	Neuroendoscopy, intracranial; with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts (including placement, replacement, or removal of ventricular catheter)	17.27	090	
	62162	Neuroendoscopy, intracranial; with fenestration or excision of colloid cyst, including placement of external ventricular catheter for drainage	17.27	090	
	62164	Neuroendoscopy, intracranial; with excision of brain tumor, including placement of external ventricular catheter for drainage	20.46	090	
	62165	Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach	18.64	090	
	62180	Ventriculocisternostomy (Torkildsen type operation)	11.09	090	
	62190	Creation of shunt; subarachnoid/subdural-atrial, -jugular, -auricular	10.46	090	
	62192	Creation of shunt; subarachnoid/subdural-peritoneal, -pleural, other terminus	10.46	090	
	62194	Replacement or irrigation, subarachnoid/subdural catheter	4.55	010	
	62200	Ventriculocisternostomy, third ventricle;	15.91	090	
	62201	Ventriculocisternostomy, third ventricle; stereotactic, neuroendoscopic method	14.46	090	
	62220	Creation of shunt; ventriculo-atrial, -jugular, -auricular	11.36	090	
	62223	Creation of shunt; ventriculo-peritoneal, -pleural, other terminus	12.27	090	
	62225	Replacement or irrigation, ventricular catheter	5.91	090	
	62230	Replacement or revision of cerebrospinal fluid shunt, obstructed valve, or distal catheter in shunt system	8.64	090	
	62252	Reprogramming of programmable cerebrospinal shunt	0.76	XXX	51/49
	62256	Removal of complete cerebrospinal fluid shunt system; without replacement	5.36	090	
	62258	Removal of complete cerebrospinal fluid shunt system; with replacement by similar or other shunt at same operation	12.46	090	
	62263	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days	3.18	010	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
62264	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day	2.77	010	
62267	Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes	2.00	000	
62268	Percutaneous aspiration, spinal cord cyst or syrinx	5.91	000	
62269	Biopsy of spinal cord, percutaneous needle	5.00	000	
■ 62270	Spinal puncture, lumbar, diagnostic;	0.60	000	
■ 62272	Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter);	0.82	000	
62273	Injection, epidural, of blood or clot patch	1.45	000	
62280	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid	1.36	010	
62281	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic	1.73	010	
62282	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)	1.82	010	
62284	Injection procedure for myelography and/or computed tomography, lumbar	1.73	000	
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar	11.36	090	
62290	Injection procedure for discography, each level; lumbar	1.55	000	
62291	Injection procedure for discography, each level; cervical or thoracic	1.64	000	
62292	Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar	9.09	090	
62294	Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal	1.73	090	
62302	Myelography via lumbar injection, including radiological supervision and interpretation; cervical	1.96	000	
62303	Myelography via lumbar injection, including radiological supervision and interpretation; thoracic	2.00	000	
62304	Myelography via lumbar injection, including radiological supervision and interpretation; lumbosacral	1.93	000	
62305	Myelography via lumbar injection, including radiological supervision and interpretation; 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)	2.10	000	
62320	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	1.73	000	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	2.00	000	
62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	1.50	000	
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	1.97	000	
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	2.00	000	
62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	1.73	000	
62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	1.24	000	
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	1.81	000	
■ 62328	Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance	1.76	000	
■ 62329	Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or CT guidance	2.09	000	
62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy	10.00	010	
62351	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy	11.82	090	
62355	Removal of previously implanted intrathecal or epidural catheter	4.55	010	
62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir	4.73	010	
62361	Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump	4.73	010	
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	5.00	010	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
62365	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion	3.00	010	
62367	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill	0.34	XXX	
62368	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming	0.46	XXX	
62369	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill	1.04	XXX	
62370	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)	1.09	XXX	
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar	6.75	090	
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; cervical	12.73	090	
63003	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; thoracic	14.55	090	
63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis	12.27	090	
63011	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; sacral	13.82	090	
63012	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)	14.55	090	
63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; cervical	15.64	090	
63016	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; thoracic	16.36	090	
63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; lumbar	15.64	090	
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	14.36	090	
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	13.91	090	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
+	63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)	4.55	ZZZ	
	63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical	16.27	090	
	63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar	15.64	090	
+	63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)	5.45	ZZZ	
+	63044	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)	5.18	ZZZ	
	63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical	17.27	090	
	63046	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic	16.82	090	
	63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar	16.82	090	
■ +	63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional vertebral segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)	5.45	ZZZ	
	63050	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;	18.37	090	
	63051	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [eg, wire, suture, mini-plates], when performed)	20.91	090	
■ +	63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	2.15	ZZZ	
■ +	63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional vertebral segment (List separately in addition to code for primary procedure)	1.90	ZZZ	
	63055	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic	18.64	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)	17.09	090	
+	63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)	6.18	ZZZ	
	63064	Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; single segment	15.64	090	
+	63066	Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; each additional segment (List separately in addition to code for primary procedure)	5.18	ZZZ	
	63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace	14.36	090	
+	63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, each additional interspace (List separately in addition to code for primary procedure)	4.82	ZZZ	
	63077	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; thoracic, single interspace	13.64	090	
+	63078	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; thoracic, each additional interspace (List separately in addition to code for primary procedure)	4.55	ZZZ	
	63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment	17.27	090	
+	63082	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)	5.73	ZZZ	
	63085	Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment	17.27	090	
+	63086	Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, each additional segment (List separately in addition to code for primary procedure)	5.73	ZZZ	
	63087	Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment	16.55	090	
+	63088	Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; each additional segment (List separately in addition to code for primary procedure)	5.55	ZZZ	
	63090	Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment	16.36	090	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
+	63091	Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; each additional segment (List separately in addition to code for primary procedure)	5.45	ZZZ	
	63101	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment	20.91	090	
	63102	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); lumbar, single segment	20.91	090	
+	63103	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic or lumbar, each additional segment (List separately in addition to code for primary procedure)	6.91	ZZZ	
	63170	Laminectomy with myelotomy (eg, Bischof or DREZ type), cervical, thoracic, or thoracolumbar	13.82	090	
	63172	Laminectomy with drainage of intramedullary cyst/syrinx; to subarachnoid space	15.27	090	
	63173	Laminectomy with drainage of intramedullary cyst/syrinx; to peritoneal or pleural space	16.82	090	
	63185	Laminectomy with rhizotomy; 1 or 2 segments	13.82	090	
	63190	Laminectomy with rhizotomy; more than 2 segments	16.55	090	
	63191	Laminectomy with section of spinal accessory nerve	12.36	090	
■	63197	Laminectomy with cordotomy, with section of both spinothalamic tracts, 1 stage, thoracic	12.82	090	
	63200	Laminectomy, with release of tethered spinal cord, lumbar	14.55	090	
	63250	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; cervical	14.91	090	
	63251	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracic	13.82	090	
	63252	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracolumbar	17.46	090	
	63265	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical	14.55	090	
	63266	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic	14.55	090	
	63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar	13.09	090	
	63268	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral	11.09	090	
	63270	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical	15.27	090	
	63271	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic	15.27	090	
	63272	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar	16.36	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	63273	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; sacral	13.82	090	
	63275	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical	16.73	090	
	63276	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, thoracic	16.73	090	
	63277	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar	15.27	090	
	63278	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, sacral	12.91	090	
	63280	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, cervical	18.18	090	
	63281	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, thoracic	18.18	090	
	63282	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, lumbar	20.00	090	
	63283	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, sacral	15.46	090	
	63285	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical	20.00	090	
	63286	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracic	20.00	090	
	63287	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracolumbar	21.82	090	
	63290	Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level	31.65	090	
+	63295	Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)	3.00	ZZZ	
	63300	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, cervical	11.27	090	
	63301	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by transthoracic approach	11.64	090	
	63302	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by thoracolumbar approach	11.64	090	
	63303	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, lumbar or sacral by transperitoneal or retroperitoneal approach	11.64	090	
	63304	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, cervical	11.27	090	
	63305	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by transthoracic approach	11.64	090	
	63306	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by thoracolumbar approach	11.64	090	
	63307	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, lumbar or sacral by transperitoneal or retroperitoneal approach	11.64	090	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
+	63308	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; each additional segment (List separately in addition to codes for single segment)	3.91	ZZZ	
	63600	Creation of lesion of spinal cord by stereotactic method, percutaneous, any modality (including stimulation and/or recording)	9.09	090	
	63610	Stereotactic stimulation of spinal cord, percutaneous, separate procedure not followed by other surgery	7.27	000	
	63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion	6.18	090	
+	63621	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)	2.00	ZZZ	
	63650	Percutaneous implantation of neurostimulator electrode array, epidural	13.36	010	
	63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	15.27	090	
	63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	6.36	010	
	63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	11.36	090	
	63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	9.27	010	
	63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	12.46	090	
■	63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	5.50	010	
■	63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	4.55	010	
	63700	Repair of meningocele; less than 5 cm diameter	10.91	090	
	63702	Repair of meningocele; larger than 5 cm diameter	11.82	090	
	63704	Repair of myelomeningocele; less than 5 cm diameter	12.73	090	
	63706	Repair of myelomeningocele; larger than 5 cm diameter	13.18	090	
	63707	Repair of dural/cerebrospinal fluid leak, not requiring laminectomy	13.64	090	
	63709	Repair of dural/cerebrospinal fluid leak or pseudomeningocele, with laminectomy	14.55	090	
	63710	Dural graft, spinal	12.73	090	
	63740	Creation of shunt, lumbar, subarachnoid-peritoneal, -pleural, or other; including laminectomy	10.91	090	
	63741	Creation of shunt, lumbar, subarachnoid-peritoneal, -pleural, or other; percutaneous, not requiring laminectomy	5.91	090	
	63744	Replacement, irrigation or revision of lumbosubarachnoid shunt	5.45	090	
	63746	Removal of entire lumbosubarachnoid shunt system without replacement	4.09	090	
■	64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)	0.41	000	
■	64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve	0.64	000	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
■	64408	Injection(s), anesthetic agent(s) and/or steroid; vagus nerve	0.55	000	
■	64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed	0.68	000	
■	64416	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed	0.45	000	
■	64417	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed	0.68	000	
■	64418	Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve	0.64	000	
■	64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	0.73	000	
■ +	64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level (List separately in addition to code for primary procedure)	0.25	ZZZ	
■	64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	0.77	000	
■	64430	Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve	0.59	000	
■	64435	Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve	0.55	000	
■	64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed	0.59	000	
■	64446	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed	0.45	000	
■	64447	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed	0.59	000	
■	64448	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed	0.41	000	
■	64449	Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)	0.82	000	
■	64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	0.35	000	
■	64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	1.81	000	
■	64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed	1.76	000	
■	64455	Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)	0.23	000	
	64461	Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)	1.20	000	
+	64462	Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)	0.66	ZZZ	
	64463	Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)	1.28	000	
■	64479	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level	0.82	000	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■ +	64480	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)	0.41	ZZZ	
■	64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level	0.68	000	
■ +	64484	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	0.34	ZZZ	
	64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	0.94	000	
	64487	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by continuous infusion(s) (includes imaging guidance, when performed)	1.08	000	
	64488	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)	1.09	000	
	64489	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by continuous infusions (includes imaging guidance, when performed)	1.47	000	
	64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level	0.55	000	
+	64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)	0.41	ZZZ	
+	64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)	0.41	ZZZ	
	64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	0.55	000	
+	64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)	0.32	ZZZ	
+	64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)	0.32	ZZZ	
	64505	Injection, anesthetic agent; sphenopalatine ganglion	0.45	000	
	64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	1.27	000	
	64517	Injection, anesthetic agent; superior hypogastric plexus	1.50	000	
	64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)	1.18	000	
	64530	Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring	1.50	000	
	64553	Percutaneous implantation of neurostimulator electrode array; cranial nerve	0.73	010	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	0.73	010	
	64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed	0.73	010	
	64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	0.36	000	
■	64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	1.55	090	
	64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	1.55	090	
	64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	1.36	090	
■	64575	Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	1.09	090	
■	64580	Open implantation of neurostimulator electrode array; neuromuscular	1.09	090	
■	64581	Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)	1.09	090	
■	64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	6.98	090	
■	64583	Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator	7.21	090	
■	64584	Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	6.08	090	
	64585	Revision or removal of peripheral neurostimulator electrode array	1.09	010	
■	64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	1.09	010	
■	64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array	0.91	010	
■	64596	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array	17.90	010	
■ +	64597	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; each additional electrode array (List separately in addition to code for primary procedure)	9.67	ZZZ	
■	64598	Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator	1.87	010	
	64600	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch	0.95	010	
	64605	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale	1.36	010	
	64610	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring	1.55	010	
	64611	Chemodenervation of parotid and submandibular salivary glands, bilateral	0.34	010	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)	1.55	010	
	64615	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)	1.19	010	
	64616	Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)	0.91	010	
	64617	Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed	1.30	010	
	64620	Destruction by neurolytic agent, intercostal nerve	0.75	010	
■	64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	3.08	010	
■	64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	3.75	010	
■	64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral	3.41	010	
■ +	64629	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure)	1.61	ZZZ	
	64630	Destruction by neurolytic agent; pudendal nerve	1.23	010	
	64632	Destruction by neurolytic agent; plantar common digital nerve	0.82	010	
	64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	2.00	010	
+	64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)	0.60	ZZZ	
	64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	1.96	010	
+	64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	0.52	ZZZ	
	64640	Destruction by neurolytic agent; other peripheral nerve or branch	0.82	010	
	64642	Chemodenervation of one extremity; 1-4 muscle(s)	1.17	000	
+	64643	Chemodenervation of one extremity; each additional extremity, 1-4 muscle(s) (List separately in addition to code for primary procedure)	0.75	ZZZ	
	64644	Chemodenervation of one extremity; 5 or more muscles	1.34	000	
+	64645	Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure)	0.93	ZZZ	
	64646	Chemodenervation of trunk muscle(s); 1-5 muscle(s)	1.22	000	
	64647	Chemodenervation of trunk muscle(s); 6 or more muscles	1.45	000	
	64650	Chemodenervation of eccrine glands; both axillae	0.27	000	
	64653	Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day	0.36	000	
	64680	Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus	2.46	010	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	64681	Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus	3.46	010	
	64702	Neuroplasty; digital, 1 or both, same digit	2.73	090	
	64704	Neuroplasty; nerve of hand or foot	3.27	090	
	64708	Neuroplasty, major peripheral nerve, arm or leg, open; other than specified	5.45	090	
	64712	Neuroplasty, major peripheral nerve, arm or leg, open; sciatic nerve	6.36	090	
	64713	Neuroplasty, major peripheral nerve, arm or leg, open; brachial plexus	6.73	090	
	64714	Neuroplasty, major peripheral nerve, arm or leg, open; lumbar plexus	5.00	090	
	64716	Neuroplasty and/or transposition; cranial nerve (specify)	5.91	090	
	64718	Neuroplasty and/or transposition; ulnar nerve at elbow	5.91	090	
	64719	Neuroplasty and/or transposition; ulnar nerve at wrist	3.95	090	
	64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	4.18	090	
	64722	Decompression; unspecified nerve(s) (specify)	4.18	090	
	64726	Decompression; plantar digital nerve	1.82	090	
+	64727	Internal neurolysis, requiring use of operating microscope (List separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis)	2.80	ZZZ	
	64732	Transection or avulsion of; supraorbital nerve	2.73	090	
	64734	Transection or avulsion of; infraorbital nerve	2.73	090	
	64736	Transection or avulsion of; mental nerve	3.27	090	
	64738	Transection or avulsion of; inferior alveolar nerve by osteotomy	4.00	090	
	64740	Transection or avulsion of; lingual nerve	5.00	090	
	64742	Transection or avulsion of; facial nerve, differential or complete	5.00	090	
	64744	Transection or avulsion of; greater occipital nerve	3.18	090	
	64746	Transection or avulsion of; phrenic nerve	2.27	090	
	64755	Transection or avulsion of; vagus nerves limited to proximal stomach (selective proximal vagotomy, proximal gastric vagotomy, parietal cell vagotomy, supra- or highly selective vagotomy)	10.00	090	
	64760	Transection or avulsion of; vagus nerve (vagotomy), abdominal	6.36	090	
	64763	Transection or avulsion of obturator nerve, extrapelvic, with or without adductor tenotomy	2.73	090	
	64766	Transection or avulsion of obturator nerve, intrapelvic, with or without adductor tenotomy	4.09	090	
	64771	Transection or avulsion of other cranial nerve, extradural	4.55	090	
	64772	Transection or avulsion of other spinal nerve, extradural	2.73	090	
	64774	Excision of neuroma; cutaneous nerve, surgically identifiable	2.09	090	
	64776	Excision of neuroma; digital nerve, 1 or both, same digit	2.18	090	
+	64778	Excision of neuroma; digital nerve, each additional digit (List separately in addition to code for primary procedure)	0.89	ZZZ	
	64782	Excision of neuroma; hand or foot, except digital nerve	2.91	090	
+	64783	Excision of neuroma; hand or foot, each additional nerve, except same digit (List separately in addition to code for primary procedure)	1.45	ZZZ	
	64784	Excision of neuroma; major peripheral nerve, except sciatic	4.27	090	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	64786	Excision of neuroma; sciatic nerve	6.09	090	
+	64787	Implantation of nerve end into bone or muscle (List separately in addition to neuroma excision)	3.18	ZZZ	
	64788	Excision of neurofibroma or neurolemmoma; cutaneous nerve	3.27	090	
	64790	Excision of neurofibroma or neurolemmoma; major peripheral nerve	5.00	090	
	64792	Excision of neurofibroma or neurolemmoma; extensive (including malignant type)	5.91	090	
	64795	Biopsy of nerve	1.82	000	
	64802	Sympathectomy, cervical	6.59	090	
	64804	Sympathectomy, cervicothoracic	9.64	090	
	64809	Sympathectomy, thoracolumbar	9.36	090	
	64818	Sympathectomy, lumbar	6.82	090	
	64820	Sympathectomy; digital arteries, each digit	3.36	090	
	64821	Sympathectomy; radial artery	3.36	090	
	64822	Sympathectomy; ulnar artery	3.36	090	
	64823	Sympathectomy; superficial palmar arch	3.36	090	
	64831	Suture of digital nerve, hand or foot; 1 nerve	3.41	090	
+	64832	Suture of digital nerve, hand or foot; each additional digital nerve (List separately in addition to code for primary procedure)	2.27	ZZZ	
	64834	Suture of 1 nerve; hand or foot, common sensory nerve	3.73	090	
	64835	Suture of 1 nerve; median motor thenar	3.91	090	
	64836	Suture of 1 nerve; ulnar motor	4.55	090	
+	64837	Suture of each additional nerve, hand or foot (List separately in addition to code for primary procedure)	2.27	ZZZ	
	64840	Suture of posterior tibial nerve	5.45	090	
	64856	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition	6.82	090	
	64857	Suture of major peripheral nerve, arm or leg, except sciatic; without transposition	5.45	090	
	64858	Suture of sciatic nerve	6.36	090	
+	64859	Suture of each additional major peripheral nerve (List separately in addition to code for primary procedure)	2.82	ZZZ	
	64861	Suture of; brachial plexus	6.36	090	
	64862	Suture of; lumbar plexus	8.00	090	
	64864	Suture of facial nerve; extracranial	6.18	090	
	64865	Suture of facial nerve; infratemporal, with or without grafting	7.73	090	
	64866	Anastomosis; facial-spinal accessory	10.91	090	
	64868	Anastomosis; facial-hypoglossal	10.91	090	
+	64872	Suture of nerve; requiring secondary or delayed suture (List separately in addition to code for primary neurorrhaphy)	1.80	ZZZ	
+	64874	Suture of nerve; requiring extensive mobilization, or transposition of nerve (List separately in addition to code for nerve suture)	2.69	ZZZ	
+	64876	Suture of nerve; requiring shortening of bone of extremity (List separately in addition to code for nerve suture)	3.05	ZZZ	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	64885	Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length	7.39	090	
	64886	Nerve graft (includes obtaining graft), head or neck; more than 4 cm length	9.09	090	
	64890	Nerve graft (includes obtaining graft), single strand, hand or foot; up to 4 cm length	5.91	090	
	64891	Nerve graft (includes obtaining graft), single strand, hand or foot; more than 4 cm length	7.27	090	
	64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length	5.91	090	
	64893	Nerve graft (includes obtaining graft), single strand, arm or leg; more than 4 cm length	7.27	090	
	64895	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length	8.91	090	
	64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length	10.91	090	
	64897	Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; up to 4 cm length	8.91	090	
	64898	Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; more than 4 cm length	10.91	090	
+	64901	Nerve graft, each additional nerve; single strand (List separately in addition to code for primary procedure)	2.95	ZZZ	
+	64902	Nerve graft, each additional nerve; multiple strands (cable) (List separately in addition to code for primary procedure)	4.45	ZZZ	
	64905	Nerve pedicle transfer; first stage	3.64	090	
	64907	Nerve pedicle transfer; second stage	5.18	090	
	64910	Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve	4.55	090	
	64911	Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve	5.36	090	
	64912	Nerve repair; with nerve allograft, each nerve, first strand (cable)	6.45	090	
+	64913	Nerve repair; with nerve allograft, each additional strand (List separately in addition to code for primary procedure)	1.31	ZZZ	
	64999	Unlisted procedure, nervous system	BR	YYY	
	65091	Evisceration of ocular contents; without implant	5.15	090	
	65093	Evisceration of ocular contents; with implant	5.62	090	
	65101	Enucleation of eye; without implant	5.15	090	
	65103	Enucleation of eye; with implant, muscles not attached to implant	5.62	090	
	65105	Enucleation of eye; with implant, muscles attached to implant	7.02	090	
	65110	Exenteration of orbit (does not include skin graft), removal of orbital contents; only	9.37	090	
	65112	Exenteration of orbit (does not include skin graft), removal of orbital contents; with therapeutic removal of bone	10.54	090	
	65114	Exenteration of orbit (does not include skin graft), removal of orbital contents; with muscle or myocutaneous flap	11.24	090	
	65125	Modification of ocular implant with placement or replacement of pegs (eg, drilling receptacle for prosthesis appendage) (separate procedure)	2.25	090	
	65130	Insertion of ocular implant secondary; after evisceration, in scleral shell	5.15	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
65135	Insertion of ocular implant secondary; after enucleation, muscles not attached to implant	5.85	090	
65140	Insertion of ocular implant secondary; after enucleation, muscles attached to implant	7.02	090	
65150	Reinsertion of ocular implant; with or without conjunctival graft	5.15	090	
65155	Reinsertion of ocular implant; with use of foreign material for reinforcement and/or attachment of muscles to implant	7.02	090	
65175	Removal of ocular implant	3.75	090	
65205	Removal of foreign body, external eye; conjunctival superficial	0.27	000	
65210	Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating	0.30	000	
65220	Removal of foreign body, external eye; corneal, without slit lamp	0.34	000	
65222	Removal of foreign body, external eye; corneal, with slit lamp	0.38	000	
65235	Removal of foreign body, intraocular; from anterior chamber of eye or lens	6.09	090	
65260	Removal of foreign body, intraocular; from posterior segment, magnetic extraction, anterior or posterior route	6.09	090	
65265	Removal of foreign body, intraocular; from posterior segment, nonmagnetic extraction	7.02	090	
65270	Repair of laceration; conjunctiva, with or without nonperforating laceration sclera, direct closure	0.56	010	
65272	Repair of laceration; conjunctiva, by mobilization and rearrangement, without hospitalization	0.84	090	
65273	Repair of laceration; conjunctiva, by mobilization and rearrangement, with hospitalization	1.40	090	
65275	Repair of laceration; cornea, nonperforating, with or without removal foreign body	1.22	090	
65280	Repair of laceration; cornea and/or sclera, perforating, not involving uveal tissue	5.62	090	
65285	Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue	7.49	090	
65286	Repair of laceration; application of tissue glue, wounds of cornea and/or sclera	2.81	090	
65290	Repair of wound, extraocular muscle, tendon and/or Tenon's capsule	3.75	090	
65400	Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium	3.93	090	
65410	Biopsy of cornea	0.70	000	
65420	Excision or transposition of pterygium; without graft	3.09	090	
65426	Excision or transposition of pterygium; with graft	4.21	090	
65430	Scraping of cornea, diagnostic, for smear and/or culture	0.33	000	
65435	Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)	0.47	000	
65436	Removal of corneal epithelium; with application of chelating agent (eg, EDTA)	0.94	090	
65450	Destruction of lesion of cornea by cryotherapy, photocoagulation or thermocauterization	0.75	090	
65600	Multiple punctures of anterior cornea (eg, for corneal erosion, tattoo)	2.53	090	
65710	Keratoplasty (corneal transplant); anterior lamellar	10.30	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	65730	Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)	12.64	090	
	65750	Keratoplasty (corneal transplant); penetrating (in aphakia)	13.11	090	
	65755	Keratoplasty (corneal transplant); penetrating (in pseudophakia)	13.58	090	
	65756	Keratoplasty (corneal transplant); endothelial	11.52	090	
+	65757	Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)	BR	ZZZ	
	65760	Keratomileusis	11.71	XXX	
	65765	Keratophakia	13.58	XXX	
	65767	Epikeratoplasty	12.64	XXX	
	65770	Keratoprosthesis	12.64	090	
	65771	Radial keratotomy	6.88	XXX	
	65772	Corneal relaxing incision for correction of surgically induced astigmatism	3.37	090	
	65775	Corneal wedge resection for correction of surgically induced astigmatism	4.21	090	
	65778	Placement of amniotic membrane on the ocular surface; without sutures	11.24	000	
	65779	Placement of amniotic membrane on the ocular surface; single layer, sutured	8.90	000	
	65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	7.02	090	
	65781	Ocular surface reconstruction; limbal stem cell allograft (eg, cadaveric or living donor)	10.77	090	
	65782	Ocular surface reconstruction; limbal conjunctival autograft (includes obtaining graft)	9.37	090	
	65785	Implantation of intrastromal corneal ring segments	22.28	090	
	65800	Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous	0.75	000	
	65810	Paracentesis of anterior chamber of eye (separate procedure); with removal of vitreous and/or discission of anterior hyaloid membrane, with or without air injection	3.75	090	
	65815	Paracentesis of anterior chamber of eye (separate procedure); with removal of blood, with or without irrigation and/or air injection	4.21	090	
	65820	Goniotomy	6.09	090	
	65850	Trabeculotomy ab externo	5.62	090	
	65855	Trabeculoplasty by laser surgery	5.06	010	
	65860	Severing adhesions of anterior segment, laser technique (separate procedure)	3.75	090	
	65865	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); goniosynechia	5.62	090	
	65870	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); anterior synechia, except goniosynechia	4.03	090	
	65875	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); posterior synechia	4.03	090	
	65880	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); corneovitreal adhesions	4.03	090	
	65900	Removal of epithelial downgrowth, anterior chamber of eye	5.81	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	65920	Removal of implanted material, anterior segment of eye	7.49	090	
	65930	Removal of blood clot, anterior segment of eye	4.78	090	
	66020	Injection, anterior chamber of eye (separate procedure); air or liquid	0.94	010	
	66030	Injection, anterior chamber of eye (separate procedure); medication	0.66	010	
	66130	Excision of lesion, sclera	4.68	090	
	66150	Fistulization of sclera for glaucoma; trephination with iridectomy	7.49	090	
	66155	Fistulization of sclera for glaucoma; thermocauterization with iridectomy	7.02	090	
	66160	Fistulization of sclera for glaucoma; sclerectomy with punch or scissors, with iridectomy	7.02	090	
	66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery	7.96	090	
	66172	Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)	9.55	090	
■	66174	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without retention of device or stent	7.96	090	
■	66175	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); with retention of device or stent	8.24	090	
	66179	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft	10.13	090	
	66180	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft	8.90	090	
	66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	9.69	090	
	66184	Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft	7.38	090	
	66185	Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft	5.34	090	
	66225	Repair of scleral staphyloma; with graft	12.17	090	
	66250	Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure	5.15	090	
	66500	Iridotomy by stab incision (separate procedure); except transfixion	2.34	090	
	66505	Iridotomy by stab incision (separate procedure); with transfixion as for iris bombe	1.87	090	
	66600	Iridectomy, with corneoscleral or corneal section; for removal of lesion	7.02	090	
	66605	Iridectomy, with corneoscleral or corneal section; with cyclectomy	9.55	090	
	66625	Iridectomy, with corneoscleral or corneal section; peripheral for glaucoma (separate procedure)	5.24	090	
	66630	Iridectomy, with corneoscleral or corneal section; sector for glaucoma (separate procedure)	5.24	090	
	66635	Iridectomy, with corneoscleral or corneal section; optical (separate procedure)	5.24	090	
	66680	Repair of iris, ciliary body (as for iridodialysis)	4.31	090	
	66682	Suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (eg, McCannel suture)	5.15	090	
	66700	Ciliary body destruction; diathermy	4.50	090	
	66710	Ciliary body destruction; cyclophotocoagulation, transscleral	4.68	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
■	66711	Ciliary body destruction; cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens	6.37	090	
	66720	Ciliary body destruction; cryotherapy	4.50	090	
	66740	Ciliary body destruction; cyclodialysis	6.09	090	
	66761	Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)	4.68	010	
	66762	Iridoplasty by photocoagulation (1 or more sessions) (eg, for improvement of vision, for widening of anterior chamber angle)	4.78	090	
	66770	Destruction of cyst or lesion iris or ciliary body (nonexcisional procedure)	4.68	090	
	66820	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler knife)	3.56	090	
	66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (1 or more stages)	3.98	090	
	66825	Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure)	6.93	090	
	66830	Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)	4.78	090	
	66840	Removal of lens material; aspiration technique, 1 or more stages	8.71	090	
	66850	Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration	9.37	090	
	66852	Removal of lens material; pars plana approach, with or without vitrectomy	11.24	090	
	66920	Removal of lens material; intracapsular	8.24	090	
	66930	Removal of lens material; intracapsular, for dislocated lens	9.37	090	
	66940	Removal of lens material; extracapsular (other than 66840, 66850, 66852)	8.90	090	
■	66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation	11.71	090	
	66983	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)	9.27	090	
■	66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation	9.74	090	
	66985	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal	7.87	090	
	66986	Exchange of intraocular lens	10.30	090	
■	66987	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation	7.95	090	

10004-69990

SURGERY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	66988	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation	6.40	090	
■	66989	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	8.05	090	
+	66990	Use of ophthalmic endoscope (List separately in addition to code for primary procedure)	0.78	ZZZ	
■	66991	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	6.45	090	
	66999	Unlisted procedure, anterior segment of eye	BR	YYY	
	67005	Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal	8.43	090	
	67010	Removal of vitreous, anterior approach (open sky technique or limbal incision); subtotal removal with mechanical vitrectomy	9.83	090	
	67015	Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)	3.93	090	
	67025	Injection of vitreous substitute, pars plana or limbal approach (fluid-gas exchange), with or without aspiration (separate procedure)	4.68	090	
	67027	Implantation of intravitreal drug delivery system (eg, ganciclovir implant), includes concomitant removal of vitreous	17.33	090	
	67028	Intravitreal injection of a pharmacologic agent (separate procedure)	1.83	000	
	67030	Dissection of vitreous strands (without removal), pars plana approach	5.62	090	
	67031	Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (1 or more stages)	4.68	090	
	67036	Vitrectomy, mechanical, pars plana approach;	13.58	090	
	67039	Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation	14.98	090	
	67040	Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation	15.92	090	
	67041	Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker)	12.64	090	
	67042	Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)	15.45	090	
	67043	Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation	15.92	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
67101	Repair of retinal detachment, including drainage of subretinal fluid when performed; cryotherapy	7.96	010	
67105	Repair of retinal detachment, including drainage of subretinal fluid when performed; photocoagulation	7.96	010	
67107	Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid	11.99	090	
67108	Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique	18.73	090	
67110	Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)	9.37	090	
67113	Repair of complex retinal detachment (eg, 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, including, when performed, air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens	16.39	090	
67115	Release of encircling material (posterior segment)	3.56	090	
67120	Removal of implanted material, posterior segment; extraocular	4.50	090	
67121	Removal of implanted material, posterior segment; intraocular	5.15	090	
■ 67141	Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; cryotherapy, diathermy	4.96	010	
■ 67145	Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; photocoagulation	5.15	010	
67208	Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; cryotherapy, diathermy	5.15	090	
67210	Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation	5.34	090	
67218	Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; radiation by implantation of source (includes removal of source)	10.30	090	
67220	Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions	5.34	090	
67221	Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion)	1.73	000	
+ 67225	Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)	0.89	ZZZ	
67227	Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), cryotherapy, diathermy	5.53	010	
67228	Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation	5.71	010	
67250	Scleral reinforcement (separate procedure); without graft	7.49	090	
67255	Scleral reinforcement (separate procedure); with graft	9.37	090	
67299	Unlisted procedure, posterior segment	BR	YYY	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	67311	Strabismus surgery, recession or resection procedure; 1 horizontal muscle	5.62	090	
	67312	Strabismus surgery, recession or resection procedure; 2 horizontal muscles	7.02	090	
	67314	Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior oblique)	6.18	090	
	67316	Strabismus surgery, recession or resection procedure; 2 or more vertical muscles (excluding superior oblique)	7.73	090	
	67318	Strabismus surgery, any procedure, superior oblique muscle	7.02	090	
+	67320	Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify) (List separately in addition to code for primary procedure)	7.82	ZZZ	
+	67331	Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (List separately in addition to code for primary procedure)	3.28	ZZZ	
+	67332	Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy) (List separately in addition to code for primary procedure)	3.98	ZZZ	
+	67334	Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)	6.18	ZZZ	
+	67335	Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)	1.87	ZZZ	
+	67340	Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to code for primary procedure)	3.51	ZZZ	
	67343	Release of extensive scar tissue without detaching extraocular muscle (separate procedure)	2.81	090	
	67345	Chemodenervation of extraocular muscle	1.78	010	
	67346	Biopsy of extraocular muscle	1.97	000	
	67399	Unlisted procedure, extraocular muscle	BR	YYY	
	67400	Orbitotomy without bone flap (frontal or transconjunctival approach); for exploration, with or without biopsy	7.96	090	
	67405	Orbitotomy without bone flap (frontal or transconjunctival approach); with drainage only	6.56	090	
	67412	Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of lesion	7.49	090	
	67413	Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of foreign body	7.49	090	
	67414	Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of bone for decompression	7.63	090	
	67415	Fine needle aspiration of orbital contents	1.12	000	
	67420	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of lesion	13.11	090	
	67430	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of foreign body	12.36	090	
	67440	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with drainage	11.71	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
67445	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of bone for decompression	10.13	090	
67450	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); for exploration, with or without biopsy	9.18	090	
67500	Retrobulbar injection; medication (separate procedure, does not include supply of medication)	0.43	000	
67505	Retrobulbar injection; alcohol	0.94	000	
67515	Injection of medication or other substance into Tenon's capsule	0.42	000	
■ 67516	Suprachoroidal space injection of pharmacologic agent (separate procedure)	1.06	000	
67550	Orbital implant (implant outside muscle cone); insertion	5.62	090	
67560	Orbital implant (implant outside muscle cone); removal or revision	5.62	090	
67570	Optic nerve decompression (eg, incision or fenestration of optic nerve sheath)	9.37	090	
67599	Unlisted procedure, orbit	BR	YYY	
67700	Blepharotomy, drainage of abscess, eyelid	0.37	010	
67710	Severing of tarsorrhaphy	0.47	010	
67715	Canthotomy (separate procedure)	0.56	010	
67800	Excision of chalazion; single	0.56	010	
67801	Excision of chalazion; multiple, same lid	0.75	010	
67805	Excision of chalazion; multiple, different lids	0.84	010	
67808	Excision of chalazion; under general anesthesia and/or requiring hospitalization, single or multiple	1.45	090	
67810	Incisional biopsy of eyelid skin including lid margin	0.56	000	
67820	Correction of trichiasis; epilation, by forceps only	0.23	000	
67825	Correction of trichiasis; epilation by other than forceps (eg, by electrosurgery, cryotherapy, laser surgery)	0.56	010	
67830	Correction of trichiasis; incision of lid margin	0.66	010	
67835	Correction of trichiasis; incision of lid margin, with free mucous membrane graft	4.68	090	
67840	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure	0.80	010	
67850	Destruction of lesion of lid margin (up to 1 cm)	0.70	010	
67875	Temporary closure of eyelids by suture (eg, Frost suture)	0.94	000	
67880	Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy;	2.29	090	
67882	Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy; with transposition of tarsal plate	3.28	090	
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	3.44	090	
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	4.64	090	
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	4.68	090	
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	8.85	090	
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	8.43	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	8.01	090	
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)	6.56	090	
67909	Reduction of overcorrection of ptosis	5.62	090	
67911	Correction of lid retraction	7.49	090	
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)	7.49	090	
67914	Repair of ectropion; suture	2.62	090	
67915	Repair of ectropion; thermocauterization	0.80	090	
67916	Repair of ectropion; excision tarsal wedge	3.84	090	
67917	Repair of ectropion; extensive (eg, tarsal strip operations)	4.68	090	
67921	Repair of entropion; suture	2.01	090	
67922	Repair of entropion; thermocauterization	0.80	090	
67923	Repair of entropion; excision tarsal wedge	3.84	090	
67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)	4.87	090	
67930	Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva direct closure; partial thickness	1.73	010	
67935	Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva direct closure; full thickness	2.34	090	
67938	Removal of embedded foreign body, eyelid	0.47	010	
67950	Canthoplasty (reconstruction of canthus)	5.62	090	
67961	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin	5.15	090	
67966	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin	6.56	090	
67971	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; up to two-thirds of eyelid, 1 stage or first stage	6.56	090	
67973	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, lower, 1 stage or first stage	7.49	090	
67974	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, upper, 1 stage or first stage	8.43	090	
67975	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; second stage	2.34	090	
67999	Unlisted procedure, eyelids	BR	YYY	
68020	Incision of conjunctiva, drainage of cyst	0.42	010	
68040	Expression of conjunctival follicles (eg, for trachoma)	0.42	000	
68100	Biopsy of conjunctiva	0.66	000	
68110	Excision of lesion, conjunctiva; up to 1 cm	0.89	010	
68115	Excision of lesion, conjunctiva; over 1 cm	1.40	010	
68130	Excision of lesion, conjunctiva; with adjacent sclera	2.81	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
68135	Destruction of lesion, conjunctiva	0.75	010	
68200	Subconjunctival injection	0.37	000	
68320	Conjunctivoplasty; with conjunctival graft or extensive rearrangement	5.62	090	
68325	Conjunctivoplasty; with buccal mucous membrane graft (includes obtaining graft)	6.56	090	
68326	Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement	6.09	090	
68328	Conjunctivoplasty, reconstruction cul-de-sac; with buccal mucous membrane graft (includes obtaining graft)	7.02	090	
68330	Repair of symblepharon; conjunctivoplasty, without graft	2.81	090	
68335	Repair of symblepharon; with free graft conjunctiva or buccal mucous membrane (includes obtaining graft)	4.21	090	
68340	Repair of symblepharon; division of symblepharon, with or without insertion of conformer or contact lens	4.21	090	
68360	Conjunctival flap; bridge or partial (separate procedure)	3.28	090	
68362	Conjunctival flap; total (such as Gunderson thin flap or purse string flap)	4.68	090	
68371	Harvesting conjunctival allograft, living donor	2.81	010	
68399	Unlisted procedure, conjunctiva	BR	YYY	
68400	Incision, drainage of lacrimal gland	1.03	010	
68420	Incision, drainage of lacrimal sac (dacryocystotomy or dacryocystostomy)	0.84	010	
68440	Snip incision of lacrimal punctum	0.47	010	
68500	Excision of lacrimal gland (dacryoadenectomy), except for tumor; total	5.62	090	
68505	Excision of lacrimal gland (dacryoadenectomy), except for tumor; partial	4.68	090	
68510	Biopsy of lacrimal gland	0.94	000	
68520	Excision of lacrimal sac (dacryocystectomy)	4.21	090	
68525	Biopsy of lacrimal sac	0.94	000	
68530	Removal of foreign body or dacryolith, lacrimal passages	3.28	010	
68540	Excision of lacrimal gland tumor; frontal approach	7.02	090	
68550	Excision of lacrimal gland tumor; involving osteotomy	7.02	090	
68700	Plastic repair of canaliculi	5.15	090	
68705	Correction of everted punctum, cautery	0.75	010	
68720	Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)	7.49	090	
68745	Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); without tube	7.96	090	
68750	Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); with insertion of tube or stent	8.43	090	
68760	Closure of the lacrimal punctum; by thermocauterization, ligation, or laser surgery	0.75	010	
68761	Closure of the lacrimal punctum; by plug, each	0.56	010	
68770	Closure of lacrimal fistula (separate procedure)	2.34	090	
68801	Dilation of lacrimal punctum, with or without irrigation	0.28	010	
68810	Probing of nasolacrimal duct, with or without irrigation;	0.70	010	
68811	Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia	1.03	010	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
68815	Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent	1.40	010	
68816	Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation	4.21	010	
68840	Probing of lacrimal canaliculi, with or without irrigation	0.37	010	
■ 68841	Insertion of drug-eluting implant, including punctal dilation when performed, into lacrimal canaliculus, each	0.34	000	
68850	Injection of contrast medium for dacryocystography	0.47	000	
68899	Unlisted procedure, lacrimal system	BR	YYY	
69000	Drainage external ear, abscess or hematoma; simple	0.52	010	
69005	Drainage external ear, abscess or hematoma; complicated	1.69	010	
69020	Drainage external auditory canal, abscess	0.56	010	
69090	Ear piercing	0.23	XXX	
69100	Biopsy external ear	0.70	000	
69105	Biopsy external auditory canal	0.70	000	
69110	Excision external ear; partial, simple repair	2.81	090	
69120	Excision external ear; complete amputation	6.56	090	
69140	Excision exostosis(es), external auditory canal	11.24	090	
69145	Excision soft tissue lesion, external auditory canal	1.87	090	
69150	Radical excision external auditory canal lesion; without neck dissection	7.02	090	
69155	Radical excision external auditory canal lesion; with neck dissection	10.30	090	
69200	Removal foreign body from external auditory canal; without general anesthesia	0.52	000	
69205	Removal foreign body from external auditory canal; with general anesthesia	2.06	010	
69209	Removal impacted cerumen using irrigation/lavage, unilateral	0.12	000	
69210	Removal impacted cerumen requiring instrumentation, unilateral	0.21	000	
69220	Debridement, mastoidectomy cavity, simple (eg, routine cleaning)	0.28	000	
69222	Debridement, mastoidectomy cavity, complex (eg, with anesthesia or more than routine cleaning)	1.26	010	
69300	Otoplasty, protruding ear, with or without size reduction	6.09	YYY	
69310	Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to injury, infection) (separate procedure)	8.90	090	
69320	Reconstruction external auditory canal for congenital atresia, single stage	8.90	090	
69399	Unlisted procedure, external ear	BR	YYY	
69420	Myringotomy including aspiration and/or eustachian tube inflation	1.03	010	
69421	Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia	1.40	010	
69424	Ventilating tube removal requiring general anesthesia	1.87	000	
69433	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia	1.40	010	
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	1.87	010	
69440	Middle ear exploration through postauricular or ear canal incision	6.09	090	
69450	Tympanolysis, transcanal	6.09	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
69501	Transmastoid antrotomy (simple mastoidectomy)	6.56	090	
69502	Mastoidectomy; complete	8.71	090	
69505	Mastoidectomy; modified radical	9.83	090	
69511	Mastoidectomy; radical	11.24	090	
69530	Petrous apicectomy including radical mastoidectomy	14.05	090	
69535	Resection temporal bone, external approach	14.05	090	
69540	Excision aural polyp	1.12	010	
69550	Excision aural glomus tumor; transcanal	9.37	090	
69552	Excision aural glomus tumor; transmastoid	11.24	090	
69554	Excision aural glomus tumor; extended (extratemporal)	14.05	090	
69601	Revision mastoidectomy; resulting in complete mastoidectomy	7.02	090	
69602	Revision mastoidectomy; resulting in modified radical mastoidectomy	11.24	090	
69603	Revision mastoidectomy; resulting in radical mastoidectomy	11.24	090	
69604	Revision mastoidectomy; resulting in tympanoplasty	11.24	090	
69610	Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch	0.84	010	
69620	Myringoplasty (surgery confined to drumhead and donor area)	7.49	090	
69631	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction	10.11	090	
69632	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg, postfenestration)	11.43	090	
69633	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis [PORP], total ossicular replacement prosthesis [TORP])	12.17	090	
69635	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction	11.71	090	
69636	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction	12.46	090	
69637	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis [PORP], total ossicular replacement prosthesis [TORP])	13.11	090	
69641	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction	12.64	090	
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	13.30	090	
69643	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction	13.11	090	

10004-69990**SURGERY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
69644	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction	13.86	090	
69645	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction	12.64	090	
69646	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction	13.58	090	
69650	Stapes mobilization	6.56	090	
69660	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material;	10.49	090	
69661	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material; with footplate drill out	10.49	090	
69662	Revision of stapedectomy or stapedotomy	12.55	090	
69666	Repair oval window fistula	9.37	090	
69667	Repair round window fistula	9.37	090	
69670	Mastoid obliteration (separate procedure)	11.24	090	
69676	Tympanic neurectomy	6.56	090	
69700	Closure postauricular fistula, mastoid (separate procedure)	2.81	090	
■ 69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral	22.76	000	
■ 69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral	23.57	000	
69710	Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone	BR	XXX	
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone	7.68	090	
■ 69714	Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor	9.27	090	
■ 69716	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or resulting in removal of less than 100 sq mm surface area of bone deep to the outer cranial cortex	5.93	090	
■ 69717	Replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor	9.55	090	
■ 69719	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex	6.16	090	
69720	Decompression facial nerve, intratemporal; lateral to geniculate ganglion	11.24	090	
69725	Decompression facial nerve, intratemporal; including medial to geniculate ganglion	18.73	090	
■ 69726	Removal, entire osseointegrated implant, skull; with percutaneous attachment to external speech processor	4.56	090	

SURGERY**10004-69990****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
■	69727	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex	5.09	090	
■	69728	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	5.67	090	
■	69729	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	6.43	090	
■	69730	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	6.56	090	
	69740	Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion	13.11	090	
	69745	Suture facial nerve, intratemporal, with or without graft or decompression; including medial to geniculate ganglion	18.73	090	
	69799	Unlisted procedure, middle ear	BR	YYY	
	69801	Labyrinthotomy, with perfusion of vestibuloactive drug(s), transcanal	8.43	000	
	69805	Endolymphatic sac operation; without shunt	11.24	090	
	69806	Endolymphatic sac operation; with shunt	13.49	090	
	69905	Labyrinthectomy; transcanal	9.37	090	
	69910	Labyrinthectomy; with mastoidectomy	11.24	090	
	69915	Vestibular nerve section, translabyrinthine approach	16.86	090	
	69930	Cochlear device implantation, with or without mastoidectomy	13.11	090	
	69949	Unlisted procedure, inner ear	BR	YYY	
	69950	Vestibular nerve section, transcranial approach	18.73	090	
	69955	Total facial nerve decompression and/or repair (may include graft)	18.73	090	
	69960	Decompression internal auditory canal	18.73	090	
	69970	Removal of tumor, temporal bone	23.41	090	
	69979	Unlisted procedure, temporal bone, middle fossa approach	BR	YYY	
+	69990	Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)	1.98	ZZZ	

5 Radiology

The relative value units in this section were determined uniquely for radiology services. Use the radiology conversion factor when determining fee amounts. The radiology conversion factor is not applicable to any other section.

The fee for a procedure or service in this section is determined by multiplying the relative value unit by the radiology conversion factor, subject to the ground rules, instructions, and definitions of the schedule.

To ensure uniformity of billing when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately. After which, charges for products may be added.

CONVERSION FACTORS

Regional conversion factors for services rendered on or after TBD.

Section	Region I	Region II	Region III	Region IV
Radiology	\$46.77	\$46.77	\$53.53	\$58.19

RADIOLOGY GROUND RULES

Definitions and rules pertaining to radiology (including nuclear medicine and diagnostic ultrasound) services are as follows:

Note: Rules used by all providers in reporting their services are presented in the General Ground Rules in the Introduction and General Guidelines section.

1A. NYS Medical Treatment Guidelines

Treatment of work-related injuries should be in accordance with any applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical

Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.

1B. Consultations

Consultations and referrals for diagnostic and therapeutic radiology are to be done only by specialists.

2. Duplication of X-Rays

Every attempt should be made to minimize the number of x-rays taken. The attending doctor or any other person or institution having possession of x-rays which pertain to the patient that are deemed to be needed for diagnostic or treatment purposes should make these x-rays available upon request.

No payments shall be made for additional x-rays when recent x-rays are available, except when supported by adequate information regarding the need for x-rays.

The use of digital or photographic media and/or imaging is not reported separately but is considered to be a component of the basic procedure and shall not merit any additional payment.

3. Multiple Diagnostic Procedures

The following adjustments apply to all diagnostic services (70010–76499, 76506–76999, 77002–77003, and 78012–78999):

- For two contiguous parts, the charge shall be the greater fee plus 50 percent of the lesser fee.
- For two remote parts, the charge shall be the greater fee plus 75 percent of the lesser fee. Bilateral procedures are considered remote parts.
- For three or more parts, whether contiguous or remote, the charge shall be the greatest fee plus 75 percent of the total of the lesser fees.
- Where more than one part is included in a single line item, it shall be charged for as a single line item. Any additional item examined shall be considered under rule 3A–C above, whichever pertains.
- No charge shall be made for comparative qualified x-rays except when such x-rays are specifically authorized by the carrier or the Chair of the Workers'

Compensation Board. Comparative x-rays specifically authorized shall be subject to fees for contiguous and remote parts as provided in 3A–D above.

- F Imaging studies of different areas taken within 7 days of the first x-ray/imaging studies and related to the injury or problem necessitating the first x-ray/imaging studies, and which could have reasonably been performed at one time, shall be subject to rule 3A–E above.

4. Xeroradiography

Imaging performed by this process shall have the identical values listed for conventional x-ray procedures of the same area and views.

5. Multiple Services Other Than Diagnostic Radiology

When multiple or bilateral procedures or services are provided at the same session, payment is for the procedure with the highest allowance plus half of the lesser procedures up to a total maximum allowance of twice the highest fee.

6. Specific Billing Instructions

The total relative value unit includes professional services plus expenses for personnel, materials, including usual contrast media and drugs, space, equipment, and other facilities. Relative value units for injection procedures include all usual pre- and postinjection care specifically related to the injection procedure, necessary local anesthesia, placement of needle or catheter, and injection of contrast media. Radiology services do not include the supply of medications, sterile trays, and other materials which may be charged for separately; in these instances, list items individually on the bill. Payment shall not exceed the cost of the items to the provider.

The listed relative value units are for the technical component plus the professional component. Total reimbursement for the professional and technical components shall not exceed the listed relative value unit for the total procedure, regardless of the site where services are rendered. Use of codes 70010–79999 without modifier 26 or TC implies that the charge is inclusive of both the professional and technical components; to report either the professional or technical component separately, use modifier 26 or TC respectively.

When either the professional or technical component is billed separately, the listed percent of the total relative value unit is apportioned as indicated in the PC/TC Split column of the fee schedule.

A) Professional Component

The professional component represents the relative value unit of the professional radiological services of the provider. This includes examination of the patient, when indicated, interpretation and written report of

the examination, and consultation with the referring provider. (Report using modifier 26.) The same radiology code should not be used by two providers during the same procedure. Codes billed with modifier 26 for the PC split, cannot be billed by two providers during the same procedure.

B) Technical Component

The technical component includes the charges for performance and/or supervision of the procedure, personnel, materials (including usual contrast media and drugs), film or xerography, space, equipment and other facilities, but excludes the cost of radioisotopes and nonionic contrast media such as the use of gadolinium in MRI procedures. (Report using modifier TC.)

When this section of the schedule is used in connection with a “conversion factor” to establish fees, it must be emphasized that the conversion factor should be applied to the total relative value units. The professional component and the technical component are percentages of this total. Providers who determine their fees by application of conversion factors to the relative value units in this section must use the percentage of the total relative value units for the professional and technical values as listed in the schedule.

Fees are for a competent diagnosis by image, expert interpretation and opinion. Size and number of films are not relevant except as indicated by minimum number listed for respective procedures.

C) Review of Diagnostic Studies

When prior studies are reviewed in conjunction with a visit, consultation, record review, or other evaluation, no separate charge is warranted for the review by the medical practitioner or other medical personnel. Neither the professional component (modifier 26) nor technical component are reimbursable under this circumstance. The review of diagnostic tests is included in the evaluation and management codes.

7. Necessity of Services or Procedures

When a patient is referred to radiologists or other specialists for services covered in the Radiology section, they shall evaluate the patient's problem and determine if the services or procedures are medically necessary. Such evaluation and necessary consultation with the referring provider is an integral part of the professional component relative value unit and does not merit any additional charges.

8. Reports and Custody of X-rays and Other Recorded Images

A written report of the findings must be submitted as prescribed by the Chair.

Films or other recorded images shall be preserved in accordance with New York State Department of Health retention requirements. They (or satisfactory reproductions) shall be made available to the attending provider, insurance carrier, or self-insured employer. When requested, carriers and self-insured employers shall return original films to the provider within 20 days of their receipt.

When a carrier or self-insured employer requests x-rays, MRI's, or other recorded images and satisfactory reproductions including electronic media are furnished in lieu of the original films, a fee of \$5.00 may be charged for the first sheet of duplicating film or for reproduction on an electronic media (e.g., digital images copied to a CD) regardless of the number of images contained on the media, and \$3.00 for each additional sheet of film or electronic media. These reproductions are not returnable to the provider. Copies of images produced by copiers (e.g., Xerox) shall not merit any additional payment and shall not be returnable to the provider; such copies should accompany the bill submitted for the particular imaging procedure. (The use of digital or photographic media and/or imaging is not reported separately but is considered to be a component of the basic procedure.) When recorded images are capable of electronic transmission, without creation of a physical copy of the film, CD or other physical reproduction, no fee may be charged for such electronic transmission.

In cases where the patient transfers from one provider to another, the original provider will promptly forward all images or copies of images to the new attending provider.

9. Materials Supplied by Provider

Pharmacy

A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of:

1. Persons practicing in hospitals as defined in section 2801 of the public health law;
2. The dispensing of drugs at no charge to their patients;
3. Persons whose practices are situated ten miles or more from a registered pharmacy;
4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution;
5. The dispensing of drugs in a medical emergency as defined in subdivision 6 of section 6810 of the State Education Law.

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional

"handling" costs added to the total cost of the item. Bill using procedure code 99070. Identify the product being given with the NDC number and amount of product being used. Except in emergencies, any medications must follow all WCB Formulary and applicable Medical Treatment Guidelines. Any variations require or Prior Authorization (PAR).

Radiopharmaceutical or other radionuclide material cost: Listed relative value units in this section do not include these costs. List the name and dosage of radiopharmaceutical material and cost. Bill with code 99070.

10. Injection Procedures

Relative value units for injection procedures include all usual pre- and postinjection care specifically related to the injection procedure, necessary local anesthesia, placement of needle or catheter, and injection of contrast media.

Vascular injection procedures are listed in the cardiovascular section under procedure codes 36000–36299. Other injection procedures are listed in appropriate sections.

11. Contrast Enhanced Magnetic Resonance Imaging

Contrast materials provided by the provider over and above those usually included with the service, for image enhancement, may be charged for separately. Listed values in this section do not include the costs of contrast agents. When billing, list the name and dosage of the contrast material used and its cost.

Payment shall not exceed the cost of the item to the provider.

12. Miscellaneous

- A. Emergency services rendered between 10:00 p.m. and 7:00 a.m. in response to requests received during those hours or on Sundays or legal holidays, provided such services are not otherwise reimbursed, may warrant an additional payment of one-third of the applicable fee. Circumstances justifying the additional payment should be set forth in a statement accompanying the bill.
- B. Relative value units for office, home and hospital visits, consultation, and other medical services are listed in the Evaluation and Management, Anesthesia, Surgery, Pathology and Laboratory, Medicine, and Physical Medicine sections.
- C. When interpretation of radiologic procedures is performed, and a radiologist is not in house and is not available by teleradiography, the treating provider may render the interpretation and write the report. All radiology guidelines and requirements must be met,

and the written report must be the official report in the medical records. The treating provider can bill for interpretation services using modifier 26 to identify the professional component of the procedure. The written report must accompany the bill.

13. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used with radiology procedures are as follows:

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component

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

32 Mandated Services

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

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced

services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

76 Repeat Procedure or Service by the Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

14. Miscellaneous and By Report Codes

- Providers should only use codes listed in the Fee Schedule. When billing a service or procedure, select the CPT code from the WCB Fee schedule that accurately identifies the service or procedure performed. If no such code is available, report the service or procedure using the closest appropriate **Miscellaneous** code in the Fee Schedule (often ending in -99). These codes may also be titled "Unlisted," "Unspecified," or "Not Otherwise Specified".
- By Report (BR) in the Relative Value (RVU) column represents services that too variable to permit assignment of RVUs. Fees for such procedures need to be justified with additional information.
 - The inclusion of a miscellaneous or by report code in this Fee Schedule does not guarantee reimbursement. All codes billed should be based on medical necessity and be in alignment with all applicable Medical Treatment Guidelines and

Fee Schedule Ground Rules. Reimbursement may be dependent on multiple factors, including but not necessarily limited to, causal relationship, clinical necessity and appropriateness of the fees submitted.

- It is the responsibility of the provider to ensure all information required to process a miscellaneous or by report procedure is included with the bill. If required information is missing, or if there is a valid code that describes the procedure, then the code may not be reimbursed.
- Nearly all miscellaneous and by report codes, require prior authorization (PAR). If a procedure or item is not recommended or not addressed in an applicable WCB Medical Treatment Guideline (MTG), then prior authorization is always required. If the procedure or item involves a body part or condition for which there is no MTG and costs over \$1,000 then prior authorization must be obtained.
- While emergency procedures/items do not require prior authorization, the circumstances must be identified and explained in the procedure record. The codes billed may be subject to review and non-payment.
- When a miscellaneous or by report code is used, the actual service/item should be identified on the bill, narrative note, and in an additional attached report.
- The price billed must be substantiated by indicating the closest comparable code found in the current fee schedule and/or with a manufacturer's invoice.
- Documentation should include: any decision making, medical necessity and explanation why an existing fee schedule code could not be used.
- Any PARs including identification numbers should also be submitted with bills.
- Miscellaneous and by report codes should not be billed merely to describe a proprietary product or procedure, when an existing fee schedule code adequately describes the procedure or item.
- Surgical miscellaneous or by report codes may require additional documentation including: time, skill, equipment necessary, diagnosis, pertinent history, and physical findings, size/ location/number of lesions or procedures.

70010-79999

RADIOLOGY

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
70010	Myelography, posterior fossa, radiological supervision and interpretation	5.61	XXX	35/65
70015	Cisternography, positive contrast, radiological supervision and interpretation	4.59	XXX	35/65
70030	Radiologic examination, eye, for detection of foreign body	1.79	XXX	40/60
70100	Radiologic examination, mandible; partial, less than 4 views	1.15	XXX	40/60
70110	Radiologic examination, mandible; complete, minimum of 4 views	1.94	XXX	40/60
70120	Radiologic examination, mastoids; less than 3 views per side	1.15	XXX	40/60
70130	Radiologic examination, mastoids; complete, minimum of 3 views per side	2.17	XXX	40/60
70134	Radiologic examination, internal auditory meati, complete	2.50	XXX	40/60
70140	Radiologic examination, facial bones; less than 3 views	1.66	XXX	40/60
70150	Radiologic examination, facial bones; complete, minimum of 3 views	2.04	XXX	40/60
70160	Radiologic examination, nasal bones, complete, minimum of 3 views	1.28	XXX	40/60
70170	Dacryocystography, nasolacrimal duct, radiological supervision and interpretation	1.99	XXX	35/65
70190	Radiologic examination; optic foramina	1.63	XXX	40/60
70200	Radiologic examination; orbits, complete, minimum of 4 views	2.07	XXX	40/60
70210	Radiologic examination, sinuses, paranasal, less than 3 views	1.40	XXX	40/60
70220	Radiologic examination, sinuses, paranasal, complete, minimum of 3 views	2.30	XXX	40/60
70240	Radiologic examination, sella turcica	1.40	XXX	40/60
■ 70250	Radiological examination, skull; less than 4 views	1.66	XXX	40/60
70260	Radiologic examination, skull; complete, minimum of 4 views	2.30	XXX	40/60
70300	Radiologic examination, teeth; single view	0.48	XXX	40/60
70310	Radiologic examination, teeth; partial examination, less than full mouth	0.92	XXX	40/60
70320	Radiologic examination, teeth; complete, full mouth	1.73	XXX	40/60
70328	Radiologic examination, temporomandibular joint, open and closed mouth; unilateral	2.09	XXX	40/60
70330	Radiologic examination, temporomandibular joint, open and closed mouth; bilateral	3.06	XXX	40/60
70332	Temporomandibular joint arthrography, radiological supervision and interpretation	4.77	XXX	35/65
70336	Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)	16.43	XXX	20/80
70350	Cephalogram, orthodontic	1.53	XXX	40/60
70355	Orthopantomogram (eg, panoramic x-ray)	1.50	XXX	40/60
70360	Radiologic examination; neck, soft tissue	1.58	XXX	40/60
70370	Radiologic examination; pharynx or larynx, including fluoroscopy and/or magnification technique	3.49	XXX	40/60
70371	Complex dynamic pharyngeal and speech evaluation by cine or video recording	6.07	XXX	40/60
70380	Radiologic examination, salivary gland for calculus	1.91	XXX	40/60
70390	Sialography, radiological supervision and interpretation	3.88	XXX	35/65
70450	Computed tomography, head or brain; without contrast material	8.61	XXX	25/75
70460	Computed tomography, head or brain; with contrast material(s)	9.91	XXX	25/75
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections	11.89	XXX	25/75

RADIOLOGY**70010-79999****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	9.36	XXX	25/75
70481	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)	10.78	XXX	25/75
70482	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections	12.92	XXX	25/75
70486	Computed tomography, maxillofacial area; without contrast material	9.11	XXX	25/75
70487	Computed tomography, maxillofacial area; with contrast material(s)	10.48	XXX	25/75
70488	Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections	12.58	XXX	25/75
70490	Computed tomography, soft tissue neck; without contrast material	9.36	XXX	25/75
70491	Computed tomography, soft tissue neck; with contrast material(s)	10.78	XXX	25/75
70492	Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections	12.92	XXX	25/75
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing	15.31	XXX	25/75
70498	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing	16.33	XXX	25/75
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)	17.70	XXX	20/80
70542	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)	20.37	XXX	20/80
70543	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences	23.43	XXX	20/80
70544	Magnetic resonance angiography, head; without contrast material(s)	14.33	XXX	20/80
70545	Magnetic resonance angiography, head; with contrast material(s)	16.86	XXX	20/80
70546	Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences	20.22	XXX	20/80
70547	Magnetic resonance angiography, neck; without contrast material(s)	14.33	XXX	20/80
70548	Magnetic resonance angiography, neck; with contrast material(s)	16.86	XXX	20/80
70549	Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences	20.22	XXX	20/80
70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material	16.53	XXX	20/80
70552	Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)	20.16	XXX	20/80
70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences	22.83	XXX	20/80
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	17.39	XXX	17/83
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	21.35	XXX	17/83

70010-79999**RADIOLOGY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
70557	Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material	39.31	XXX	11/89
70558	Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); with contrast material(s)	43.69	XXX	11/89
70559	Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material(s), followed by contrast material(s) and further sequences	51.75	XXX	11/89
71045	Radiologic examination, chest; single view	0.83	XXX	46/54
71046	Radiologic examination, chest; 2 views	1.27	XXX	36/64
71047	Radiologic examination, chest; 3 views	1.62	XXX	36/64
71048	Radiologic examination, chest; 4 or more views	1.74	XXX	39/61
71100	Radiologic examination, ribs, unilateral; 2 views	1.68	XXX	40/60
71101	Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views	1.94	XXX	40/60
71110	Radiologic examination, ribs, bilateral; 3 views	2.04	XXX	40/60
71111	Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views	2.42	XXX	40/60
71120	Radiologic examination; sternum, minimum of 2 views	1.48	XXX	40/60
71130	Radiologic examination; sternoclavicular joint or joints, minimum of 3 views	1.79	XXX	40/60
■ 71250	Computed tomography, thorax, diagnostic; without contrast material	11.00	XXX	25/75
■ 71260	Computed tomography, thorax, diagnostic; with contrast material(s)	12.64	XXX	25/75
■ 71270	Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections	15.20	XXX	25/75
■ 71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)	7.13	XXX	36/64
71275	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing	18.61	XXX	25/75
71550	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)	21.01	XXX	20/80
71551	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)	24.15	XXX	20/80
71552	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences	28.99	XXX	20/80
71555	Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)	21.37	XXX	20/80
72020	Radiologic examination, spine, single view, specify level	1.28	XXX	40/60
72040	Radiologic examination, spine, cervical; 2 or 3 views	1.82	XXX	40/60
72050	Radiologic examination, spine, cervical; 4 or 5 views	2.32	XXX	40/60
72052	Radiologic examination, spine, cervical; 6 or more views	2.75	XXX	40/60

RADIOLOGY**70010-79999****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
72070	Radiologic examination, spine; thoracic, 2 views	1.76	XXX	40/60
72072	Radiologic examination, spine; thoracic, 3 views	1.89	XXX	40/60
72074	Radiologic examination, spine; thoracic, minimum of 4 views	2.17	XXX	40/60
72080	Radiologic examination, spine; thoracolumbar junction, minimum of 2 views	1.84	XXX	40/60
72081	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view	1.61	XXX	35/65
72082	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 2 or 3 views	2.60	XXX	26/74
72083	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 4 or 5 views	3.13	XXX	25/75
72084	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); minimum of 6 views	3.64	XXX	25/75
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views	1.66	XXX	40/60
72110	Radiologic examination, spine, lumbosacral; minimum of 4 views	2.42	XXX	40/60
72114	Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views	3.06	XXX	40/60
72120	Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views	2.37	XXX	40/60
72125	Computed tomography, cervical spine; without contrast material	11.00	XXX	25/75
72126	Computed tomography, cervical spine; with contrast material	12.64	XXX	25/75
72127	Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections	15.20	XXX	25/75
72128	Computed tomography, thoracic spine; without contrast material	11.00	XXX	25/75
72129	Computed tomography, thoracic spine; with contrast material	12.64	XXX	25/75
72130	Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections	15.20	XXX	25/75
72131	Computed tomography, lumbar spine; without contrast material	11.00	XXX	25/75
72132	Computed tomography, lumbar spine; with contrast material	12.64	XXX	25/75
72133	Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections	15.20	XXX	25/75
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material	16.63	XXX	20/80
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)	20.59	XXX	20/80
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material	18.14	XXX	20/80
72147	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)	19.96	XXX	20/80
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	17.24	XXX	20/80
72149	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)	19.69	XXX	20/80
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical	24.00	XXX	20/80

70010-79999**RADIOLOGY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
72157	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic	24.70	XXX	20/80
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar	23.41	XXX	20/80
72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)	21.45	XXX	20/80
72170	Radiologic examination, pelvis; 1 or 2 views	1.45	XXX	40/60
72190	Radiologic examination, pelvis; complete, minimum of 3 views	1.84	XXX	40/60
72191	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	16.13	XXX	25/75
72192	Computed tomography, pelvis; without contrast material	9.20	XXX	25/75
72193	Computed tomography, pelvis; with contrast material(s)	10.59	XXX	25/75
72194	Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections	12.71	XXX	25/75
72195	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)	17.01	XXX	20/80
72196	Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)	19.58	XXX	20/80
72197	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences	23.49	XXX	20/80
72198	Magnetic resonance angiography, pelvis, with or without contrast material(s)	20.86	XXX	20/80
72200	Radiologic examination, sacroiliac joints; less than 3 views	1.53	XXX	40/60
72202	Radiologic examination, sacroiliac joints; 3 or more views	1.81	XXX	40/60
72220	Radiologic examination, sacrum and coccyx, minimum of 2 views	1.56	XXX	40/60
72240	Myelography, cervical, radiological supervision and interpretation	8.16	XXX	35/65
72255	Myelography, thoracic, radiological supervision and interpretation	7.60	XXX	35/65
72265	Myelography, lumbosacral, radiological supervision and interpretation	8.01	XXX	35/65
72270	Myelography, 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation	10.76	XXX	35/65
72285	Discography, cervical or thoracic, radiological supervision and interpretation	12.83	XXX	35/65
72295	Discography, lumbar, radiological supervision and interpretation	12.11	XXX	35/65
73000	Radiologic examination; clavicle, complete	1.58	XXX	40/60
73010	Radiologic examination; scapula, complete	1.66	XXX	40/60
73020	Radiologic examination, shoulder; 1 view	1.40	XXX	40/60
73030	Radiologic examination, shoulder; complete, minimum of 2 views	1.79	XXX	40/60
73040	Radiologic examination, shoulder, arthrography, radiological supervision and interpretation	4.77	XXX	35/65
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	1.58	XXX	40/60
73060	Radiologic examination; humerus, minimum of 2 views	1.48	XXX	40/60
73070	Radiologic examination, elbow; 2 views	1.33	XXX	40/60
73080	Radiologic examination, elbow; complete, minimum of 3 views	1.48	XXX	40/60
73085	Radiologic examination, elbow, arthrography, radiological supervision and interpretation	4.69	XXX	35/65

RADIOLOGY**70010-79999****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
73090	Radiologic examination; forearm, 2 views	1.28	XXX	40/60
73092	Radiologic examination; upper extremity, infant, minimum of 2 views	1.35	XXX	40/60
73100	Radiologic examination, wrist; 2 views	1.17	XXX	40/60
73110	Radiologic examination, wrist; complete, minimum of 3 views	1.33	XXX	40/60
73115	Radiologic examination, wrist, arthrography, radiological supervision and interpretation	3.37	XXX	35/65
73120	Radiologic examination, hand; 2 views	1.20	XXX	40/60
73130	Radiologic examination, hand; minimum of 3 views	1.33	XXX	40/60
73140	Radiologic examination, finger(s), minimum of 2 views	1.01	XXX	40/60
73200	Computed tomography, upper extremity; without contrast material	9.20	XXX	25/75
73201	Computed tomography, upper extremity; with contrast material(s)	10.59	XXX	25/75
73202	Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections	12.71	XXX	25/75
73206	Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing	16.13	XXX	25/75
73218	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)	14.48	XXX	20/80
73219	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s)	17.04	XXX	20/80
73220	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s), followed by contrast material(s) and further sequences	20.45	XXX	20/80
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)	16.61	XXX	20/80
73222	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)	19.11	XXX	20/80
73223	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences	22.94	XXX	20/80
73225	Magnetic resonance angiography, upper extremity, with or without contrast material(s)	17.96	XXX	20/80
73501	Radiologic examination, hip, unilateral, with pelvis when performed; 1 view	1.25	XXX	32/68
73502	Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views	1.73	XXX	27/73
73503	Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views	2.15	XXX	28/72
73521	Radiologic examination, hips, bilateral, with pelvis when performed; 2 views	1.56	XXX	30/70
73522	Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views	2.04	XXX	31/69
73523	Radiologic examination, hips, bilateral, with pelvis when performed; minimum of 5 views	2.36	XXX	29/71
73525	Radiologic examination, hip, arthrography, radiological supervision and interpretation	4.77	XXX	35/65
73551	Radiologic examination, femur; 1 view	1.17	XXX	30/70
73552	Radiologic examination, femur; minimum 2 views	1.37	XXX	29/71
73560	Radiologic examination, knee; 1 or 2 views	1.40	XXX	40/60
73562	Radiologic examination, knee; 3 views	1.66	XXX	40/60

70010-79999**RADIOLOGY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
73564	Radiologic examination, knee; complete, 4 or more views	1.86	XXX	40/60
73565	Radiologic examination, knee; both knees, standing, anteroposterior	1.40	XXX	40/60
73580	Radiologic examination, knee, arthrography, radiological supervision and interpretation	5.66	XXX	35/65
73590	Radiologic examination; tibia and fibula, 2 views	1.53	XXX	40/60
73592	Radiologic examination; lower extremity, infant, minimum of 2 views	1.53	XXX	40/60
73600	Radiologic examination, ankle; 2 views	1.38	XXX	40/60
73610	Radiologic examination, ankle; complete, minimum of 3 views	1.48	XXX	40/60
73615	Radiologic examination, ankle, arthrography, radiological supervision and interpretation	4.69	XXX	35/65
73620	Radiologic examination, foot; 2 views	1.43	XXX	40/60
73630	Radiologic examination, foot; complete, minimum of 3 views	1.48	XXX	40/60
73650	Radiologic examination; calcaneus, minimum of 2 views	1.28	XXX	40/60
73660	Radiologic examination; toe(s), minimum of 2 views	1.12	XXX	40/60
73700	Computed tomography, lower extremity; without contrast material	9.20	XXX	25/75
73701	Computed tomography, lower extremity; with contrast material(s)	10.59	XXX	25/75
73702	Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections	12.71	XXX	25/75
73706	Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing	16.13	XXX	25/75
73718	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)	17.04	XXX	20/80
73719	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)	19.60	XXX	20/80
73720	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences	23.51	XXX	20/80
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material	16.61	XXX	20/80
73722	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; with contrast material(s)	19.11	XXX	20/80
73723	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s), followed by contrast material(s) and further sequences	22.94	XXX	20/80
73725	Magnetic resonance angiography, lower extremity, with or without contrast material(s)	18.45	XXX	20/80
74018	Radiologic examination, abdomen; 1 view	1.33	XXX	40/60
74019	Radiologic examination, abdomen; 2 views	1.39	XXX	35/65
74021	Radiologic examination, abdomen; 3 or more views	1.62	XXX	35/65
■ 74022	Radiologic examination, complete acute abdomen series, including 2 or more views of the abdomen (eg, supine, erect, decubitus), and a single view chest	2.55	XXX	40/60
74150	Computed tomography, abdomen; without contrast material	10.25	XXX	25/75
74160	Computed tomography, abdomen; with contrast material(s)	11.80	XXX	25/75
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	14.15	XXX	25/75

RADIOLOGY**70010-79999****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
74174	Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	21.13	XXX	19/81
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing	17.57	XXX	25/75
74176	Computed tomography, abdomen and pelvis; without contrast material	7.06	XXX	37/63
74177	Computed tomography, abdomen and pelvis; with contrast material(s)	10.82	XXX	24/76
74178	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions	14.13	XXX	21/79
74181	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)	17.01	XXX	20/80
74182	Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)	19.58	XXX	20/80
74183	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences	23.49	XXX	20/80
74185	Magnetic resonance angiography, abdomen, with or without contrast material(s)	20.46	XXX	20/80
74190	Peritoneogram (eg, after injection of air or contrast), radiological supervision and interpretation	2.04	XXX	35/65
■	74210 Radiologic examination, pharynx and/or cervical esophagus, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study	2.52	XXX	40/60
■	74220 Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study	2.63	XXX	40/60
■	74221 Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study	4.83	XXX	30/70
■	74230 Radiologic examination, swallowing function, with cineradiography/ videoradiography, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study	3.19	XXX	40/60
	74235 Removal of foreign body(s), esophageal, with use of balloon catheter, radiological supervision and interpretation	6.38	XXX	35/65
■	74240 Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study	3.52	XXX	40/60
■	74246 Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered	3.77	XXX	40/60
■ +	74248 Radiologic small intestine follow-through study, including multiple serial images (List separately in addition to code for primary procedure for upper GI radiologic examination)	3.64	ZZZ	40/60
■	74250 Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study	2.93	XXX	40/60
■	74251 Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; double-contrast (eg, high-density barium and air via enteroclysis tube) study, including glucagon, when administered	3.39	XXX	40/60

70010-79999

RADIOLOGY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	13.40	XXX	21/79
	74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	15.19	XXX	18/82
	74263	Computed tomographic (CT) colonography, screening, including image postprocessing	16.08	XXX	16/84
■	74270	Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study	4.13	XXX	40/60
■	74280	Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high density barium and air) study, including glucagon, when administered	5.41	XXX	40/60
	74283	Therapeutic enema, contrast or air, for reduction of intussusception or other intraluminal obstruction (eg, meconium ileus)	6.22	XXX	40/60
	74290	Cholecystography, oral contrast	2.12	XXX	40/60
	74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation	2.55	XXX	35/65
+	74301	Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure)	1.45	ZZZ	35/65
	74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	7.06	XXX	35/65
	74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	7.04	XXX	35/65
	74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	7.47	XXX	35/65
	74340	Introduction of long gastrointestinal tube (eg, Miller-Abbott), including multiple fluoroscopies and images, radiological supervision and interpretation	3.83	XXX	35/65
	74355	Percutaneous placement of enteroclysis tube, radiological supervision and interpretation	5.58	XXX	35/65
	74360	Intraluminal dilation of strictures and/or obstructions (eg, esophagus), radiological supervision and interpretation	7.37	XXX	35/65
	74363	Percutaneous transhepatic dilation of biliary duct stricture with or without placement of stent, radiological supervision and interpretation	5.30	XXX	35/65
	74400	Urography (pyelography), intravenous, with or without KUB, with or without tomography	3.83	XXX	40/60
	74410	Urography, infusion, drip technique and/or bolus technique;	4.08	XXX	40/60
	74415	Urography, infusion, drip technique and/or bolus technique; with nephrotomography	4.59	XXX	40/60
	74420	Urography, retrograde, with or without KUB	2.55	XXX	40/60
■	74425	Urography, antegrade, radiological supervision and interpretation	2.93	XXX	35/65
	74430	Cystography, minimum of 3 views, radiological supervision and interpretation	2.40	XXX	35/65
	74440	Vasography, vesiculography, or epididymography, radiological supervision and interpretation	2.68	XXX	35/65
	74445	Corpora cavernosography, radiological supervision and interpretation	3.54	XXX	35/65

RADIOLOGY

70010-79999

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
	74450	Urethrocystography, retrograde, radiological supervision and interpretation	3.19	XXX	35/65
	74455	Urethrocystography, voiding, radiological supervision and interpretation	3.49	XXX	35/65
	74470	Radiologic examination, renal cyst study, translumbar, contrast visualization, radiological supervision and interpretation	3.32	XXX	35/65
■	74485	Dilation of ureter(s) or urethra, radiological supervision and interpretation	6.20	XXX	35/65
	74712	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation	20.59	XXX	31/69
+	74713	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; each additional gestation (List separately in addition to code for primary procedure)	9.95	ZZZ	39/61
	74740	Hysterosalpingography, radiological supervision and interpretation	3.06	XXX	35/65
	74742	Transcervical catheterization of fallopian tube, radiological supervision and interpretation	3.44	XXX	35/65
	74775	Perineogram (eg, vaginogram, for sex determination or extent of anomalies)	3.95	XXX	40/60
	75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	19.77	XXX	23/77
	75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	26.88	XXX	20/80
	75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	24.51	XXX	19/81
	75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	30.83	XXX	18/82
+	75565	Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure)	3.16	ZZZ	14/86
	75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	4.47	XXX	23/77
	75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	5.36	XXX	62/38
■	75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of left ventricular [LV] cardiac function, right ventricular [RV] structure and function and evaluation of vascular structures, if performed)	7.15	XXX	66/34
	75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	22.34	XXX	20/80
■	75580	Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional	38.66	XXX	4/96
	75600	Aortography, thoracic, without serialography, radiological supervision and interpretation	16.54	XXX	10/90
	75605	Aortography, thoracic, by serialography, radiological supervision and interpretation	19.22	XXX	15/85

70010-79999**RADIOLOGY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
75625	Aortography, abdominal, by serialography, radiological supervision and interpretation	19.37	XXX	15/85
75630	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation	20.45	XXX	15/85
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing	42.99	XXX	25/75
75705	Angiography, spinal, selective, radiological supervision and interpretation	18.62	XXX	20/80
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	16.79	XXX	15/85
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	20.76	XXX	15/85
75726	Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and interpretation	20.58	XXX	15/85
75731	Angiography, adrenal, unilateral, selective, radiological supervision and interpretation	11.42	XXX	15/85
75733	Angiography, adrenal, bilateral, selective, radiological supervision and interpretation	15.63	XXX	15/85
75736	Angiography, pelvic, selective or supraseductive, radiological supervision and interpretation	19.51	XXX	15/85
75741	Angiography, pulmonary, unilateral, selective, radiological supervision and interpretation	19.17	XXX	15/85
75743	Angiography, pulmonary, bilateral, selective, radiological supervision and interpretation	20.16	XXX	15/85
75746	Angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation	16.52	XXX	15/85
75756	Angiography, internal mammary, radiological supervision and interpretation	18.75	XXX	15/85
+ 75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	4.05	ZZZ	10/90
75801	Lymphangiography, extremity only, unilateral, radiological supervision and interpretation	10.07	XXX	20/80
75803	Lymphangiography, extremity only, bilateral, radiological supervision and interpretation	12.14	XXX	20/80
75805	Lymphangiography, pelvic/abdominal, unilateral, radiological supervision and interpretation	13.08	XXX	20/80
75807	Lymphangiography, pelvic/abdominal, bilateral, radiological supervision and interpretation	14.03	XXX	20/80
75809	Shuntogram for investigation of previously placed indwelling nonvascular shunt (eg, LeVeen shunt, ventriculoperitoneal shunt, indwelling infusion pump), radiological supervision and interpretation	4.34	XXX	35/65
75810	Splenoportography, radiological supervision and interpretation	19.44	XXX	15/85
75820	Venography, extremity, unilateral, radiological supervision and interpretation	4.59	XXX	35/65
75822	Venography, extremity, bilateral, radiological supervision and interpretation	6.91	XXX	35/65
75825	Venography, caval, inferior, with serialography, radiological supervision and interpretation	19.44	XXX	15/85

RADIOLOGY**70010-79999****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
75827	Venography, caval, superior, with serialography, radiological supervision and interpretation	19.44	XXX	15/85
75831	Venography, renal, unilateral, selective, radiological supervision and interpretation	18.95	XXX	15/85
75833	Venography, renal, bilateral, selective, radiological supervision and interpretation	22.64	XXX	15/85
75840	Venography, adrenal, unilateral, selective, radiological supervision and interpretation	12.16	XXX	15/85
75842	Venography, adrenal, bilateral, selective, radiological supervision and interpretation	19.97	XXX	15/85
75860	Venography, venous sinus (eg, petrosal and inferior sagittal) or jugular, catheter, radiological supervision and interpretation	17.77	XXX	15/85
75870	Venography, superior sagittal sinus, radiological supervision and interpretation	15.91	XXX	15/85
75872	Venography, epidural, radiological supervision and interpretation	20.32	XXX	15/85
75880	Venography, orbital, radiological supervision and interpretation	5.84	XXX	15/85
75885	Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation	23.59	XXX	15/85
75887	Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation	11.60	XXX	15/85
75889	Hepatic venography, wedged or free, with hemodynamic evaluation, radiological supervision and interpretation	20.88	XXX	15/85
75891	Hepatic venography, wedged or free, without hemodynamic evaluation, radiological supervision and interpretation	20.22	XXX	15/85
75893	Venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation	8.34	XXX	10/90
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	48.93	XXX	10/90
75898	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis	12.65	XXX	75/25
75901	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation	51.51	XXX	10/90
75902	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation	51.51	XXX	10/90
75956	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation	22.19	XXX	10/90
75957	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation	19.00	XXX	10/90

70010-79999

RADIOLOGY

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
75958	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological supervision and interpretation	12.67	XXX	10/90
75959	Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation	11.09	XXX	10/90
75970	Transcatheter biopsy, radiological supervision and interpretation	19.58	XXX	10/90
75984	Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision and interpretation	4.39	XXX	35/65
75989	Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation	7.91	XXX	20/80
76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time	2.81	XXX	35/65
76080	Radiologic examination, abscess, fistula or sinus tract study, radiological supervision and interpretation	2.35	XXX	35/65
76098	Radiological examination, surgical specimen	1.15	XXX	40/60
76100	Radiologic examination, single plane body section (eg, tomography), other than with urography	3.32	XXX	40/60
76120	Cineradiography/videoradiography, except where specifically included	2.81	XXX	40/60
+	76125 Cineradiography/videoradiography to complement routine examination (List separately in addition to code for primary procedure)	2.30	ZZZ	40/60
76140	Consultation on X-ray examination made elsewhere, written report	BR	XXX	
■	76145 Medical physics dose evaluation for radiation exposure that exceeds institutional review threshold, including report	44.03	XXX	
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation	4.40	XXX	15/85
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation	5.65	XXX	44/56
76380	Computed tomography, limited or localized follow-up study	6.61	XXX	26/74
76390	Magnetic resonance spectroscopy	15.42	XXX	14/86
■	76391 Magnetic resonance (eg, vibration) elastography	11.61	XXX	25/75
76496	Unlisted fluoroscopic procedure (eg, diagnostic, interventional)	BR	XXX	
76497	Unlisted computed tomography procedure (eg, diagnostic, interventional)	BR	XXX	
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	BR	XXX	
76499	Unlisted diagnostic radiographic procedure	BR	XXX	
76506	Echoencephalography, real time with image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents, and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated	4.44	XXX	45/55

RADIOLOGY

70010-79999

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
	76510	Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter	6.63	XXX	50/50
	76511	Ophthalmic ultrasound, diagnostic; quantitative A-scan only	4.85	XXX	45/55
	76512	Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)	5.36	XXX	45/55
■	76513	Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy, unilateral or bilateral	5.10	XXX	40/60
	76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)	0.87	XXX	45/55
	76516	Ophthalmic biometry by ultrasound echography, A-scan;	5.10	XXX	45/55
	76519	Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation	5.10	XXX	45/55
	76529	Ophthalmic ultrasonic foreign body localization	4.59	XXX	45/55
	76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	4.05	XXX	45/55
	76604	Ultrasound, chest (includes mediastinum), real time with image documentation	5.10	XXX	45/55
	76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	4.51	XXX	34/66
	76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	3.70	XXX	39/61
	76700	Ultrasound, abdominal, real time with image documentation; complete	5.10	XXX	45/55
	76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	3.83	XXX	45/55
	76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	3.97	XXX	29/71
	76770	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete	4.87	XXX	45/55
	76775	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited	3.14	XXX	45/55
	76776	Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation	4.90	XXX	30/70
	76800	Ultrasound, spinal canal and contents	5.56	XXX	45/55
	76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation	4.51	XXX	45/55
+	76802	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	2.26	ZZZ	45/55
	76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation	4.51	XXX	45/55
+	76810	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	6.58	ZZZ	45/55

70010-79999**RADIOLOGY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation	5.42	XXX	45/55
+	76812	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	2.70	ZZZ	45/55
	76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation	4.21	XXX	45/55
+	76814	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation (List separately in addition to code for primary procedure)	2.81	XXX	57/43
	76815	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses	3.32	XXX	45/55
	76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus	2.91	XXX	45/55
	76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal	4.51	XXX	45/55
	76818	Fetal biophysical profile; with non-stress testing	4.74	XXX	45/55
	76819	Fetal biophysical profile; without non-stress testing	4.72	XXX	45/55
	76820	Doppler velocimetry, fetal; umbilical artery	3.49	XXX	30/70
	76821	Doppler velocimetry, fetal; middle cerebral artery	3.88	XXX	35/65
	76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;	5.99	XXX	45/55
	76826	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study	3.60	XXX	45/55
	76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete	3.83	XXX	45/55
	76828	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study	2.30	XXX	45/55
	76830	Ultrasound, transvaginal	5.10	XXX	45/55
	76831	Saline infusion sonohysterography (SIS), including color flow Doppler, when performed	5.89	XXX	45/55
	76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete	4.46	XXX	45/55
	76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)	4.08	XXX	45/55
	76870	Ultrasound, scrotum and contents	3.83	XXX	45/55
	76872	Ultrasound, transrectal;	5.46	XXX	45/55
	76873	Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)	4.59	XXX	45/55
	76881	Ultrasound, complete joint (ie, joint space and peri-articular soft tissue structures) real-time with image documentation	4.46	XXX	25/75

RADIOLOGY

70010-79999

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
■	76882	Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation	1.28	XXX	51/49
	76932	Ultrasonic guidance for endomyocardial biopsy, imaging supervision and interpretation	4.41	YYY	45/55
	76936	Ultrasound guided compression repair of arterial pseudoaneurysm or arteriovenous fistulae (includes diagnostic ultrasound evaluation, compression of lesion and imaging)	13.54	XXX	20/80
+	76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)	1.51	ZZZ	20/80
	76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	4.49	YYY	20/80
	76941	Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation	3.70	XXX	45/55
	76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	4.97	XXX	45/55
	76945	Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation	3.70	XXX	45/55
	76946	Ultrasonic guidance for amniocentesis, imaging supervision and interpretation	4.13	XXX	45/55
	76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation	4.72	XXX	45/55
	76965	Ultrasonic guidance for interstitial radioelement application	4.59	XXX	45/55
	76975	Gastrointestinal endoscopic ultrasound, supervision and interpretation	6.68	XXX	45/55
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method	2.09	XXX	31/69
■	76981	Ultrasound, elastography; parenchyma (eg, organ)	4.72	XXX	27/73
■	76982	Ultrasound, elastography; first target lesion	4.13	XXX	30/70
■ +	76983	Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)	2.65	ZZZ	40/60
■	76984	Ultrasound, intraoperative thoracic aorta (eg, epiaortic), diagnostic	1.39	XXX	100/0
■	76987	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report	4.25	XXX	100/0
■	76988	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only	2.68	XXX	100/0
■	76989	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; interpretation and report only	1.59	XXX	100/0
	76998	Ultrasonic guidance, intraoperative	2.79	XXX	
	76999	Unlisted ultrasound procedure (eg, diagnostic, interventional)	BR	XXX	

70010-79999

RADIOLOGY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
+	77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)	3.11	ZZZ	22/78
+	77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	2.81	ZZZ	34/66
+	77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)	2.73	ZZZ	38/62
	77011	Computed tomography guidance for stereotactic localization	11.61	XXX	16/84
	77012	Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation	11.61	XXX	15/85
	77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	20.55	XXX	36/64
	77014	Computed tomography guidance for placement of radiation therapy fields	5.36	XXX	27/73
■	77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	20.15	XXX	16/84
■	77022	Magnetic resonance imaging guidance for, and monitoring of, parenchymal tissue ablation	27.41	XXX	31/69
■	77046	Magnetic resonance imaging, breast, without contrast material; unilateral	12.34	XXX	31/69
■	77047	Magnetic resonance imaging, breast, without contrast material; bilateral	12.72	XXX	33/67
■	77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral	19.55	XXX	28/72
■	77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral	19.91	XXX	31/69
	77053	Mammary ductogram or galactogram, single duct, radiological supervision and interpretation	4.26	XXX	15/85
	77054	Mammary ductogram or galactogram, multiple ducts, radiological supervision and interpretation	4.85	XXX	14/86
■	77061	Diagnostic digital breast tomosynthesis; unilateral	BR	XXX	
■	77062	Diagnostic digital breast tomosynthesis; bilateral	BR	XXX	
+	77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	2.30	ZZZ	54/46
	77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	5.65	XXX	30/70
	77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	7.14	XXX	30/70
	77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	5.75	XXX	28/72
	77071	Manual application of stress performed by physician or other qualified health care professional for joint radiography, including contralateral joint if indicated	1.28	XXX	

RADIOLOGY**70010-79999****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
77072	Bone age studies	1.66	XXX	32/68
77073	Bone length studies (orthoroentgenogram, scanogram)	2.30	XXX	31/69
77074	Radiologic examination, osseous survey; limited (eg, for metastases)	2.52	XXX	37/63
77075	Radiologic examination, osseous survey; complete (axial and appendicular skeleton)	4.08	XXX	33/67
77077	Joint survey, single view, 2 or more joints (specify)	2.37	XXX	27/73
77078	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine)	5.36	XXX	10/90
77080	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	6.48	XXX	11/89
77081	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	2.04	XXX	28/72
77084	Magnetic resonance (eg, proton) imaging, bone marrow blood supply	2.68	XXX	40/60
77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment	2.37	XXX	27/73
77086	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)	1.76	XXX	23/77
77261	Therapeutic radiology treatment planning; simple	6.68	XXX	
77262	Therapeutic radiology treatment planning; intermediate	8.75	XXX	
77263	Therapeutic radiology treatment planning; complex	11.93	XXX	
77280	Therapeutic radiology simulation-aided field setting; simple	11.35	XXX	30/70
77285	Therapeutic radiology simulation-aided field setting; intermediate	16.65	XXX	30/70
77290	Therapeutic radiology simulation-aided field setting; complex	21.32	XXX	30/70
+	77293 Respiratory motion management simulation (List separately in addition to code for primary procedure)	19.87	ZZZ	22/78
77295	3-dimensional radiotherapy plan, including dose-volume histograms	26.83	XXX	30/70
77299	Unlisted procedure, therapeutic radiology clinical treatment planning	BR	XXX	
77300	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician	4.56	XXX	50/50
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	8.21	XXX	55/45
77306	Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)	6.36	XXX	48/52
77307	Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)	7.14	XXX	55/45
77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)	5.10	XXX	45/55
77317	Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)	7.65	XXX	45/55

70010-79999**RADIOLOGY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
77318	Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)	10.84	XXX	50/50
77321	Special teletherapy port plan, particles, hemibody, total body	8.52	XXX	35/65
77331	Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician	3.03	XXX	80/20
77332	Treatment devices, design and construction; simple (simple block, simple bolus)	4.08	XXX	50/50
77333	Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)	5.00	XXX	50/50
77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)	9.64	XXX	45/55
77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy	3.37	XXX	0/100
77338	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan	12.11	XXX	47/53
77370	Special medical radiation physics consultation	5.25	XXX	0/100
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	40.65	XXX	0/100
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	30.86	XXX	0/100
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	57.54	XXX	0/100
77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple	14.64	XXX	
77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex	14.69	XXX	
■ 77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed	2.74	XXX	39/61
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services	BR	XXX	
77401	Radiation treatment delivery, superficial and/or ortho voltage, per day	2.19	XXX	0/100
■ 77402	Radiation treatment delivery, => 1 MeV; simple	2.23	XXX	0/100
■ 77407	Radiation treatment delivery, => 1 MeV; intermediate	2.87	XXX	0/100
77412	Radiation treatment delivery, => 1 MeV; complex	3.65	XXX	0/100
77417	Therapeutic radiology port image(s)	2.22	XXX	0/100
77423	High energy neutron radiation treatment delivery, 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)	3.21	XXX	0/100
77424	Intraoperative radiation treatment delivery, x-ray, single treatment session	0.00	XXX	
77425	Intraoperative radiation treatment delivery, electrons, single treatment session	0.00	XXX	
77427	Radiation treatment management, 5 treatments	9.24	XXX	

RADIOLOGY**70010-79999****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
77431	Radiation therapy management with complete course of therapy consisting of 1 or 2 fractions only	2.96	XXX	
77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)	25.83	XXX	
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	37.00	XXX	
77469	Intraoperative radiation treatment management	12.79	XXX	
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)	25.71	XXX	30/70
77499	Unlisted procedure, therapeutic radiology treatment management	BR	XXX	
77520	Proton treatment delivery; simple, without compensation	BR	XXX	0/100
77522	Proton treatment delivery; simple, with compensation	BR	XXX	0/100
77523	Proton treatment delivery; intermediate	BR	XXX	0/100
77525	Proton treatment delivery; complex	BR	XXX	0/100
77600	Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)	10.61	XXX	50/50
77605	Hyperthermia, externally generated; deep (ie, heating to depths greater than 4 cm)	14.28	XXX	50/50
77610	Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators	8.06	XXX	50/50
77615	Hyperthermia generated by interstitial probe(s); more than 5 interstitial applicators	11.73	XXX	50/50
77620	Hyperthermia generated by intracavitary probe(s)	6.89	XXX	50/50
77750	Infusion or instillation of radioelement solution (includes 3-month follow-up care)	12.75	090	85/15
77761	Intracavitary radiation source application; simple	10.66	090	75/25
77762	Intracavitary radiation source application; intermediate	15.76	090	75/25
77763	Intracavitary radiation source application; complex	21.66	090	80/20
77767	Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter up to 2.0 cm or 1 channel	9.57	XXX	24/76
77768	Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions	15.03	XXX	20/80
77770	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel	6.76	XXX	38/62
77771	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels	20.27	XXX	29/71
77772	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels	30.14	XXX	30/70
77778	Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed	31.88	000	80/20
77789	Surface application of low dose rate radionuclide source	2.63	000	80/20
77790	Supervision, handling, loading of radiation source	3.32	XXX	80/20
77799	Unlisted procedure, clinical brachytherapy	BR	XXX	

70010-79999

RADIOLOGY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	78012	Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)	3.50	XXX	11/89
	78013	Thyroid imaging (including vascular flow, when performed);	8.30	XXX	9/91
	78014	Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)	10.44	XXX	10/90
	78015	Thyroid carcinoma metastases imaging; limited area (eg, neck and chest only)	5.74	XXX	30/70
	78016	Thyroid carcinoma metastases imaging; with additional studies (eg, urinary recovery)	6.09	XXX	30/70
	78018	Thyroid carcinoma metastases imaging; whole body	9.56	XXX	30/70
+	78020	Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure)	1.91	ZZZ	30/70
	78070	Parathyroid planar imaging (including subtraction, when performed);	2.55	XXX	30/70
	78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)	15.46	XXX	16/84
	78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization	17.90	XXX	18/82
	78075	Adrenal imaging, cortex and/or medulla	3.83	XXX	30/70
	78099	Unlisted endocrine procedure, diagnostic nuclear medicine	BR	XXX	
	78102	Bone marrow imaging; limited area	4.46	XXX	25/75
	78103	Bone marrow imaging; multiple areas	7.01	XXX	25/75
	78104	Bone marrow imaging; whole body	7.65	XXX	25/75
	78110	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling	2.55	XXX	25/75
	78111	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); multiple samplings	3.83	XXX	25/75
	78120	Red cell volume determination (separate procedure); single sampling	2.81	XXX	25/75
	78121	Red cell volume determination (separate procedure); multiple samplings	4.72	XXX	25/75
	78122	Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique)	7.14	XXX	25/75
■	78130	Red cell survival study	5.74	XXX	25/75
	78140	Labeled red cell sequestration, differential organ/tissue (eg, splenic and/or hepatic)	5.64	XXX	25/75
	78185	Spleen imaging only, with or without vascular flow	4.34	XXX	25/75
	78191	Platelet survival study	8.19	XXX	25/75
	78195	Lymphatics and lymph nodes imaging	7.06	XXX	25/75
	78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	BR	XXX	
	78201	Liver imaging; static only	5.10	XXX	25/75
	78202	Liver imaging; with vascular flow	5.61	XXX	25/75
	78215	Liver and spleen imaging; static only	7.01	XXX	25/75
	78216	Liver and spleen imaging; with vascular flow	8.19	XXX	25/75

RADIOLOGY**70010-79999****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
78226	Hepatobiliary system imaging, including gallbladder when present;	14.12	XXX	11/89
78227	Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed	19.33	XXX	9/91
78230	Salivary gland imaging;	4.31	XXX	25/75
78231	Salivary gland imaging; with serial images	4.49	XXX	25/75
78232	Salivary gland function study	4.59	XXX	25/75
78258	Esophageal motility	6.43	XXX	25/75
78261	Gastric mucosa imaging	6.07	XXX	25/75
78262	Gastroesophageal reflux study	6.63	XXX	25/75
78264	Gastric emptying imaging study (eg, solid, liquid, or both);	6.81	XXX	25/75
78265	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit	17.24	XXX	12/88
78266	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days	20.54	XXX	11/89
78267	Urea breath test, C-14 (isotopic); acquisition for analysis	0.48	XXX	0/100
78268	Urea breath test, C-14 (isotopic); analysis	4.10	XXX	0/100
78278	Acute gastrointestinal blood loss imaging	7.73	XXX	25/75
78282	Gastrointestinal protein loss	4.28	XXX	25/75
78290	Intestine imaging (eg, ectopic gastric mucosa, Meckel's localization, volvulus)	5.87	XXX	25/75
78291	Peritoneal-venous shunt patency test (eg, for LeVeen, Denver shunt)	5.10	XXX	25/75
78299	Unlisted gastrointestinal procedure, diagnostic nuclear medicine	BR	XXX	
78300	Bone and/or joint imaging; limited area	5.87	XXX	30/70
78305	Bone and/or joint imaging; multiple areas	7.27	XXX	30/70
78306	Bone and/or joint imaging; whole body	7.78	XXX	30/70
78315	Bone and/or joint imaging; 3 phase study	8.29	XXX	30/70
78350	Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry	2.73	XXX	30/70
78351	Bone density (bone mineral content) study, 1 or more sites; dual photon absorptiometry, 1 or more sites	3.75	XXX	30/70
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine	BR	XXX	
78414	Determination of central c-v hemodynamics (non-imaging) (eg, ejection fraction with probe technique) with or without pharmacologic intervention or exercise, single or multiple determinations	6.63	XXX	30/70
78428	Cardiac shunt detection	5.23	XXX	30/70
■ 78429	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan	20.51	XXX	17/83
■ 78430	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	23.53	XXX	14/86

70010-79999

RADIOLOGY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	27.57	XXX	14/86
■	78432	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);	30.34	XXX	14/86
■	78433	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan	32.36	XXX	14/86
■ +	78434	Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)	9.15	ZZZ	14/86
	78445	Non-cardiac vascular flow imaging (ie, angiography, venography)	6.30	XXX	30/70
	78451	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	8.67	XXX	30/70
	78452	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	14.28	XXX	21/79
	78453	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	7.40	XXX	15/85
	78454	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	7.27	XXX	34/66
	78456	Acute venous thrombosis imaging, peptide	12.37	XXX	13/87
	78457	Venous thrombosis imaging, venogram; unilateral	5.25	XXX	30/70
	78458	Venous thrombosis imaging, venogram; bilateral	8.19	XXX	30/70
■	78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study;	5.89	XXX	30/70
	78466	Myocardial imaging, infarct avid, planar; qualitative or quantitative	7.93	XXX	30/70
	78468	Myocardial imaging, infarct avid, planar; with ejection fraction by first pass technique	7.27	XXX	30/70
	78469	Myocardial imaging, infarct avid, planar; tomographic SPECT with or without quantification	8.49	XXX	20/80
	78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing	8.31	XXX	30/70

RADIOLOGY

70010-79999

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
	78473	Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification	14.97	XXX	30/70
	78481	Cardiac blood pool imaging (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification	8.80	XXX	30/70
	78483	Cardiac blood pool imaging (planar), first pass technique; multiple studies, at rest and with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification	18.11	XXX	30/70
■	78491	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)	17.01	XXX	16/84
■	78492	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic)	21.45	XXX	16/84
	78494	Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing	14.13	XXX	30/70
+	78496	Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (List separately in addition to code for primary procedure)	2.78	ZZZ	30/70
	78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine	BR	XXX	
	78579	Pulmonary ventilation imaging (eg, aerosol or gas)	7.51	XXX	13/87
	78580	Pulmonary perfusion imaging (eg, particulate)	6.43	XXX	25/75
	78582	Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging	13.84	XXX	16/84
	78597	Quantitative differential pulmonary perfusion, including imaging when performed	8.46	XXX	17/83
	78598	Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed	12.99	XXX	13/87
	78599	Unlisted respiratory procedure, diagnostic nuclear medicine	BR	XXX	25/75
	78600	Brain imaging, less than 4 static views;	5.05	XXX	25/75
	78601	Brain imaging, less than 4 static views; with vascular flow	6.38	XXX	25/75
	78605	Brain imaging, minimum 4 static views;	6.25	XXX	25/75
	78606	Brain imaging, minimum 4 static views; with vascular flow	7.17	XXX	25/75
	78608	Brain imaging, positron emission tomography (PET); metabolic evaluation	5.89	XXX	
	78609	Brain imaging, positron emission tomography (PET); perfusion evaluation	5.89	XXX	
	78610	Brain imaging, vascular flow only	2.91	XXX	25/75
	78630	Cerebrospinal fluid flow, imaging (not including introduction of material); cisternography	8.11	XXX	25/75
	78635	Cerebrospinal fluid flow, imaging (not including introduction of material); ventriculography	6.38	XXX	25/75
	78645	Cerebrospinal fluid flow, imaging (not including introduction of material); shunt evaluation	6.38	XXX	25/75
	78650	Cerebrospinal fluid leakage detection and localization	8.93	XXX	25/75
	78660	Radiopharmaceutical dacryocystography	4.26	XXX	25/75
	78699	Unlisted nervous system procedure, diagnostic nuclear medicine	BR	XXX	

70010-79999

RADIOLOGY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	78700	Kidney imaging morphology;	5.43	XXX	30/70
	78701	Kidney imaging morphology; with vascular flow	6.38	XXX	30/70
	78707	Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention	9.81	XXX	30/70
	78708	Kidney imaging morphology; with vascular flow and function, single study, with pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)	10.22	XXX	30/70
	78709	Kidney imaging morphology; with vascular flow and function, multiple studies, with and without pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)	10.55	XXX	30/70
	78725	Kidney function study, non-imaging radioisotopic study	5.74	XXX	30/70
+	78730	Urinary bladder residual study (List separately in addition to code for primary procedure)	2.55	ZZZ	30/70
	78740	Ureteral reflux study (radiopharmaceutical voiding cystogram)	4.56	XXX	30/70
	78761	Testicular imaging with vascular flow	6.09	XXX	30/70
	78799	Unlisted genitourinary procedure, diagnostic nuclear medicine	BR	XXX	
■	78800	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, single area (eg, head, neck, chest, pelvis), single day imaging	5.61	XXX	25/75
■	78801	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, 2 or more areas (eg, abdomen and pelvis, head and chest), 1 or more days imaging or single area imaging over 2 or more days	7.09	XXX	25/75
■	78802	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, whole body, single day imaging	8.95	XXX	25/75
■	78803	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), single area (eg, head, neck, chest, pelvis) or acquisition, single day imaging	9.54	XXX	25/75
■	78804	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, whole body, requiring 2 or more days imaging	10.20	XXX	25/75
	78808	Injection procedure for radiopharmaceutical localization by non-imaging probe study, intravenous (eg, parathyroid adenoma)	1.66	XXX	
	78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	17.09	XXX	12/88
	78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	21.17	XXX	12/88
	78813	Positron emission tomography (PET) imaging; whole body	21.93	XXX	12/88
	78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)	21.42	XXX	12/88
	78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	23.58	XXX	12/88

RADIOLOGY**70010-79999****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	24.22	XXX	12/88
■	78830	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis) or acquisition, single day imaging	19.00	XXX	15/85
■	78831	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, chest and abdomen) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition over 2 or more days	28.24	XXX	13/87
■	78832	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, chest and abdomen) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition over 2 or more days	35.81	XXX	12/88
■ +	78835	Radiopharmaceutical quantification measurement(s) single area (List separately in addition to code for primary procedure)	3.95	ZZZ	23/77
	78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine	BR	XXX	
	79005	Radiopharmaceutical therapy, by oral administration	8.62	XXX	45/55
	79101	Radiopharmaceutical therapy, by intravenous administration	8.98	XXX	60/40
	79200	Radiopharmaceutical therapy, by intracavitary administration	9.08	XXX	50/50
	79300	Radiopharmaceutical therapy, by interstitial radioactive colloid administration	5.25	XXX	60/40
	79403	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion	10.20	XXX	60/40
	79440	Radiopharmaceutical therapy, by intra-articular administration	7.65	XXX	60/40
	79445	Radiopharmaceutical therapy, by intra-arterial particulate administration	8.62	XXX	55/45
	79999	Radiopharmaceutical therapy, unlisted procedure	BR	XXX	

6 Pathology and Laboratory

The relative value units in this section were determined uniquely for pathology and laboratory services. Use the pathology and laboratory conversion factor when determining fee amounts. The pathology and laboratory conversion factor is not applicable to any other section.

The fee for a procedure or service in this section is determined by multiplying the relative value by the pathology and laboratory conversion factor, subject to the ground rules, instructions, and definitions of the schedule.

To ensure uniformity of billing when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately. After which, charges for products may be added.

CONVERSION FACTORS

Regional conversion factors for services rendered on or after TBD.

Section	Region I	Region II	Region III	Region IV
Pathology and Laboratory	\$1.06	\$1.06	\$1.21	\$1.31

PATHOLOGY AND LABORATORY GROUND RULES

Definitions and rules pertaining to pathology and laboratory services are as follows:

Note: Rules used by all providers in reporting their services are presented in the General Ground Rules in the Introduction and General Guidelines section.

1A. NYS Medical Treatment Guidelines

Treatment of work-related injuries should be in accordance with any applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines

does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.

1B. Attending Provider

The attending provider will not make a charge for obtaining and handling of specimen, except for spinal puncture and also routine venipuncture, or unless otherwise specified.

2. Materials Supplied by Provider

Pharmacy

A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of:

- Persons practicing in hospitals as defined in section 2801 of the public health law;
- The dispensing of drugs at no charge to their patients;
- Persons whose practices are situated ten miles or more from a registered pharmacy;
- The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution;
- The dispensing of drugs in a medical emergency as defined in subdivision 6 of section 6810 of the State Education Law.

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070. Except in emergencies, any medications must follow all WCB Formulary and applicable Medical Treatment Guidelines. Any variations require or prior authorization (PAR).

3. Referral Laboratory

When the service or procedure is performed by other than the attending provider, be it hospital, commercial, or other laboratory, only the laboratory rendering the service may bill and such shall be submitted directly to the responsible payer.

4. Narrative Reports

A detailed narrative report must be submitted with all services provided. Physicians & Nurse Practitioners narrative reports must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Physician Assistants must include Work Status & Temporary Impairment Percentages. Providers are strongly encouraged to use the narrative template format found on the WCB webpage [CMS-1500 Requirements](#).

Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/assessment of the patient.

Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed.

Any ordered medications, durable medical equipment, tests, or procedures should be thoroughly explained.

All entries in the medical record must be legible to another reader.

5. Miscellaneous and By Report Codes

- Providers should only use codes listed in the Fee Schedule. When billing a service or procedure, select the CPT code from the WCB Fee schedule that accurately identifies the service or procedure performed. If no such code is available, report the service or procedure using the closest appropriate **Miscellaneous** code in the Fee Schedule (often ending in -99). These codes may also be titled "Unlisted," "Unspecified," or "Not Otherwise Specified".
- By Report (BR) in the Relative Value (RVU) column represents services that too variable to permit assignment of RVUs. Fees for such procedures need to be justified with additional information.
 - The inclusion of a miscellaneous or by report code in this Fee Schedule does not guarantee reimbursement. All codes billed should be based on medical necessity and be in alignment with all applicable Medical Treatment Guidelines and Fee Schedule Ground Rules. Reimbursement may be dependent on multiple factors, including but not necessarily limited to, causal relationship, clinical necessity and appropriateness of the fees submitted.

- It is the responsibility of the provider to ensure all information required to process a miscellaneous or by report procedure is included with the bill. If required information is missing, or if there is a valid code that describes the procedure, then the code may not be reimbursed.
- Nearly all miscellaneous and by report codes, require prior authorization (PAR). If a procedure or item is not recommended or not addressed in an applicable WCB Medical Treatment Guideline (MTG), then prior authorization is always required. If the procedure or item involves a body part or condition for which there is no MTG and costs over \$1,000 then prior authorization must be obtained.
- While emergency procedures/items do not require prior authorization, the circumstances must be identified and explained in the procedure record. The codes billed may be subject to review and non-payment.
- When a miscellaneous or by report code is used, the actual service/item should be identified on the bill, narrative note, and in an additional attached report.
- The price billed must be substantiated by indicating the closest comparable code found in the current fee schedule and/or with a manufacturer's invoice.
- Documentation should include: any decision making, medical necessity and explanation why an existing fee schedule code could not be used.
- Any PARs including identification numbers should also be submitted with bills.
- Miscellaneous and by report codes should not be billed merely to describe a proprietary product or procedure, when an existing fee schedule code adequately describes the procedure or item.
- Surgical miscellaneous or by report codes may require additional documentation including: time, skill, equipment necessary, diagnosis, pertinent history, and physical findings, size/ location/number of lesions or procedures.

6. Indices or Ratios

Tests which produce an index or ratio based on mathematical calculations from two or more other results may not be billed as a separate independent test (e.g., A/G ratio, free thyroxine index).

7. Treatment by Out-of-State Providers

Labwork that is billed by out-of-state laboratories shall fall under WCB regulations for out-of-state treatment.

- A. Claimant lives outside of New York State, and treats outside of NYS:

A claimant who lives outside of New York State may treat with a qualified out-of-state medical provider/laboratory. The medical treatment shall conform to the Medical Treatment Guidelines and the Ground Rules included herein. This includes obtaining any required Prior Authorization (PAR).

Payment for medical treatment/labwork shall be at the Fee Schedule amount for work related injuries and illnesses as available in the state where treatment is rendered/labwork was drawn, or if there is no such fee schedule, then such charges shall be as prevail in the community for similar treatment. Out-of-state providers are required to use only those CPT codes listed in the current applicable New York State WCB fee schedules.

Presence of a CPT code in this fee schedule does not imply medical necessity which is determined by the NYS Medical Treatment Guidelines.

All fees shall be subject to the jurisdiction of the Board.

- B. Claimant lives in New York State but treats outside of New York State:

Labwork billed by out-of-state agency for claimant that lives in NY and/or for ordering provider office that is located in NY: A claimant who lives in New York State may treat with a qualified or Board authorized out-of-state medical provider when such treatment must conform to the Workers' Compensation Law and regulations, the Medical Treatment Guidelines and the Medical Fee Schedule. This includes obtaining any required Prior Authorization (PAR).

Payment shall be made to the medical provider/laboratory as set forth herein and using the regional conversion factor for the NY ZIP code where the claimant resides.

Out-of-state medical treatment that does not "further the economic and humanitarian objective" of Workers' Compensation Law may be denied by the Board.

A medical provider who has had a NYS WCB authorization suspended, revoked or surrendered shall not be qualified to treat out-of-state.

Providers should only use codes listed in the Fee Schedule.

8. Organ or Disease-Oriented Panels

The AMA assigns CPT codes to organ or disease oriented panels consisting of groups of specified tests. If all tests of a CPT defined panel are performed, the provider/supplier shall bill the panel code. The panel codes shall be used when the tests are ordered as that panel. For example,

if the individually ordered tests are cholesterol (82465), triglycerides (84478), and HDL cholesterol (83718), the service should be reported as a lipid panel (80061).

9. Specific Billing Instructions

The relative value units listed in this section include recording the specimen, performing the test, and reporting the result. They do not include specimen collection, transfer, or individual patient administrative services. (For reporting collection and handling, see the 99000 series.)

The listed relative value units are total values that include both the professional and technical components. Utilization of the listed code without modifier 26 or TC implies that there will only be one charge, inclusive of the professional and technical components. The listed relative value units apply to provider.

The column designated PC/TC Split indicates the percent of the global fee (relative value unit) for the technical and professional components of the procedure.

A) Professional Component

The professional component represents the value of the professional pathology services of the physician. This includes examination of the patient, when indicated, interpretation and written report of the laboratory procedure, and consultation with the referring provider. (Report using modifier 26.)

B) Technical Component

The technical component includes the charges for performance and/or supervision of the procedure, personnel, materials, space, equipment, and other facilities. (Report using modifier TC.)

10. Collection and Handling

Relative value units assigned to each test represent only the cost of performing the individual test, be it manual or automated. The collection, handling, and patient administrative services have been assigned relative value units and separate code numbers.

Collection and handling procedures:

- A. Report collection, handling, and patient administrative services separately, where applicable. For venipuncture, see procedure 36415; for capillary specimen, see procedure 36416; for handling, see procedures 99000–99001.
- B. Only the provider or laboratory drawing the blood or obtaining the specimen is entitled to collection and handling fees.
- C. Relative value units for specimen collection, handling, and patient administrative services are assigned in relation to the complexity of the process.

- D. A collection and handling charge can be reported by the provider or laboratory performing the service even though there is no billing for the test itself. The test ordered and the name of the testing facility should be indicated.
- E. When collection and handling is performed at the testing facility (laboratory), the laboratory may include separate charges for the services.

11. Review of Diagnostic Studies

When prior studies are reviewed in conjunction with a visit, consultation, record review, or other evaluation, no separate charge is warranted for the review by the medical practitioner or other medical personnel. Neither the professional component (modifier 26) nor the pathology consultation codes are reimbursable under this circumstance. The review of diagnostic tests is included in the evaluation and management codes.

12. Drug Screening

Drug screening may be required for long term pain management. The clinical recommendations provided in the most recently adopted version of any applicable Medical Treatment Guideline shall take precedence over any guidance in any of the Fee Schedule Ground Rules.

Drug Testing—Urine Drug Testing (UDT) (or the testing of blood or any other body fluid) is a mandatory component of chronic opioid management, as part of the baseline assessment and ongoing re-assessment of opioid therapy. Baseline drug testing should be obtained on all transferring patients who are already using opioids or when a patient is being considered for ongoing opioid therapy. The table below offers guidance as to frequency of regular, random drug testing. Individual CPT codes for substances should not be billed when 80305, 80306, 80307 can be used. If an individual drug test must be used, documentation should explain medical necessity of using a specific individual CPT code. See Ground Rule 8.

Confidentiality and Reporting UDT Results (from Medical Treatment Guidelines):

- UDT results are not to be released to the carrier, employer or the Board. However, the treating physician must certify the patient's adherence to or noncompliance with the Patient Understanding for Opioid Treatment Form in the medical record.
- Noncompliance would include (but not necessarily be limited to) evidence that patient is taking any non-prescribed drug(s) or not taking those drugs prescribed as part of treatment.
- Noncompliance can also be a refusal to undergo UDT, as noted above.
- Please also see any applicable Medical Treatment Guidelines.

- Nothing in this paragraph shall preclude the Board from requesting, nor absolve a provider from the responsibility to provide the result of UDT when such request is part of a confidential request for information as part of an investigation of provider practices or related Board Quality Assurance activities—which are not part of the patient's case file.

Risk Category (Score)	Random Drug Frequency
Low Risk	Periodic (At least once/year)
Moderate Risk	Regular (At least 2/year)
High Risk	Frequent (At least 3-4/year)
Aberrant Behavior	At time of visit

Random drug screening (urine or other method) should be performed at the point of care using a quick or rapid screening test method utilizing a stick/dip stick, cup or similar device. Reimbursement will be limited to 1 unit of 80305, 80306, or 80307. In addition, the provider may bill the appropriate evaluation and management code commensurate with the services rendered.

Drug Testing (urine or any other body fluid) by a laboratory—Drug testing performed by a laboratory (whether the lab is located at the point of care or not) should not be a regular part of the non-acute pain management treatment protocol, but rather shall be used as confirmatory testing upon receipt of unexpected or unexplained UDT results (Red Flags).

Red Flags include:

- Negative for opioid(s) prescribed
- Positive for amphetamine or methamphetamine
- Positive for cocaine or metabolites
- Positive for drug not prescribed (benzodiazepines, opioids, etc.)
- Positive for alcohol

Upon documentation of the Red Flag, the provider shall direct confirmatory testing using GCL, GC/MS or LC/MS. Such tests shall be billed using 1 unit of 80375 for 1–3 drugs; 1 unit of 80376 for 4–6 drugs; or 1 unit of 80377 for 7 or more drugs.

13. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used with pathology and laboratory procedures are as follows:

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component

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

32 Mandated Services

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

52 Reduced Services

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

90 Reference (Outside) Laboratory

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

91 Repeat Clinical Diagnostic Laboratory Test

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

92 Alternative Laboratory Platform Testing

When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701–86703 and 87389). The test does not require permanent dedicated space; hence by its design it may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
80047	Basic metabolic panel (Calcium, ionized) This panel must include the following: Calcium, ionized (82330) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea Nitrogen (BUN) (84520)	14.79	XXX	0/100
80048	Basic metabolic panel (Calcium, total) This panel must include the following: Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)	12.94	XXX	0/100
80050	General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Thyroid stimulating hormone (TSH) (84443)	33.89	XXX	0/100
80051	Electrolyte panel This panel must include the following: Carbon dioxide (bicarbonate) (82374) Chloride (82435) Potassium (84132) Sodium (84295)	10.47	XXX	0/100
80053	Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520)	17.87	XXX	0/100
80055	Obstetric panel This panel must include the following: Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Hepatitis B surface antigen (HBsAg) (87340) Antibody, rubella (86762) Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART) (86592) Antibody screen, RBC, each serum technique (86850) Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901)	38.81	XXX	0/100
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)	23.72	XXX	0/100
80069	Renal function panel This panel must include the following: Albumin (82040) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphorus inorganic (phosphate) (84100) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)	14.17	XXX	0/100
80074	Acute hepatitis panel This panel must include the following: Hepatitis A antibody (HAAb), IgM antibody (86709) Hepatitis B core antibody (HBcAb), IgM antibody (86705) Hepatitis B surface antigen (HBsAg) (87340) Hepatitis C antibody (86803)	57.91	XXX	0/100
80076	Hepatic function panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Bilirubin, direct (82248) Phosphatase, alkaline (84075) Protein, total (84155) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450)	12.32	XXX	0/100
80081	Obstetric panel (includes HIV testing)	83.06	XXX	0/100
■ 80143	Acetaminophen	18.98	XXX	0/100
■ 80145	Adalimumab	38.93	XXX	0/100
80150	Amikacin	27.72	XXX	0/100
■ 80151	Amiodarone	18.98	XXX	0/100
80155	Caffeine	34.58	XXX	0/100

PATHOLOGY AND LABORATORY**80047-89398****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	80156	Carbamazepine; total	24.64	XXX	0/100
	80157	Carbamazepine; free	24.64	XXX	0/100
	80158	Cyclosporine	36.97	XXX	0/100
	80159	Clozapine	20.36	XXX	0/100
■	80161	Carbamazepine; -10,11-epoxide	18.98	XXX	0/100
	80162	Digoxin; total	23.41	XXX	0/100
	80163	Digoxin; free	14.87	XXX	0/100
	80164	Valproic acid (dipropylacetic acid); total	24.64	XXX	0/100
	80165	Valproic acid (dipropylacetic acid); free	14.87	XXX	0/100
■	80167	Felbamate	18.98	XXX	0/100
	80168	Ethosuximide	27.72	XXX	0/100
	80169	Everolimus	15.19	XXX	0/100
	80170	Gentamicin	24.64	XXX	0/100
	80171	Gabapentin, whole blood, serum, or plasma	19.39	XXX	0/100
	80173	Haloperidol	30.81	XXX	0/100
	80175	Lamotrigine	14.54	XXX	0/100
	80176	Lidocaine	24.64	XXX	0/100
	80177	Levetiracetam	14.54	XXX	0/100
	80178	Lithium	14.17	XXX	0/100
■	80179	Salicylate	18.98	XXX	0/100
	80180	Mycophenolate (mycophenolic acid)	20.04	XXX	0/100
■	80181	Flecainide	18.98	XXX	0/100
	80183	Oxcarbazepine	14.54	XXX	0/100
	80184	Phenobarbital	24.64	XXX	0/100
	80185	Phenytoin; total	23.41	XXX	0/100
	80186	Phenytoin; free	24.64	XXX	0/100
■	80187	Posaconazole	27.48	XXX	0/100
	80188	Primidone	24.64	XXX	0/100
■	80189	Itraconazole	27.48	XXX	0/100
	80190	Procainamide;	24.64	XXX	0/100
	80192	Procainamide; with metabolites (eg, n-acetyl procainamide)	33.89	XXX	0/100
■	80193	Leflunomide	38.93	XXX	0/100
	80194	Quinidine	24.64	XXX	0/100
	80195	Sirolimus	33.89	XXX	0/100
	80197	Tacrolimus	36.97	XXX	0/100
	80198	Theophylline	23.41	XXX	0/100
	80199	Tiagabine	24.24	XXX	0/100
	80200	Tobramycin	27.72	XXX	0/100
	80201	Topiramate	24.64	XXX	0/100
	80202	Vancomycin	24.64	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	80203	Zonisamide	14.54	XXX	0/100
■	80204	Methotrexate	38.93	XXX	0/100
■	80210	Rufinamide	27.48	XXX	0/100
■	80220	Hydroxychloroquine	18.98	XXX	0/100
■	80230	Infliximab	38.93	XXX	0/100
■	80235	Lacosamide	27.48	XXX	0/100
■	80280	Vedolizumab	38.93	XXX	0/100
■	80285	Voriconazole	27.48	XXX	0/100
	80299	Quantitation of therapeutic drug, not elsewhere specified	30.81	XXX	0/100
	80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (eg, utilizing immunoassay [eg, dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service	11.96	XXX	0/100
	80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (eg, utilizing immunoassay [eg, dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service	16.16	XXX	0/100
	80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service	30.00	XXX	
	80320	Alcohols	0.00	XXX	
	80321	Alcohol biomarkers; 1 or 2	0.00	XXX	
	80322	Alcohol biomarkers; 3 or more	0.00	XXX	
	80323	Alkaloids, not otherwise specified	0.00	XXX	
	80324	Amphetamines; 1 or 2	0.00	XXX	
	80325	Amphetamines; 3 or 4	0.00	XXX	
	80326	Amphetamines; 5 or more	0.00	XXX	
	80327	Anabolic steroids; 1 or 2	0.00	XXX	
	80328	Anabolic steroids; 3 or more	0.00	XXX	
	80329	Analgesics, non-opioid; 1 or 2	0.00	XXX	
	80330	Analgesics, non-opioid; 3-5	0.00	XXX	
	80331	Analgesics, non-opioid; 6 or more	0.00	XXX	
	80332	Antidepressants, serotonergic class; 1 or 2	0.00	XXX	
	80333	Antidepressants, serotonergic class; 3-5	0.00	XXX	
	80334	Antidepressants, serotonergic class; 6 or more	0.00	XXX	
	80335	Antidepressants, tricyclic and other cyclical; 1 or 2	0.00	XXX	
	80336	Antidepressants, tricyclic and other cyclical; 3-5	0.00	XXX	
	80337	Antidepressants, tricyclic and other cyclical; 6 or more	0.00	XXX	
	80338	Antidepressants, not otherwise specified	0.00	XXX	
	80339	Antiepileptics, not otherwise specified; 1-3	0.00	XXX	

PATHOLOGY AND LABORATORY**80047-89398****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
80340	Antiepileptics, not otherwise specified; 4-6	0.00	XXX	
80341	Antiepileptics, not otherwise specified; 7 or more	0.00	XXX	
80342	Antipsychotics, not otherwise specified; 1-3	0.00	XXX	
80343	Antipsychotics, not otherwise specified; 4-6	0.00	XXX	
80344	Antipsychotics, not otherwise specified; 7 or more	0.00	XXX	
80345	Barbiturates	0.00	XXX	
80346	Benzodiazepines; 1-12	0.00	XXX	
80347	Benzodiazepines; 13 or more	0.00	XXX	
80348	Buprenorphine	0.00	XXX	
80349	Cannabinoids, natural	0.00	XXX	
80350	Cannabinoids, synthetic; 1-3	0.00	XXX	
80351	Cannabinoids, synthetic; 4-6	0.00	XXX	
80352	Cannabinoids, synthetic; 7 or more	0.00	XXX	
80353	Cocaine	0.00	XXX	
80354	Fentanyl	0.00	XXX	
80355	Gabapentin, non-blood	0.00	XXX	
80356	Heroin metabolite	0.00	XXX	
80357	Ketamine and norketamine	0.00	XXX	
80358	Methadone	0.00	XXX	
80359	Methylenedioxyamphetamines (MDA, MDEA, MDMA)	0.00	XXX	
80360	Methylphenidate	0.00	XXX	
80361	Opiates, 1 or more	0.00	XXX	
80362	Opioids and opiate analogs; 1 or 2	0.00	XXX	
80363	Opioids and opiate analogs; 3 or 4	0.00	XXX	
80364	Opioids and opiate analogs; 5 or more	0.00	XXX	
80365	Oxycodone	0.00	XXX	
80366	Pregabalin	0.00	XXX	
80367	Propoxyphene	0.00	XXX	
80368	Sedative hypnotics (non-benzodiazepines)	0.00	XXX	
80369	Skeletal muscle relaxants; 1 or 2	0.00	XXX	
80370	Skeletal muscle relaxants; 3 or more	0.00	XXX	
80371	Stimulants, synthetic	0.00	XXX	
80372	Tapentadol	0.00	XXX	
80373	Tramadol	0.00	XXX	
80374	Stereoisomer (enantiomer) analysis, single drug class	0.00	XXX	
80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3	43.26	XXX	0/100
80376	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6	64.89	XXX	0/100
80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more	86.52	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
80400	ACTH stimulation panel; for adrenal insufficiency This panel must include the following: Cortisol (82533 x 2)	57.91	XXX	0/100
80402	ACTH stimulation panel; for 21 hydroxylase deficiency This panel must include the following: Cortisol (82533 x 2) 17 hydroxyprogesterone (83498 x 2)	106.59	XXX	0/100
80406	ACTH stimulation panel; for 3 beta-hydroxydehydrogenase deficiency This panel must include the following: Cortisol (82533 x 2) 17 hydroxypregnenolone (84143 x 2)	99.19	XXX	0/100
80408	Aldosterone suppression evaluation panel (eg, saline infusion) This panel must include the following: Aldosterone (82088 x 2) Renin (84244 x 2)	133.08	XXX	0/100
80410	Calcitonin stimulation panel (eg, calcium, pentagastrin) This panel must include the following: Calcitonin (82308 x 3)	118.91	XXX	0/100
80412	Corticotrophic releasing hormone (CRH) stimulation panel This panel must include the following: Cortisol (82533 x 6) Adrenocorticotrophic hormone (ACTH) (82024 x 6)	295.73	XXX	0/100
80414	Chorionic gonadotropin stimulation panel; testosterone response This panel must include the following: Testosterone (84403 x 2 on 3 pooled blood samples)	43.74	XXX	0/100
■ 80415	Chorionic gonadotropin stimulation panel; estradiol response This panel must include the following: Estradiol, total (82670 x 2 on 3 pooled blood samples)	43.74	XXX	0/100
80416	Renal vein renin stimulation panel (eg, captopril) This panel must include the following: Renin (84244 x 6)	138.01	XXX	0/100
80417	Peripheral vein renin stimulation panel (eg, captopril) This panel must include the following: Renin (84244 x 2)	59.15	XXX	0/100
80418	Combined rapid anterior pituitary evaluation panel This panel must include the following: Adrenocorticotrophic hormone (ACTH) (82024 x 4) Luteinizing hormone (LH) (83002 x 4) Follicle stimulating hormone (FSH) (83001 x 4) Prolactin (84146 x 4) Human growth hormone (HGH) (83003 x 4) Cortisol (82533 x 4) Thyroid stimulating hormone (TSH) (84443 x 4)	823.73	XXX	0/100
80420	Dexamethasone suppression panel, 48 hour This panel must include the following: Free cortisol, urine (82530 x 2) Cortisol (82533 x 2) Volume measurement for timed collection (81050 x 2)	104.74	XXX	0/100
80422	Glucagon tolerance panel; for insulinoma This panel must include the following: Glucose (82947 x 3) Insulin (83525 x 3)	65.31	XXX	0/100
80424	Glucagon tolerance panel; for pheochromocytoma This panel must include the following: Catecholamines, fractionated (82384 x 2)	63.46	XXX	0/100
80426	Gonadotropin releasing hormone stimulation panel This panel must include the following: Follicle stimulating hormone (FSH) (83001 x 4) Luteinizing hormone (LH) (83002 x 4)	154.03	XXX	0/100
80428	Growth hormone stimulation panel (eg, arginine infusion, l-dopa administration) This panel must include the following: Human growth hormone (HGH) (83003 x 4)	77.01	XXX	0/100
80430	Growth hormone suppression panel (glucose administration) This panel must include the following: Glucose (82947 x 3) Human growth hormone (HGH) (83003 x 4)	93.65	XXX	0/100
80432	Insulin-induced C-peptide suppression panel This panel must include the following: Insulin (83525) C-peptide (84681 x 5) Glucose (82947 x 5)	166.96	XXX	0/100
80434	Insulin tolerance panel; for ACTH insufficiency This panel must include the following: Cortisol (82533 x 5) Glucose (82947 x 5)	110.90	XXX	0/100
80435	Insulin tolerance panel; for growth hormone deficiency This panel must include the following: Glucose (82947 x 5) Human growth hormone (HGH) (83003 x 5)	117.68	XXX	0/100

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

Code	Description	Relative Value	FUD	PC/TC Split
80436	Metrapone panel This panel must include the following: Cortisol (82533 x 2) 11 deoxycortisol (82634 x 2)	108.43	XXX	0/100
80438	Thyrotropin releasing hormone (TRH) stimulation panel; 1 hour This panel must include the following: Thyroid stimulating hormone (TSH) (84443 x 3)	51.75	XXX	0/100
80439	Thyrotropin releasing hormone (TRH) stimulation panel; 2 hour This panel must include the following: Thyroid stimulating hormone (TSH) (84443 x 4)	64.69	XXX	0/100
■	80503 Pathology clinical consultation; for a clinical problem, with limited review of patient's history and medical records and straightforward medical decision making. When using time for code selection, 5-20 minutes of total time is spent on the date of the consultation.	26.50	XXX	
■	80504 Pathology clinical consultation; for a moderately complex clinical problem, with review of patient's history and medical records and moderate level of medical decision making. When using time for code selection, 21-40 minutes of total time is spent on the date of the consultation.	51.37	XXX	
■	80505 Pathology clinical consultation; for a highly complex clinical problem, with comprehensive review of patient's history and medical records and high level of medical decision making. When using time for code selection, 41-60 minutes of total time is spent on the date of the consultation.	93.90	XXX	
■ +	80506 Pathology clinical consultation; prolonged service, each additional 30 minutes (List separately in addition to code for primary procedure)	41.22	ZZZ	
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy	7.09	XXX	0/100
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy	7.09	XXX	0/100
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy	5.54	XXX	0/100
81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy	5.54	XXX	0/100
81005	Urinalysis; qualitative or semiquantitative, except immunoassays	4.93	XXX	0/100
81007	Urinalysis; bacteriuria screen, except by culture or dipstick	7.39	XXX	0/100
81015	Urinalysis; microscopic only	5.54	XXX	0/100
81020	Urinalysis; 2 or 3 glass test	6.78	XXX	0/100
81025	Urine pregnancy test, by visual color comparison methods	10.47	XXX	0/100
81050	Volume measurement for timed collection, each	4.93	XXX	0/100
81099	Unlisted urinalysis procedure	BR	XXX	
81105	Human Platelet Antigen 1 genotyping (HPA-1), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-1a/b (L33P)	135.42	XXX	0/100
81106	Human Platelet Antigen 2 genotyping (HPA-2), GP1BA (glycoprotein Ib [platelet], alpha polypeptide [GPIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-2a/b (T145M)	135.42	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
81107	Human Platelet Antigen 3 genotyping (HPA-3), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex], antigen CD41 [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-3a/b (I843S)	135.42	XXX	0/100
81108	Human Platelet Antigen 4 genotyping (HPA-4), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-4a/b (R143Q)	135.42	XXX	0/100
81109	Human Platelet Antigen 5 genotyping (HPA-5), ITGA2 (integrin, alpha 2 [CD49B, alpha 2 subunit of VLA-2 receptor] [GPIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant (eg, HPA-5a/b (K505E))	135.42	XXX	0/100
81110	Human Platelet Antigen 6 genotyping (HPA-6w), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa, antigen CD61] [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-6a/b (R489Q)	135.42	XXX	0/100
81111	Human Platelet Antigen 9 genotyping (HPA-9w), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex], antigen CD41 [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-9a/b (V837M)	135.42	XXX	0/100
81112	Human Platelet Antigen 15 genotyping (HPA-15), CD109 (CD109 molecule) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-15a/b (S682Y)	135.42	XXX	0/100
81120	IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble) (eg, glioma), common variants (eg, R132H, R132C)	173.56	XXX	0/100
81121	IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (eg, glioma), common variants (eg, R140W, R172M)	265.67	XXX	0/100
81161	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	250.48	XXX	0/100
■ 81162	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis (ie, detection of large gene rearrangements)	2022.59	XXX	0/100
■ 81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	473.42	XXX	0/100
■ 81164	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	590.88	XXX	0/100
■ 81165	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	286.28	XXX	0/100
■ 81166	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	304.93	XXX	0/100
■ 81167	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	286.28	XXX	0/100
■ 81168	CCND1/IGH (t(11;14)) (eg, mantle cell lymphoma) translocation analysis, major breakpoint, qualitative and quantitative, if performed	209.72	XXX	0/100

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

Code	Description	Relative Value	FUD	PC/TC Split
81170	ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib tyrosine kinase inhibitor resistance), gene analysis, variants in the kinase domain	269.23	XXX	0/100
■ 81171	AFF2 (ALF transcription elongation factor 2 [FMR2]) (eg, fragile X intellectual disability 2 [FRAXE]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	138.72	XXX	0/100
■ 81172	AFF2 (ALF transcription elongation factor 2 [FMR2]) (eg, fragile X intellectual disability 2 [FRAXE]) gene analysis; characterization of alleles (eg, expanded size and methylation status)	278.10	XXX	0/100
■ 81173	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; full gene sequence	304.93	XXX	0/100
■ 81174	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; known familial variant	187.47	XXX	0/100
81175	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; full gene sequence	634.77	XXX	0/100
81176	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; targeted sequence analysis (eg, exon 12)	268.26	XXX	0/100
■ 81177	ATN1 (atrophin 1) (eg, dentatorubral-pallidoluysian atrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	138.72	XXX	0/100
■ 81178	ATXN1 (ataxin 1) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	138.72	XXX	0/100
■ 81179	ATXN2 (ataxin 2) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	138.72	XXX	0/100
■ 81180	ATXN3 (ataxin 3) (eg, spinocerebellar ataxia, Machado-Joseph disease) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	138.72	XXX	0/100
■ 81181	ATXN7 (ataxin 7) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	138.72	XXX	0/100
■ 81182	ATXN8OS (ATXN8 opposite strand [non-protein coding]) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	138.72	XXX	0/100
■ 81183	ATXN10 (ataxin 10) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	138.72	XXX	0/100
■ 81184	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	138.72	XXX	0/100
■ 81185	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; full gene sequence	855.89	XXX	0/100
■ 81186	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; known familial variant	187.47	XXX	0/100
■ 81187	CNBP (CCHC-type zinc finger nucleic acid binding protein) (eg, myotonic dystrophy type 2) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	138.72	XXX	0/100
■ 81188	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	138.72	XXX	0/100
■ 81189	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; full gene sequence	278.10	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	81190	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; known familial variant(s)	187.47	XXX	0/100
■	81191	NTRK1 (neurotrophic receptor tyrosine kinase 1) (eg, solid tumors) translocation analysis	209.72	XXX	0/100
■	81192	NTRK2 (neurotrophic receptor tyrosine kinase 2) (eg, solid tumors) translocation analysis	209.72	XXX	0/100
■	81193	NTRK3 (neurotrophic receptor tyrosine kinase 3) (eg, solid tumors) translocation analysis	209.72	XXX	0/100
■	81194	NTRK (neurotrophic receptor tyrosine kinase 1, 2, and 3) (eg, solid tumors) translocation analysis	524.13	XXX	0/100
	81200	ASPA (aspartoacylase) (eg, Canavan disease) gene analysis, common variants (eg, E285A, Y231X)	0.00	XXX	
	81201	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	0.00	XXX	0/100
	81202	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	0.00	XXX	0/100
	81203	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	0.00	XXX	0/100
■	81204	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; characterization of alleles (eg, expanded size or methylation status)	138.72	XXX	0/100
	81205	BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, maple syrup urine disease) gene analysis, common variants (eg, R183P, G278S, E422X)	0.00	XXX	
	81206	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	0.00	XXX	
	81207	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	0.00	XXX	
	81208	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative	0.00	XXX	
	81209	BLM (Bloom syndrome, RecQ helicase-like) (eg, Bloom syndrome) gene analysis, 2281del6ins7 variant	0.00	XXX	
	81210	BRAF (B-Raf proto-oncogene, serine/threonine kinase) (eg, colon cancer, melanoma), gene analysis, V600 variant(s)	0.00	XXX	
■	81212	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants	0.00	XXX	
■	81215	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	0.00	XXX	
■	81216	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	0.00	XXX	
■	81217	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	0.00	XXX	
	81218	CEBPA (CCAAT/enhancer binding protein [C/EBP], alpha) (eg, acute myeloid leukemia), gene analysis, full gene sequence	0.00	XXX	0/100

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
	81219	CALR (calreticulin) (eg, myeloproliferative disorders), gene analysis, common variants in exon 9	0.00	XXX	0/100
	81220	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	0.00	XXX	
	81221	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants	0.00	XXX	
	81222	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants	0.00	XXX	
	81223	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence	0.00	XXX	
	81224	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	0.00	XXX	
	81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	0.00	XXX	
	81226	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)	0.00	XXX	
	81227	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	0.00	XXX	
■	81228	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number variants, comparative genomic hybridization [CGH] microarray analysis	0.00	XXX	
■	81229	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants, comparative genomic hybridization (CGH) microarray analysis	0.00	XXX	
	81230	CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (eg, drug metabolism), gene analysis, common variant(s) (eg, *2, *22)	0.00	XXX	0/100
	81231	CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *7)	0.00	XXX	0/100
	81232	DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (eg, *2A, *4, *5, *6)	0.00	XXX	0/100
■	81233	BTK (Bruton's tyrosine kinase) (eg, chronic lymphocytic leukemia) gene analysis, common variants (eg, C481S, C481R, C481F)	177.33	XXX	0/100
■	81234	DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; evaluation to detect abnormal (expanded) alleles	138.72	XXX	0/100
	81235	EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)	0.00	XXX	0/100
■	81236	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, myelodysplastic syndrome, myeloproliferative neoplasms) gene analysis, full gene sequence	286.28	XXX	0/100
■	81237	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, diffuse large B-cell lymphoma) gene analysis, common variant(s) (eg, codon 646)	177.33	XXX	0/100
	81238	F9 (coagulation factor IX) (eg, hemophilia B), full gene sequence	0.00	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	81239	DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; characterization of alleles (eg, expanded size)	278.10	XXX	0/100
	81240	F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G>A variant	0.00	XXX	
	81241	F5 (coagulation factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant	0.00	XXX	
	81242	FANCC (Fanconi anemia, complementation group C) (eg, Fanconi anemia, type C) gene analysis, common variant (eg, IVS4+4A>T)	0.00	XXX	
■	81243	FMR1 (fragile X messenger ribonucleoprotein 1) (eg, fragile X syndrome, X-linked intellectual disability [XLID]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	0.00	XXX	
■	81244	FMR1 (fragile X messenger ribonucleoprotein 1) (eg, fragile X syndrome, X-linked intellectual disability [XLID]) gene analysis; characterization of alleles (eg, expanded size and promoter methylation status)	0.00	XXX	
	81245	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; internal tandem duplication (ITD) variants (ie, exons 14, 15)	0.00	XXX	
	81246	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; tyrosine kinase domain (TKD) variants (eg, D835, I836)	0.00	XXX	0/100
	81247	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; common variant(s) (eg, A, A-)	0.00	XXX	0/100
	81248	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; known familial variant(s)	0.00	XXX	0/100
	81249	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; full gene sequence	0.00	XXX	0/100
	81250	G6PC (glucose-6-phosphatase, catalytic subunit) (eg, Glycogen storage disease, type 1a, von Gierke disease) gene analysis, common variants (eg, R83C, Q347X)	0.00	XXX	
	81251	GBA (glucosidase, beta, acid) (eg, Gaucher disease) gene analysis, common variants (eg, N370S, 84GG, L444P, IVS2+1G>A)	0.00	XXX	
	81252	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	0.00	XXX	0/100
	81253	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants	0.00	XXX	0/100
	81254	GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])	0.00	XXX	0/100
	81255	HEXA (hexosaminidase A [alpha polypeptide]) (eg, Tay-Sachs disease) gene analysis, common variants (eg, 1278insTATC, 1421+1G>C, G269S)	0.00	XXX	
	81256	HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D)	0.00	XXX	
	81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, Constant Spring)	0.00	XXX	
	81258	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; known familial variant	0.00	XXX	0/100
	81259	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; full gene sequence	0.00	XXX	0/100

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
	81260	IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase complex-associated protein) (eg, familial dysautonomia) gene analysis, common variants (eg, 2507+6T>C, R696P)	0.00	XXX	
	81261	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology (eg, polymerase chain reaction)	0.00	XXX	
	81262	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)	0.00	XXX	
	81263	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis	0.00	XXX	
	81264	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	0.00	XXX	
	81265	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)	0.00	XXX	
+	81266	Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure)	0.00	XXX	
	81267	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection	0.00	XXX	
	81268	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type	0.00	XXX	
	81269	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; duplication/deletion variants	0.00	XXX	0/100
	81270	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant	0.00	XXX	
■	81271	HTT (huntingtin) (eg, Huntington disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	138.72	XXX	0/100
	81272	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, gastrointestinal stromal tumor [GIST], acute myeloid leukemia, melanoma), gene analysis, targeted sequence analysis (eg, exons 8, 11, 13, 17, 18)	0.00	XXX	0/100
	81273	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, mastocytosis), gene analysis, D816 variant(s)	0.00	XXX	0/100
■	81274	HTT (huntingtin) (eg, Huntington disease) gene analysis; characterization of alleles (eg, expanded size)	278.10	XXX	0/100
	81275	KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; variants in exon 2 (eg, codons 12 and 13)	0.00	XXX	
	81276	KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; additional variant(s) (eg, codon 61, codon 146)	0.00	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	81277	Cytogenomic neoplasia (genome-wide) microarray analysis, interrogation of genomic regions for copy number and loss-of-heterozygosity variants for chromosomal abnormalities	1173.25	XXX	0/100
■	81278	IGH@/BCL2 (t(14;18)) (eg, follicular lymphoma) translocation analysis, major breakpoint region (MBR) and minor cluster region (mcr) breakpoints, qualitative or quantitative	209.72	XXX	0/100
■	81279	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) targeted sequence analysis (eg, exons 12 and 13)	187.47	XXX	0/100
	81283	IFNL3 (interferon, lambda 3) (eg, drug response), gene analysis, rs12979860 variant	0.00	XXX	0/100
■	81284	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; evaluation to detect abnormal (expanded) alleles	138.72	XXX	0/100
■	81285	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; characterization of alleles (eg, expanded size)	278.10	XXX	0/100
■	81286	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; full gene sequence	278.10	XXX	0/100
■	81287	MGMT (O-6-methylguanine-DNA methyltransferase) (eg, glioblastoma multiforme) promoter methylation analysis	0.00	XXX	0/100
	81288	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; promoter methylation analysis	0.00	XXX	0/100
■	81289	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; known familial variant(s)	187.47	XXX	0/100
	81290	MCOLN1 (mucolipin 1) (eg, Mucopolipidosis, type IV) gene analysis, common variants (eg, IVS3-2A>G, del6.4kb)	0.00	XXX	
	81291	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)	0.00	XXX	
	81292	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	0.00	XXX	
	81293	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	0.00	XXX	
	81294	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	0.00	XXX	
	81295	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	0.00	XXX	
	81296	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	0.00	XXX	
	81297	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	0.00	XXX	
	81298	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	0.00	XXX	
	81299	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	0.00	XXX	

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

Code	Description	Relative Value	FUD	PC/TC Split
81300	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	0.00	XXX	
81301	Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed	0.00	XXX	
81302	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis	0.00	XXX	
81303	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant	0.00	XXX	
81304	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants	0.00	XXX	
■ 81305	MYD88 (myeloid differentiation primary response 88) (eg, Waldenstrom's macroglobulinemia, lymphoplasmacytic leukemia) gene analysis, p.Leu265Pro (L265P) variant	177.33	XXX	0/100
■ 81306	NUDT15 (nudix hydrolase 15) (eg, drug metabolism) gene analysis, common variant(s) (eg, *2, *3, *4, *5, *6)	294.78	XXX	0/100
■ 81307	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; full gene sequence	684.12	XXX	0/100
■ 81308	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; known familial variant	304.93	XXX	0/100
■ 81309	PIK3CA (phosphatidylinositol-4, 5-biphosphate 3-kinase, catalytic subunit alpha) (eg, colorectal and breast cancer) gene analysis, targeted sequence analysis (eg, exons 7, 9, 20)	278.10	XXX	0/100
81310	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, exon 12 variants	0.00	XXX	
81311	NRAS (neuroblastoma RAS viral [v-ras] oncogene homolog) (eg, colorectal carcinoma), gene analysis, variants in exon 2 (eg, codons 12 and 13) and exon 3 (eg, codon 61)	0.00	XXX	0/100
■ 81312	PABPN1 (poly[A] binding protein nuclear 1) (eg, oculopharyngeal muscular dystrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	138.72	XXX	0/100
81313	PCA3/KLK3 (prostate cancer antigen 3 [non-protein coding]/kallikrein-related peptidase 3 [prostate specific antigen]) ratio (eg, prostate cancer)	0.00	XXX	0/100
81314	PDGFRA (platelet-derived growth factor receptor, alpha polypeptide) (eg, gastrointestinal stromal tumor [GIST]), gene analysis, targeted sequence analysis (eg, exons 12, 18)	0.00	XXX	0/100
81315	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	0.00	XXX	
81316	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative	0.00	XXX	
81317	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	0.00	XXX	
81318	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	0.00	XXX	

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	81319	PMS2 (postmeiotic segregation increased 2 [<i>S. cerevisiae</i>]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	0.00	XXX	
■	81320	PLCG2 (phospholipase C gamma 2) (eg, chronic lymphocytic leukemia) gene analysis, common variants (eg, R665W, S707F, L845F)	294.78	XXX	0/100
	81321	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis	0.00	XXX	0/100
	81322	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant	0.00	XXX	0/100
	81323	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant	0.00	XXX	0/100
	81324	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; duplication/deletion analysis	0.00	XXX	0/100
	81325	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; full sequence analysis	0.00	XXX	0/100
	81326	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; known familial variant	0.00	XXX	0/100
■	81327	SEPT9 (Septin9) (eg, colorectal cancer) promoter methylation analysis	0.00	XXX	
	81328	SLC01B1 (solute carrier organic anion transporter family, member 1B1) (eg, adverse drug reaction), gene analysis, common variant(s) (eg, *5)	0.00	XXX	0/100
■	81329	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; dosage/deletion analysis (eg, carrier testing), includes SMN2 (survival of motor neuron 2, centromeric) analysis, if performed	138.72	XXX	0/100
	81330	SMPD1(sphingomyelin phosphodiesterase 1, acid lysosomal) (eg, Niemann-Pick disease, Type A) gene analysis, common variants (eg, R496L, L302P, fsP330)	0.00	XXX	
	81331	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	0.00	XXX	
	81332	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)	0.00	XXX	
■	81333	TGFBI (transforming growth factor beta-induced) (eg, corneal dystrophy) gene analysis, common variants (eg, R124H, R124C, R124L, R555W, R555Q)	138.72	XXX	0/100
	81334	RUNX1 (runt related transcription factor 1) (eg, acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy), gene analysis, targeted sequence analysis (eg, exons 3-8)	0.00	XXX	0/100
	81335	TPMT (thiopurine S-methyltransferase) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3)	0.00	XXX	0/100
■	81336	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; full gene sequence	304.93	XXX	0/100
■	81337	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; known familial sequence variant(s)	187.47	XXX	0/100
■	81338	MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; common variants (eg, W515A, W515K, W515L, W515R)	152.14	XXX	0/100
■	81339	MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; sequence analysis, exon 10	187.47	XXX	0/100

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

Code	Description	Relative Value	FUD	PC/TC Split
81340	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	0.00	XXX	
81341	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)	0.00	XXX	
81342	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	0.00	XXX	
■ 81343	PPP2R2B (protein phosphatase 2 regulatory subunit Bbeta) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	138.72	XXX	0/100
■ 81344	TBP (TATA box binding protein) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	138.72	XXX	0/100
■ 81345	TERT (telomerase reverse transcriptase) (eg, thyroid carcinoma, glioblastoma multiforme) gene analysis, targeted sequence analysis (eg, promoter region)	187.47	XXX	0/100
81346	TYMS (thymidylate synthetase) (eg, 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (eg, tandem repeat variant)	0.00	XXX	0/100
■ 81347	SF3B1 (splicing factor [3b] subunit B1) (eg, myelodysplastic syndrome/acute myeloid leukemia) gene analysis, common variants (eg, A672T, E622D, L833F, R625C, R625L)	195.32	XXX	0/100
■ 81348	SRSF2 (serine and arginine-rich splicing factor 2) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variants (eg, P95H, P95L)	177.33	XXX	0/100
■ 81349	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number and loss-of-heterozygosity variants, low-pass sequencing analysis	1211.53	XXX	0/100
■ 81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, drug metabolism, hereditary unconjugated hyperbilirubinemia [Gilbert syndrome]) gene analysis, common variants (eg, *28, *36, *37)	0.00	XXX	
■ 81351	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; full gene sequence	649.12	XXX	0/100
■ 81352	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; targeted sequence analysis (eg, 4 oncology)	333.39	XXX	0/100
■ 81353	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; known familial variant	311.47	XXX	0/100
81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variant(s) (eg, -1639G>A, c.173+1000C>T)	0.00	XXX	
■ 81357	U2AF1 (U2 small nuclear RNA auxiliary factor 1) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variants (eg, S34F, S34Y, Q157R, Q157P)	195.32	XXX	0/100
■ 81360	ZRSR2 (zinc finger CCCH-type, RNA binding motif and serine/arginine-rich 2) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variant(s) (eg, E65fs, E122fs, R448fs)	195.32	XXX	0/100
81361	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (eg, HbS, HbC, HbE)	0.00	XXX	0/100
81362	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)	0.00	XXX	0/100
81363	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)	0.00	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
81364	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence	0.00	XXX	0/100
81370	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1	0.00	XXX	
81371	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, and -DRB1 (eg, verification typing)	0.00	XXX	
81372	HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C)	0.00	XXX	
81373	HLA Class I typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-A, -B, or -C), each	0.00	XXX	
81374	HLA Class I typing, low resolution (eg, antigen equivalents); one antigen equivalent (eg, B*27), each	0.00	XXX	
81375	HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1	0.00	XXX	
81376	HLA Class II typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	0.00	XXX	
81377	HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each	0.00	XXX	
81378	HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C, and -DRB1	0.00	XXX	
81379	HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)	0.00	XXX	
81380	HLA Class I typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-A, -B, or -C), each	0.00	XXX	
81381	HLA Class I typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, B*57:01P), each	0.00	XXX	
81382	HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	0.00	XXX	
81383	HLA Class II typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, HLA-DQB1*06:02P), each	0.00	XXX	
■ 81400	Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)	0.00	XXX	
■ 81401	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)	0.00	XXX	
■ 81402	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity [LOH], uniparental disomy [UPD])	0.00	XXX	
■ 81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)	0.00	XXX	

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
■	81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)	0.00	XXX	
■	81405	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons, regionally targeted cytogenomic array analysis)	0.00	XXX	
■	81406	Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons)	0.00	XXX	
■	81407	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)	0.00	XXX	
■	81408	Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)	0.00	XXX	
	81410	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); genomic sequence analysis panel, must include sequencing of at least 9 genes, including FBN1, TGFB1, TGFB2, COL3A1, MYH11, ACTA2, SLC2A10, SMAD3, and MYLK	0.00	XXX	0/100
	81411	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); duplication/deletion analysis panel, must include analyses for TGFB1, TGFB2, MYH11, and COL3A1	0.00	XXX	0/100
	81412	Ashkenazi Jewish associated disorders (eg, Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Fanconi anemia group C, Gaucher disease, Tay-Sachs disease), genomic sequence analysis panel, must include sequencing of at least 9 genes, including ASPA, BLM, CFTR, FANCC, GBA, HEXA, IKBKAP, MCOLN1, and SMPD1	0.00	XXX	0/100
	81413	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic sequence analysis panel, must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A	0.00	XXX	0/100
	81414	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); duplication/deletion gene analysis panel, must include analysis of at least 2 genes, including KCNH2 and KCNQ1	0.00	XXX	0/100
	81415	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	0.00	XXX	0/100
+	81416	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (eg, parents, siblings) (List separately in addition to code for primary procedure)	0.00	XXX	0/100
	81417	Exome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained exome sequence (eg, updated knowledge or unrelated condition/syndrome)	0.00	XXX	0/100
■	81418	Drug metabolism (eg, pharmacogenomics) genomic sequence analysis panel, must include testing of at least 6 genes, including CYP2C19, CYP2D6, and CYP2D6 duplication/deletion analysis	927.54	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	81419	Epilepsy genomic sequence analysis panel, must include analyses for ALDH7A1, CACNA1A, CDKL5, CHD2, GABRG2, GRIN2A, KCNQ2, MECP2, PCDH19, POLG, PRRT2, SCN1A, SCN1B, SCN2A, SCN8A, SLC2A1, SLC9A6, STXBP1, SYNGAP1, TCF4, TPP1, TSC1, TSC2, and ZEB2	2476.71	XXX	0/100
	81420	Fetal chromosomal aneuploidy (eg, trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21	0.00	XXX	0/100
	81422	Fetal chromosomal microdeletion(s) genomic sequence analysis (eg, DiGeorge syndrome, Cri-du-chat syndrome), circulating cell-free fetal DNA in maternal blood	0.00	XXX	0/100
	81425	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	0.00	XXX	
+	81426	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator genome (eg, parents, siblings) (List separately in addition to code for primary procedure)	0.00	XXX	
	81427	Genome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained genome sequence (eg, updated knowledge or unrelated condition/syndrome)	0.00	XXX	
	81430	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel, must include sequencing of at least 60 genes, including CDH23, CLRN1, GJB2, GPR98, MTRNR1, MYO7A, MYO15A, PCDH15, OTOF, SLC26A4, TMC1, TMPRSS3, USH1C, USH1G, USH2A, and WFS1	0.00	XXX	0/100
	81431	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); duplication/deletion analysis panel, must include copy number analyses for STRC and DFNB1 deletions in GJB2 and GJB6 genes	0.00	XXX	0/100
	81432	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes, always including BRCA1, BRCA2, CDH1, MLH1, MSH2, MSH6, PALB2, PTEN, STK11, and TP53	0.00	XXX	0/100
	81433	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); duplication/deletion analysis panel, must include analyses for BRCA1, BRCA2, MLH1, MSH2, and STK11	0.00	XXX	0/100
	81434	Hereditary retinal disorders (eg, retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR, and USH2A	0.00	XXX	0/100
	81435	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); genomic sequence analysis panel, must include sequencing of at least 10 genes, including APC, BMPR1A, CDH1, MLH1, MSH2, MSH6, MUTYH, PTEN, SMAD4, and STK11	0.00	XXX	0/100
	81436	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); duplication/deletion analysis panel, must include analysis of at least 5 genes, including MLH1, MSH2, EPCAM, SMAD4, and STK11	0.00	XXX	0/100

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

Code	Description	Relative Value	FUD	PC/TC Split
81437	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); genomic sequence analysis panel, must include sequencing of at least 6 genes, including MAX, SDHB, SDHC, SDHD, TMEM127, and VHL	0.00	XXX	0/100
81438	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); duplication/deletion analysis panel, must include analyses for SDHB, SDHC, SDHD, and VHL	0.00	XXX	0/100
81439	Hereditary cardiomyopathy (eg, hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy), genomic sequence analysis panel, must include sequencing of at least 5 cardiomyopathy-related genes (eg, DSG2, MYBPC3, MYH7, PKP2, TTN)	0.00	XXX	0/100
81440	Nuclear encoded mitochondrial genes (eg, neurologic or myopathic phenotypes), genomic sequence panel, must include analysis of at least 100 genes, including BCS1L, C10orf2, COQ2, COX10, DGUOK, MPV17, OPA1, PDSS2, POLG, POLG2, RRM2B, SCO1, SCO2, SLC25A4, SUCLA2, SUCLG1, TAZ, TK2, and TYMP	0.00	XXX	0/100
■ 81441	Inherited bone marrow failure syndromes (IBMFS) (eg, Fanconi anemia, dyskeratosis congenita, Diamond-Blackfan anemia, Shwachman-Diamond syndrome, GATA2 deficiency syndrome, congenital amegakaryocytic thrombocytopenia) sequence analysis panel, must include sequencing of at least 30 genes, including BRCA2, BRIP1, DKC1, FANCA, FANCB, FANCC, FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, GATA1, GATA2, MPL, NHP2, NOP10, PALB2, RAD51C, RPL11, RPL35A, RPL5, RPS10, RPS19, RPS24, RPS26, RPS7, SBDS, TERT, and TINF2	2476.71	XXX	0/100
81442	Noonan spectrum disorders (eg, Noonan syndrome, cardio-facio-cutaneous syndrome, Costello syndrome, LEOPARD syndrome, Noonan-like syndrome), genomic sequence analysis panel, must include sequencing of at least 12 genes, including BRAF, CBL, HRAS, KRAS, MAP2K1, MAP2K2, NRAS, PTPN11, RAF1, RIT1, SHOC2, and SOS1	0.00	XXX	0/100
■ 81443	Genetic testing for severe inherited conditions (eg, cystic fibrosis, Ashkenazi Jewish-associated disorders [eg, Bloom syndrome, Canavan disease, Fanconi anemia type C, mucopolidosis type VI, Gaucher disease, Tay-Sachs disease], beta hemoglobinopathies, phenylketonuria, galactosemia), genomic sequence analysis panel, must include sequencing of at least 15 genes (eg, ACADM, ARSA, ASPA, ATP7B, BCKDHA, BCKDHB, BLM, CFTR, DHCR7, FANCC, G6PC, GAA, GALT, GBA, GBE1, HBB, HEXA, IKBKAP, MCOLN1, PAH)	2476.71	XXX	0/100
■ 81445	Solid organ neoplasm, genomic sequence analysis panel, 5-50 genes, interrogation for sequence variants and copy number variants or rearrangements, if performed; DNA analysis or combined DNA and RNA analysis	0.00	XXX	0/100
81448	Hereditary peripheral neuropathies (eg, Charcot-Marie-Tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-related genes (eg, BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, SPTLC1)	0.00	XXX	0/100
■ 81449	Solid organ neoplasm, genomic sequence analysis panel, 5-50 genes, interrogation for sequence variants and copy number variants or rearrangements, if performed; RNA analysis	604.62	XXX	0/100
■ 81450	Hematolymphoid neoplasm or disorder, genomic sequence analysis panel, 5-50 genes, interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis	0.00	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	81451	Hematolymphoid neoplasm or disorder, genomic sequence analysis panel, 5-50 genes, interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; RNA analysis	768.21	XXX	0/100
■	81455	Solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes, genomic sequence analysis panel, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis	0.00	XXX	0/100
■	81456	Solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes, genomic sequence analysis panel, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; RNA analysis	2953.08	XXX	0/100
■	81457	Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, microsatellite instability	907.26	XXX	
■	81458	Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, copy number variants and microsatellite instability	1058.41	XXX	
■	81459	Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden, and rearrangements	3023.75	XXX	
	81460	Whole mitochondrial genome (eg, Leigh syndrome, mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes [MELAS], myoclonic epilepsy with ragged-red fibers [MERFF], neuropathy, ataxia, and retinitis pigmentosa [NARP], Leber hereditary optic neuropathy [LHON]), genomic sequence, must include sequence analysis of entire mitochondrial genome with heteroplasmy detection	0.00	XXX	0/100
■	81462	Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants and rearrangements	1209.57	XXX	
■	81463	Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis, copy number variants, and microsatellite instability	1360.72	XXX	
■	81464	Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden, and rearrangements	3326.39	XXX	
	81465	Whole mitochondrial genome large deletion analysis panel (eg, Kearns-Sayre syndrome, chronic progressive external ophthalmoplegia), including heteroplasmy detection, if performed	0.00	XXX	0/100
	81470	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); genomic sequence analysis panel, must include sequencing of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3, and SLC16A2	0.00	XXX	
	81471	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); duplication/deletion gene analysis, must include analysis of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3, and SLC16A2	0.00	XXX	
	81479	Unlisted molecular pathology procedure	0.00	XXX	

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

Code	Description	Relative Value	FUD	PC/TC Split
81490	Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays, utilizing serum, prognostic algorithm reported as a disease activity score	0.00	XXX	0/100
81493	Coronary artery disease, mRNA, gene expression profiling by real-time RT-PCR of 23 genes, utilizing whole peripheral blood, algorithm reported as a risk score	0.00	XXX	0/100
81500	Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status, algorithm reported as a risk score	0.00	XXX	0/100
81503	Oncology (ovarian), biochemical assays of five proteins (CA-125, apolipoprotein A1, beta-2 microglobulin, transferrin, and pre-albumin), utilizing serum, algorithm reported as a risk score	0.00	XXX	0/100
81504	Oncology (tissue of origin), microarray gene expression profiling of > 2000 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as tissue similarity scores	0.00	XXX	0/100
81506	Endocrinology (type 2 diabetes), biochemical assays of seven analytes (glucose, HbA1c, insulin, hs-CRP, adiponectin, ferritin, interleukin 2-receptor alpha), utilizing serum or plasma, algorithm reporting a risk score	0.00	XXX	0/100
81507	Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy	0.00	XXX	0/100
81508	Fetal congenital abnormalities, biochemical assays of two proteins (PAPP-A, hCG [any form]), utilizing maternal serum, algorithm reported as a risk score	0.00	XXX	0/100
81509	Fetal congenital abnormalities, biochemical assays of three proteins (PAPP-A, hCG [any form], DIA), utilizing maternal serum, algorithm reported as a risk score	0.00	XXX	0/100
81510	Fetal congenital abnormalities, biochemical assays of three analytes (AFP, uE3, hCG [any form]), utilizing maternal serum, algorithm reported as a risk score	0.00	XXX	0/100
81511	Fetal congenital abnormalities, biochemical assays of four analytes (AFP, uE3, hCG [any form], DIA) utilizing maternal serum, algorithm reported as a risk score (may include additional results from previous biochemical testing)	0.00	XXX	0/100
81512	Fetal congenital abnormalities, biochemical assays of five analytes (AFP, uE3, total hCG, hyperglycosylated hCG, DIA) utilizing maternal serum, algorithm reported as a risk score	0.00	XXX	0/100
■	81513 Infectious disease, bacterial vaginosis, quantitative real-time amplification of RNA markers for Atopobium vaginae, Gardnerella vaginalis, and Lactobacillus species, utilizing vaginal-fluid specimens, algorithm reported as a positive or negative result for bacterial vaginosis	144.28	XXX	0/100
■	81514 Infectious disease, bacterial vaginosis and vaginitis, quantitative real-time amplification of DNA markers for Gardnerella vaginalis, Atopobium vaginae, Megaspheara type 1, Bacterial Vaginosis Associated Bacteria-2 (BVAB-2), and Lactobacillus species (L. crispatus and L. jensenii), utilizing vaginal-fluid specimens, algorithm reported as a positive or negative for high likelihood of bacterial vaginosis, includes separate detection of Trichomonas vaginalis and/or Candida species (C. albicans, C. tropicalis, C. parapsilosis, C. dubliniensis), Candida glabrata, Candida krusei, when reported	265.99	XXX	0/100
■	81517 Liver disease, analysis of 3 biomarkers (hyaluronic acid [HA], procollagen III amino terminal peptide [PIIINP], tissue inhibitor of metalloproteinase 1 [TIMP-1]), using immunoassays, utilizing serum, prognostic algorithm reported as a risk score and risk of liver fibrosis and liver-related clinical events within 5 years	178.31	XXX	0/100

80047-89398

PATHOLOGY AND LABORATORY

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	81518	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 11 genes (7 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithms reported as percentage risk for metastatic recurrence and likelihood of benefit from extended endocrine therapy	3917.27	XXX	0/100
	81519	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 21 genes, utilizing formalin-fixed paraffin embedded tissue, algorithm reported as recurrence score	0.00	XXX	0/100
	81520	Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score	0.00	XXX	0/100
	81521	Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis	0.00	XXX	0/100
■	81522	Oncology (breast), mRNA, gene expression profiling by RT-PCR of 12 genes (8 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk score	3917.27	XXX	0/100
■	81523	Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70 content genes and 31 housekeeping genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk to distant metastasis	3917.27	XXX	0/100
	81525	Oncology (colon), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence score	0.00	XXX	0/100
	81528	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result	0.00	XXX	0/100
■	81529	Oncology (cutaneous melanoma), mRNA, gene expression profiling by real-time RT-PCR of 31 genes (28 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk, including likelihood of sentinel lymph node metastasis	7275.39	XXX	0/100
	81535	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; first single drug or drug combination	0.00	XXX	0/100
+	81536	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; each additional single drug or drug combination (List separately in addition to code for primary procedure)	0.00	XXX	0/100
	81538	Oncology (lung), mass spectrometric 8-protein signature, including amyloid A, utilizing serum, prognostic and predictive algorithm reported as good versus poor overall survival	0.00	XXX	0/100
	81539	Oncology (high-grade prostate cancer), biochemical assay of four proteins (Total PSA, Free PSA, Intact PSA, and human kallikrein-2 [hK2]), utilizing plasma or serum, prognostic algorithm reported as a probability score	0.00	XXX	0/100
	81540	Oncology (tumor of unknown origin), mRNA, gene expression profiling by real-time RT-PCR of 92 genes (87 content and 5 housekeeping) to classify tumor into main cancer type and subtype, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a probability of a predicted main cancer type and subtype	0.00	XXX	0/100

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
	81541	Oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score	0.00	XXX	0/100
■	81542	Oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score	3917.27	XXX	0/100
■	81546	Oncology (thyroid), mRNA, gene expression analysis of 10,196 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (eg, benign or suspicious)	3641.13	XXX	0/100
	81551	Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy	0.00	XXX	
■	81552	Oncology (uveal melanoma), mRNA, gene expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis	7865.29	XXX	0/100
■	81554	Pulmonary disease (idiopathic pulmonary fibrosis [IPF]), mRNA, gene expression analysis of 190 genes, utilizing transbronchial biopsies, diagnostic algorithm reported as categorical result (eg, positive or negative for high probability of usual interstitial pneumonia [UIP])	5507.34	XXX	0/100
■	81560	Transplantation medicine (allograft rejection, pediatric liver and small bowel), measurement of donor and third-party-induced CD154+T-cytotoxic memory cells, utilizing whole peripheral blood, algorithm reported as a rejection risk score	648.13	XXX	0/100
	81595	Cardiology (heart transplant), mRNA, gene expression profiling by real-time quantitative PCR of 20 genes (11 content and 9 housekeeping), utilizing subfraction of peripheral blood, algorithm reported as a rejection risk score	0.00	XXX	0/100
■	81596	Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, and haptoglobin) utilizing serum, prognostic algorithm reported as scores for fibrosis and necroinflammatory activity in liver	72.96	XXX	0/100
	81599	Unlisted multianalyte assay with algorithmic analysis	0.00	XXX	
	82009	Ketone body(s) (eg, acetone, acetoacetic acid, beta-hydroxybutyrate); qualitative	6.16	XXX	0/100
	82010	Ketone body(s) (eg, acetone, acetoacetic acid, beta-hydroxybutyrate); quantitative	12.32	XXX	0/100
	82013	Acetylcholinesterase	24.64	XXX	0/100
	82016	Acylcarnitines; qualitative, each specimen	34.50	XXX	0/100
	82017	Acylcarnitines; quantitative, each specimen	27.11	XXX	0/100
	82024	Adrenocorticotrophic hormone (ACTH)	55.45	XXX	0/100
	82030	Adenosine, 5-monophosphate, cyclic (cyclic AMP)	43.13	XXX	0/100
	82040	Albumin; serum, plasma or whole blood	8.01	XXX	0/100
	82042	Albumin; other source, quantitative, each specimen	9.86	XXX	0/100
	82043	Albumin; urine (eg, microalbumin), quantitative	21.56	XXX	0/100
	82044	Albumin; urine (eg, microalbumin), semiquantitative (eg, reagent strip assay)	11.09	XXX	0/100
	82045	Albumin; ischemia modified	44.35	XXX	0/100
■	82075	Alcohol (ethanol); breath	11.09	XXX	0/100
■	82077	Alcohol (ethanol); any specimen except urine and breath, immunoassay (eg, IA, EIA, ELISA, RIA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)	17.34	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
82085	Aldolase	18.48	XXX	0/100
82088	Aldosterone	49.29	XXX	0/100
82103	Alpha-1-antitrypsin; total	24.64	XXX	0/100
82104	Alpha-1-antitrypsin; phenotype	33.89	XXX	0/100
82105	Alpha-fetoprotein (AFP); serum	28.96	XXX	0/100
82106	Alpha-fetoprotein (AFP); amniotic fluid	28.96	XXX	0/100
82107	Alpha-fetoprotein (AFP); AFP-L3 fraction isoform and total AFP (including ratio)	33.89	XXX	0/100
82108	Aluminum	36.97	XXX	0/100
82120	Amines, vaginal fluid, qualitative	5.03	XXX	0/100
82127	Amino acids; single, qualitative, each specimen	17.87	XXX	0/100
82128	Amino acids; multiple, qualitative, each specimen	17.87	XXX	0/100
82131	Amino acids; single, quantitative, each specimen	83.17	XXX	0/100
82135	Aminolevulinic acid, delta (ALA)	27.11	XXX	0/100
82136	Amino acids, 2 to 5 amino acids, quantitative, each specimen	83.17	XXX	0/100
82139	Amino acids, 6 or more amino acids, quantitative, each specimen	83.17	XXX	0/100
82140	Ammonia	21.56	XXX	0/100
82143	Amniotic fluid scan (spectrophotometric)	22.80	XXX	0/100
82150	Amylase	9.86	XXX	0/100
82154	Androstenediol glucuronide	40.05	XXX	0/100
82157	Androstenedione	36.97	XXX	0/100
82160	Androsterone	40.05	XXX	0/100
82163	Angiotensin II	36.97	XXX	0/100
82164	Angiotensin I - converting enzyme (ACE)	30.81	XXX	0/100
■ 82166	Anti-mullerian hormone (AMH)	38.93	XXX	0/100
82172	Apolipoprotein, each	20.33	XXX	0/100
82175	Arsenic	33.89	XXX	0/100
82180	Ascorbic acid (Vitamin C), blood	17.87	XXX	0/100
82190	Atomic absorption spectroscopy, each analyte	36.97	XXX	0/100
82232	Beta-2 microglobulin	33.89	XXX	0/100
82239	Bile acids; total	19.72	XXX	0/100
82240	Bile acids; cholyglycine	43.74	XXX	0/100
82247	Bilirubin; total	8.01	XXX	0/100
82248	Bilirubin; direct	8.01	XXX	0/100
82252	Bilirubin; feces, qualitative	5.54	XXX	0/100
82261	Biotinidase, each specimen	8.63	XXX	0/100
82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)	6.16	XXX	0/100
82271	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; other sources	5.54	XXX	0/100

PATHOLOGY AND LABORATORY**80047-89398****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
82272	Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening	5.54	XXX	0/100
82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations	30.81	XXX	0/100
82286	Bradykinin	49.29	XXX	0/100
82300	Cadmium	33.89	XXX	0/100
82306	Vitamin D; 25 hydroxy, includes fraction(s), if performed	46.21	XXX	0/100
82308	Calcitonin	47.44	XXX	0/100
82310	Calcium; total	8.01	XXX	0/100
82330	Calcium; ionized	22.80	XXX	0/100
82331	Calcium; after calcium infusion test	9.86	XXX	0/100
82340	Calcium; urine quantitative, timed specimen	9.86	XXX	0/100
82355	Calculus; qualitative analysis	21.56	XXX	0/100
82360	Calculus; quantitative analysis, chemical	23.41	XXX	0/100
82365	Calculus; infrared spectroscopy	23.41	XXX	0/100
82370	Calculus; X-ray diffraction	21.56	XXX	0/100
82373	Carbohydrate deficient transferrin	21.56	XXX	0/100
82374	Carbon dioxide (bicarbonate)	8.01	XXX	0/100
82375	Carboxyhemoglobin; quantitative	20.95	XXX	0/100
82376	Carboxyhemoglobin; qualitative	7.39	XXX	0/100
82378	Carcinoembryonic antigen (CEA)	32.04	XXX	0/100
82379	Carnitine (total and free), quantitative, each specimen	32.04	XXX	0/100
82380	Carotene	18.48	XXX	0/100
82382	Catecholamines; total urine	32.04	XXX	0/100
82383	Catecholamines; blood	46.21	XXX	0/100
82384	Catecholamines; fractionated	46.21	XXX	0/100
82387	Cathepsin-D	43.13	XXX	0/100
82390	Ceruloplasmin	19.72	XXX	0/100
82397	Chemiluminescent assay	22.80	XXX	0/100
82415	Chloramphenicol	30.81	XXX	0/100
82435	Chloride; blood	8.01	XXX	0/100
82436	Chloride; urine	8.63	XXX	0/100
82438	Chloride; other source	8.63	XXX	0/100
82441	Chlorinated hydrocarbons, screen	22.18	XXX	0/100
82465	Cholesterol, serum or whole blood, total	8.32	XXX	0/100
82480	Cholinesterase; serum	14.79	XXX	0/100
82482	Cholinesterase; RBC	22.18	XXX	0/100
82485	Chondroitin B sulfate, quantitative	36.97	XXX	0/100
82495	Chromium	36.97	XXX	0/100
82507	Citrate	46.21	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
82523	Collagen cross links, any method	52.00	XXX	0/100
82525	Copper	24.64	XXX	0/100
82528	Corticosterone	36.97	XXX	0/100
82530	Cortisol; free	33.89	XXX	0/100
82533	Cortisol; total	28.96	XXX	0/100
82540	Creatine	8.93	XXX	0/100
82542	Column chromatography, includes mass spectrometry, if performed (eg, HPLC, LC, LC/MS, LC/MS-MS, GC, GC/MS-MS, GC/MS, HPLC/MS), non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen	24.64	XXX	0/100
82550	Creatine kinase (CK), (CPK); total	9.24	XXX	0/100
82552	Creatine kinase (CK), (CPK); isoenzymes	24.64	XXX	0/100
82553	Creatine kinase (CK), (CPK); MB fraction only	11.40	XXX	0/100
82554	Creatine kinase (CK), (CPK); isoforms	21.56	XXX	0/100
82565	Creatinine; blood	8.01	XXX	0/100
82570	Creatinine; other source	9.86	XXX	0/100
82575	Creatinine; clearance	17.87	XXX	0/100
82585	Cryofibrinogen	12.32	XXX	0/100
82595	Cryoglobulin, qualitative or semi-quantitative (eg, cryocrit)	12.32	XXX	0/100
82600	Cyanide	24.64	XXX	0/100
82607	Cyanocobalamin (Vitamin B-12);	24.64	XXX	0/100
82608	Cyanocobalamin (Vitamin B-12); unsaturated binding capacity	28.34	XXX	0/100
82610	Cystatin C	17.93	XXX	0/100
82615	Cystine and homocystine, urine, qualitative	18.48	XXX	0/100
82626	Dehydroepiandrosterone (DHEA)	42.82	XXX	0/100
82627	Dehydroepiandrosterone-sulfate (DHEA-S)	36.97	XXX	0/100
82633	Desoxycorticosterone, 11-	49.29	XXX	0/100
82634	Deoxycortisol, 11-	43.13	XXX	0/100
82638	Dibucaine number	17.25	XXX	0/100
■ 82642	Dihydrotestosterone (DHT)	29.77	XXX	0/100
82652	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed	49.29	XXX	0/100
■ 82653	Elastase, pancreatic (EL-1), fecal; quantitative	23.23	XXX	0/100
■ 82656	Elastase, pancreatic (EL-1), fecal; qualitative or semi-quantitative	15.10	XXX	0/100
82657	Enzyme activity in blood cells, cultured cells, or tissue, not elsewhere specified; nonradioactive substrate, each specimen	23.59	XXX	0/100
82658	Enzyme activity in blood cells, cultured cells, or tissue, not elsewhere specified; radioactive substrate, each specimen	25.88	XXX	0/100
82664	Electrophoretic technique, not elsewhere specified	28.34	XXX	0/100
82668	Erythropoietin	40.05	XXX	0/100
■ 82670	Estradiol; total	28.96	XXX	0/100
82671	Estrogens; fractionated	51.75	XXX	0/100
82672	Estrogens; total	36.97	XXX	0/100

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

Code	Description	Relative Value	FUD	PC/TC Split
82677	Estriol	26.49	XXX	0/100
82679	Estrone	40.05	XXX	0/100
■ 82681	Estradiol; free, direct measurement (eg, equilibrium dialysis)	28.14	XXX	0/100
82693	Ethylene glycol	30.81	XXX	0/100
82696	Etiocholanolone	43.13	XXX	0/100
82705	Fat or lipids, feces; qualitative	9.24	XXX	0/100
82710	Fat or lipids, feces; quantitative	34.50	XXX	0/100
82715	Fat differential, feces, quantitative	14.79	XXX	0/100
82725	Fatty acids, nonesterified	14.79	XXX	0/100
82726	Very long chain fatty acids	23.59	XXX	0/100
82728	Ferritin	22.80	XXX	0/100
82731	Fetal fibronectin, cervicovaginal secretions, semi-quantitative	22.80	XXX	0/100
82735	Fluoride	26.49	XXX	0/100
82746	Folic acid; serum	25.26	XXX	0/100
82747	Folic acid; RBC	30.19	XXX	0/100
82757	Fructose, semen	16.02	XXX	0/100
82759	Galactokinase, RBC	19.72	XXX	0/100
82760	Galactose	20.33	XXX	0/100
82775	Galactose-1-phosphate uridyl transferase; quantitative	25.88	XXX	0/100
82776	Galactose-1-phosphate uridyl transferase; screen	8.32	XXX	0/100
82777	Galectin-3	39.75	XXX	0/100
82784	Gammaglobulin (immunoglobulin); IgA, IgD, IgG, IgM, each	20.95	XXX	0/100
82785	Gammaglobulin (immunoglobulin); IgE	26.49	XXX	0/100
82787	Gammaglobulin (immunoglobulin); immunoglobulin subclasses (eg, IgG1, 2, 3, or 4), each	65.92	XXX	0/100
82800	Gases, blood, pH only	16.02	XXX	0/100
82803	Gases, blood, any combination of pH, pCO ₂ , pO ₂ , CO ₂ , HCO ₃ (including calculated O ₂ saturation);	31.42	XXX	0/100
82805	Gases, blood, any combination of pH, pCO ₂ , pO ₂ , CO ₂ , HCO ₃ (including calculated O ₂ saturation); with O ₂ saturation, by direct measurement, except pulse oximetry	33.89	XXX	0/100
82810	Gases, blood, O ₂ saturation only, by direct measurement, except pulse oximetry	17.25	XXX	0/100
82820	Hemoglobin-oxygen affinity (pO ₂ for 50% hemoglobin saturation with oxygen)	21.56	XXX	0/100
82930	Gastric acid analysis, includes pH if performed, each specimen	10.47	XXX	0/100
82938	Gastrin after secretin stimulation	30.19	XXX	0/100
82941	Gastrin	30.19	XXX	0/100
82943	Glucagon	36.35	XXX	0/100
82945	Glucose, body fluid, other than blood	26.49	XXX	0/100
82946	Glucagon tolerance test	20.33	XXX	0/100
82947	Glucose; quantitative, blood (except reagent strip)	8.01	XXX	0/100
82948	Glucose; blood, reagent strip	6.16	XXX	0/100
82950	Glucose; post glucose dose (includes glucose)	10.47	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	82951	Glucose; tolerance test (GTT), 3 specimens (includes glucose)	22.80	XXX	0/100
+	82952	Glucose; tolerance test, each additional beyond 3 specimens (List separately in addition to code for primary procedure)	6.16	XXX	0/100
	82955	Glucose-6-phosphate dehydrogenase (G6PD); quantitative	23.41	XXX	0/100
	82960	Glucose-6-phosphate dehydrogenase (G6PD); screen	12.32	XXX	0/100
	82962	Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use	6.16	XXX	0/100
	82963	Glucosidase, beta	30.81	XXX	0/100
	82965	Glutamate dehydrogenase	8.63	XXX	0/100
	82977	Glutaryltransferase, gamma (GGT)	8.01	XXX	0/100
	82978	Glutathione	21.56	XXX	0/100
	82979	Glutathione reductase, RBC	15.40	XXX	0/100
	82985	Glycated protein	12.94	XXX	0/100
	83001	Gonadotropin; follicle stimulating hormone (FSH)	30.81	XXX	0/100
	83002	Gonadotropin; luteinizing hormone (LH)	30.81	XXX	0/100
	83003	Growth hormone, human (HGH) (somatotropin)	30.81	XXX	0/100
	83006	Growth stimulation expressed gene 2 (ST2, Interleukin 1 receptor like-1)	67.87	XXX	0/100
	83009	Helicobacter pylori, blood test analysis for urease activity, non-radioactive isotope (eg, C-13)	88.07	XXX	0/100
	83010	Haptoglobin; quantitative	22.80	XXX	0/100
	83012	Haptoglobin; phenotypes	24.64	XXX	0/100
	83013	Helicobacter pylori; breath test analysis for urease activity, non-radioactive isotope (eg, C-13)	88.07	XXX	0/100
	83014	Helicobacter pylori; drug administration	10.38	XXX	0/100
	83015	Heavy metal (eg, arsenic, barium, beryllium, bismuth, antimony, mercury); qualitative, any number of analytes	40.66	XXX	0/100
	83018	Heavy metal (eg, arsenic, barium, beryllium, bismuth, antimony, mercury); quantitative, each, not elsewhere specified	43.13	XXX	0/100
	83020	Hemoglobin fractionation and quantitation; electrophoresis (eg, A2, S, C, and/or F)	23.10	XXX	30/70
	83021	Hemoglobin fractionation and quantitation; chromatography (eg, A2, S, C, and/or F)	30.81	XXX	0/100
	83026	Hemoglobin; by copper sulfate method, non-automated	5.54	XXX	0/100
	83030	Hemoglobin; F (fetal), chemical	16.02	XXX	0/100
	83033	Hemoglobin; F (fetal), qualitative	9.24	XXX	0/100
	83036	Hemoglobin; glycosylated (A1C)	16.63	XXX	0/100
	83037	Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use	15.40	XXX	0/100
	83045	Hemoglobin; methemoglobin, qualitative	6.16	XXX	0/100
	83050	Hemoglobin; methemoglobin, quantitative	7.39	XXX	0/100
	83051	Hemoglobin; plasma	8.01	XXX	0/100
	83060	Hemoglobin; sulfhemoglobin, quantitative	14.17	XXX	0/100
	83065	Hemoglobin; thermolabile	4.93	XXX	0/100
	83068	Hemoglobin; unstable, screen	6.78	XXX	0/100

PATHOLOGY AND LABORATORY**80047-89398****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
83069	Hemoglobin; urine	4.93	XXX	0/100
83070	Hemosiderin, qualitative	7.39	XXX	0/100
83080	b-Hexosaminidase, each assay	19.10	XXX	0/100
83088	Histamine	47.44	XXX	0/100
83090	Homocysteine	17.87	XXX	0/100
83150	Homovanillic acid (HVA)	30.81	XXX	0/100
83491	Hydroxycorticosteroids, 17- (17-OHCS)	36.35	XXX	0/100
83497	Hydroxyindolacetic acid, 5-(HIAA)	28.96	XXX	0/100
83498	Hydroxyprogesterone, 17-d	41.89	XXX	0/100
83500	Hydroxyproline; free	30.81	XXX	0/100
83505	Hydroxyproline; total	40.05	XXX	0/100
83516	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, multiple step method	19.72	XXX	0/100
83518	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, single step method (eg, reagent strip)	12.32	XXX	0/100
83519	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, by radioimmunoassay (eg, RIA)	25.88	XXX	0/100
83520	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified	22.18	XXX	0/100
■ 83521	Immunoglobulin light chains (ie, kappa, lambda), free, each	17.34	XXX	0/100
83525	Insulin; total	24.03	XXX	0/100
83527	Insulin; free	27.11	XXX	0/100
83528	Intrinsic factor	32.04	XXX	0/100
■ 83529	Interleukin-6 (IL-6)	17.34	XXX	0/100
83540	Iron	8.01	XXX	0/100
83550	Iron binding capacity	10.78	XXX	0/100
83570	Isocitric dehydrogenase (IDH)	14.79	XXX	0/100
83582	Ketogenic steroids, fractionation	25.26	XXX	0/100
83586	Ketosteroids, 17- (17-KS); total	24.64	XXX	0/100
83593	Ketosteroids, 17- (17-KS); fractionation	54.22	XXX	0/100
83605	Lactate (lactic acid)	19.72	XXX	0/100
83615	Lactate dehydrogenase (LD), (LDH);	8.32	XXX	0/100
83625	Lactate dehydrogenase (LD), (LDH); isoenzymes, separation and quantitation	24.64	XXX	0/100
83630	Lactoferrin, fecal; qualitative	18.48	XXX	0/100
83631	Lactoferrin, fecal; quantitative	21.56	XXX	0/100
83632	Lactogen, human placental (HPL) human chorionic somatomammotropin	39.43	XXX	0/100
83633	Lactose, urine, qualitative	7.39	XXX	0/100
83655	Lead	15.40	XXX	0/100
83661	Fetal lung maturity assessment; lecithin sphingomyelin (L/S) ratio	53.11	XXX	0/100
83662	Fetal lung maturity assessment; foam stability test	15.40	XXX	0/100
83663	Fetal lung maturity assessment; fluorescence polarization	15.40	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
83664	Fetal lung maturity assessment; lamellar body density	15.40	XXX	0/100
83670	Leucine aminopeptidase (LAP)	22.18	XXX	0/100
83690	Lipase	14.17	XXX	0/100
83695	Lipoprotein (a)	11.71	XXX	0/100
83698	Lipoprotein-associated phospholipase A2 (Lp-PLA2)	21.56	XXX	0/100
83700	Lipoprotein, blood; electrophoretic separation and quantitation	19.10	XXX	0/100
83701	Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (eg, electrophoresis, ultracentrifugation)	24.64	XXX	0/100
83704	Lipoprotein, blood; quantitation of lipoprotein particle number(s) (eg, by nuclear magnetic resonance spectroscopy), includes lipoprotein particle subclass(es), when performed	27.72	XXX	0/100
83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)	11.71	XXX	0/100
83719	Lipoprotein, direct measurement; VLDL cholesterol	12.94	XXX	0/100
83721	Lipoprotein, direct measurement; LDL cholesterol	12.32	XXX	0/100
■ 83722	Lipoprotein, direct measurement; small dense LDL cholesterol	34.68	XXX	0/100
83727	Luteinizing releasing factor (LRH)	33.89	XXX	0/100
83735	Magnesium	8.63	XXX	0/100
83775	Malate dehydrogenase	14.17	XXX	0/100
83785	Manganese	36.97	XXX	0/100
83789	Mass spectrometry and tandem mass spectrometry (eg, MS, MS/MS, MALDI, MS-TOF, QTOF), non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen	27.72	XXX	0/100
83825	Mercury, quantitative	32.04	XXX	0/100
83835	Metanephrines	32.04	XXX	0/100
83857	Methemalbumin	18.48	XXX	0/100
83861	Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity	21.70	XXX	0/100
83864	Mucopolysaccharides, acid, quantitative	18.48	XXX	0/100
83872	Mucin, synovial fluid (Ropes test)	8.01	XXX	0/100
83873	Myelin basic protein, cerebrospinal fluid	33.89	XXX	0/100
83874	Myoglobin	27.72	XXX	0/100
83876	Myeloperoxidase (MPO)	24.64	XXX	0/100
83880	Natriuretic peptide	36.97	XXX	0/100
83883	Nephelometry, each analyte not elsewhere specified	22.80	XXX	0/100
83885	Nickel	32.96	XXX	0/100
83915	Nucleotidase 5'-	17.25	XXX	0/100
83916	Oligoclonal immune (oligoclonal bands)	29.57	XXX	0/100
83918	Organic acids; total, quantitative, each specimen	46.21	XXX	0/100
83919	Organic acids; qualitative, each specimen	30.81	XXX	0/100
83921	Organic acid, single, quantitative	30.81	XXX	0/100
83930	Osmolality; blood	9.24	XXX	0/100

PATHOLOGY AND LABORATORY**80047-89398****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
83935	Osmolality; urine	13.55	XXX	0/100
83937	Osteocalcin (bone g1a protein)	44.36	XXX	0/100
83945	Oxalate	22.18	XXX	0/100
83950	Oncoprotein; HER-2/neu	32.04	XXX	0/100
83951	Oncoprotein; des-gamma-carboxy-prothrombin (DCP)	98.58	XXX	0/100
83970	Parathormone (parathyroid hormone)	49.29	XXX	0/100
83986	pH; body fluid, not otherwise specified	6.78	XXX	0/100
83987	pH; exhaled breath condensate	6.16	XXX	0/100
83992	Phencyclidine (PCP)	30.81	XXX	0/100
83993	Calprotectin, fecal	33.27	XXX	0/100
84030	Phenylalanine (PKU), blood	8.63	XXX	0/100
84035	Phenylketones, qualitative	6.16	XXX	0/100
84060	Phosphatase, acid; total	15.40	XXX	0/100
84066	Phosphatase, acid; prostatic	20.33	XXX	0/100
84075	Phosphatase, alkaline;	8.32	XXX	0/100
84078	Phosphatase, alkaline; heat stable (total not included)	15.09	XXX	0/100
84080	Phosphatase, alkaline; isoenzymes	26.49	XXX	0/100
84081	Phosphatidylglycerol	36.97	XXX	0/100
84085	Phosphogluconate, 6-, dehydrogenase, RBC	16.02	XXX	0/100
84087	Phosphohexose isomerase	17.25	XXX	0/100
84100	Phosphorus inorganic (phosphate);	8.01	XXX	0/100
84105	Phosphorus inorganic (phosphate); urine	9.86	XXX	0/100
84106	Porphobilinogen, urine; qualitative	11.71	XXX	0/100
84110	Porphobilinogen, urine; quantitative	15.40	XXX	0/100
84112	Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (eg, placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-fetoprotein), qualitative, each specimen	17.87	XXX	0/100
84119	Porphyrins, urine; qualitative	16.02	XXX	0/100
84120	Porphyrins, urine; quantitation and fractionation	28.96	XXX	0/100
84126	Porphyrins, feces, quantitative	27.72	XXX	0/100
84132	Potassium; serum, plasma or whole blood	8.01	XXX	0/100
84133	Potassium; urine	8.63	XXX	0/100
84134	Prealbumin	18.48	XXX	0/100
84135	Pregnanediol	30.81	XXX	0/100
84138	Pregnanetriol	30.81	XXX	0/100
84140	Pregnenolone	36.97	XXX	0/100
84143	17-hydroxypregnenolone	36.97	XXX	0/100
84144	Progesterone	30.81	XXX	0/100
84145	Procalcitonin (PCT)	34.91	XXX	0/100
84146	Prolactin	30.81	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
84150	Prostaglandin, each	33.89	XXX	0/100
84152	Prostate specific antigen (PSA); complexed (direct measurement)	30.81	XXX	0/100
84153	Prostate specific antigen (PSA); total	30.81	XXX	0/100
84154	Prostate specific antigen (PSA); free	30.81	XXX	0/100
84155	Protein, total, except by refractometry; serum, plasma or whole blood	8.01	XXX	0/100
84156	Protein, total, except by refractometry; urine	8.01	XXX	0/100
84157	Protein, total, except by refractometry; other source (eg, synovial fluid, cerebrospinal fluid)	8.01	XXX	0/100
84160	Protein, total, by refractometry, any source	6.16	XXX	0/100
84163	Pregnancy-associated plasma protein-A (PAPP-A)	19.82	XXX	0/100
84165	Protein; electrophoretic fractionation and quantitation, serum	22.18	XXX	20/80
84166	Protein; electrophoretic fractionation and quantitation, other fluids with concentration (eg, urine, CSF)	22.18	XXX	20/80
84181	Protein; Western Blot, with interpretation and report, blood or other body fluid	33.89	XXX	30/70
84182	Protein; Western Blot, with interpretation and report, blood or other body fluid, immunological probe for band identification, each	49.29	XXX	30/70
84202	Protoporphyrin, RBC; quantitative	19.72	XXX	0/100
84203	Protoporphyrin, RBC; screen	10.78	XXX	0/100
84206	Proinsulin	46.21	XXX	0/100
84207	Pyridoxal phosphate (Vitamin B-6)	46.21	XXX	0/100
84210	Pyruvate	22.18	XXX	0/100
84220	Pyruvate kinase	18.48	XXX	0/100
84228	Quinine	24.64	XXX	0/100
84233	Receptor assay; estrogen	43.74	XXX	0/100
84234	Receptor assay; progesterone	43.74	XXX	0/100
84235	Receptor assay; endocrine, other than estrogen or progesterone (specify hormone)	43.74	XXX	0/100
84238	Receptor assay; non-endocrine (specify receptor)	61.61	XXX	0/100
84244	Renin	39.43	XXX	0/100
84252	Riboflavin (Vitamin B-2)	25.88	XXX	0/100
84255	Selenium	30.81	XXX	0/100
84260	Serotonin	56.68	XXX	0/100
84270	Sex hormone binding globulin (SHBG)	32.65	XXX	0/100
84275	Sialic acid	19.72	XXX	0/100
84285	Silica	41.89	XXX	0/100
84295	Sodium; serum, plasma or whole blood	8.01	XXX	0/100
84300	Sodium; urine	8.63	XXX	0/100
84302	Sodium; other source	8.63	XXX	0/100
84305	Somatomedin	46.21	XXX	0/100
84307	Somatostatin	33.89	XXX	0/100
84311	Spectrophotometry, analyte not elsewhere specified	13.55	XXX	0/100

PATHOLOGY AND LABORATORY**80047-89398****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
84315	Specific gravity (except urine)	4.31	XXX	0/100
84375	Sugars, chromatographic, TLC or paper chromatography	24.64	XXX	0/100
84376	Sugars (mono-, di-, and oligosaccharides); single qualitative, each specimen	7.23	XXX	0/100
84377	Sugars (mono-, di-, and oligosaccharides); multiple qualitative, each specimen	7.23	XXX	0/100
84378	Sugars (mono-, di-, and oligosaccharides); single quantitative, each specimen	15.10	XXX	0/100
84379	Sugars (mono-, di-, and oligosaccharides); multiple quantitative, each specimen	15.10	XXX	0/100
84392	Sulfate, urine	7.61	XXX	0/100
84402	Testosterone; free	35.12	XXX	0/100
84403	Testosterone; total	28.96	XXX	0/100
84410	Testosterone; bioavailable, direct measurement (eg, differential precipitation)	56.88	XXX	0/100
84425	Thiamine (Vitamin B-1)	33.89	XXX	0/100
84430	Thiocyanate	21.56	XXX	0/100
84431	Thromboxane metabolite(s), including thromboxane if performed, urine	22.02	XXX	0/100
84432	Thyroglobulin	30.81	XXX	0/100
■ 84433	Thiopurine S-methyltransferase (TPMT)	22.58	XXX	0/100
84436	Thyroxine; total	11.09	XXX	0/100
84437	Thyroxine; requiring elution (eg, neonatal)	12.32	XXX	0/100
84439	Thyroxine; free	18.48	XXX	0/100
84442	Thyroxine binding globulin (TBG)	21.56	XXX	0/100
84443	Thyroid stimulating hormone (TSH)	25.88	XXX	0/100
84445	Thyroid stimulating immune globulins (TSI)	80.09	XXX	0/100
84446	Tocopherol alpha (Vitamin E)	24.64	XXX	0/100
84449	Transcortin (cortisol binding globulin)	29.57	XXX	0/100
84450	Transferase; aspartate amino (AST) (SGOT)	8.63	XXX	0/100
84460	Transferase; alanine amino (ALT) (SGPT)	8.63	XXX	0/100
84466	Transferrin	21.56	XXX	0/100
84478	Triglycerides	8.63	XXX	0/100
84479	Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)	11.09	XXX	0/100
84480	Triiodothyronine T3; total (TT-3)	24.64	XXX	0/100
84481	Triiodothyronine T3; free	32.65	XXX	0/100
84482	Triiodothyronine T3; reverse	27.72	XXX	0/100
84484	Troponin, quantitative	12.90	XXX	0/100
84485	Trypsin; duodenal fluid	12.32	XXX	0/100
84488	Trypsin; feces, qualitative	8.01	XXX	0/100
84490	Trypsin; feces, quantitative, 24-hour collection	9.24	XXX	0/100
84510	Tyrosine	16.02	XXX	0/100
84512	Troponin, qualitative	10.06	XXX	0/100
84520	Urea nitrogen; quantitative	8.01	XXX	0/100
84525	Urea nitrogen; semiquantitative (eg, reagent strip test)	6.16	XXX	0/100
84540	Urea nitrogen, urine	9.86	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
84545	Urea nitrogen, clearance	12.32	XXX	0/100
84550	Uric acid; blood	8.01	XXX	0/100
84560	Uric acid; other source	9.86	XXX	0/100
84577	Urobilinogen, feces, quantitative	12.32	XXX	0/100
84578	Urobilinogen, urine; qualitative	5.54	XXX	0/100
84580	Urobilinogen, urine; quantitative, timed specimen	11.71	XXX	0/100
84583	Urobilinogen, urine; semiquantitative	5.54	XXX	0/100
84585	Vanillylmandelic acid (VMA), urine	30.81	XXX	0/100
84586	Vasoactive intestinal peptide (VIP)	47.44	XXX	0/100
84588	Vasopressin (antidiuretic hormone, ADH)	50.52	XXX	0/100
84590	Vitamin A	28.96	XXX	0/100
84591	Vitamin, not otherwise specified	28.34	XXX	0/100
84597	Vitamin K	28.34	XXX	0/100
84600	Volatiles (eg, acetic anhydride, diethylether)	21.56	XXX	0/100
84620	Xylose absorption test, blood and/or urine	27.11	XXX	0/100
84630	Zinc	24.64	XXX	0/100
84681	C-peptide	36.97	XXX	0/100
84702	Gonadotropin, chorionic (hCG); quantitative	24.64	XXX	0/100
84703	Gonadotropin, chorionic (hCG); qualitative	14.17	XXX	0/100
84704	Gonadotropin, chorionic (hCG); free beta chain	23.41	XXX	0/100
84830	Ovulation tests, by visual color comparison methods for human luteinizing hormone	15.40	XXX	0/100
84999	Unlisted chemistry procedure	BR	XXX	
85002	Bleeding time	12.94	XXX	0/100
85004	Blood count; automated differential WBC count	9.24	XXX	0/100
85007	Blood count; blood smear, microscopic examination with manual differential WBC count	7.39	XXX	0/100
85008	Blood count; blood smear, microscopic examination without manual differential WBC count	4.93	XXX	0/100
85009	Blood count; manual differential WBC count, buffy coat	7.39	XXX	0/100
85013	Blood count; spun microhematocrit	5.54	XXX	0/100
85014	Blood count; hematocrit (Hct)	5.54	XXX	0/100
85018	Blood count; hemoglobin (Hgb)	5.54	XXX	0/100
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	11.40	XXX	0/100
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	10.78	XXX	0/100
85032	Blood count; manual cell count (erythrocyte, leukocyte, or platelet) each	9.24	XXX	0/100
85041	Blood count; red blood cell (RBC), automated	8.63	XXX	0/100
85044	Blood count; reticulocyte, manual	9.24	XXX	0/100
85045	Blood count; reticulocyte, automated	8.63	XXX	0/100

PATHOLOGY AND LABORATORY**80047-89398****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
85046	Blood count; reticulocytes, automated, including 1 or more cellular parameters (eg, reticulocyte hemoglobin content [CHR], immature reticulocyte fraction [IRF], reticulocyte volume [MRV], RNA content), direct measurement	7.23	XXX	0/100
85048	Blood count; leukocyte (WBC), automated	8.63	XXX	0/100
85049	Blood count; platelet, automated	8.63	XXX	0/100
85055	Reticulated platelet assay	34.91	XXX	0/100
85060	Blood smear, peripheral, interpretation by physician with written report	21.56	XXX	
85097	Bone marrow, smear interpretation	55.45	XXX	
85130	Chromogenic substrate assay	18.48	XXX	0/100
85170	Clot retraction	6.47	XXX	0/100
85175	Clot lysis time, whole blood dilution	12.32	XXX	0/100
85210	Clotting; factor II, prothrombin, specific	18.48	XXX	0/100
85220	Clotting; factor V (AcG or proaccelerin), labile factor	36.97	XXX	0/100
85230	Clotting; factor VII (proconvertin, stable factor)	36.97	XXX	0/100
85240	Clotting; factor VIII (AHG), 1-stage	40.05	XXX	0/100
85244	Clotting; factor VIII related antigen	49.29	XXX	0/100
85245	Clotting; factor VIII, VW factor, ristocetin cofactor	30.81	XXX	0/100
85246	Clotting; factor VIII, VW factor antigen	49.29	XXX	0/100
85247	Clotting; factor VIII, von Willebrand factor, multimetric analysis	49.29	XXX	0/100
85250	Clotting; factor IX (PTC or Christmas)	40.05	XXX	0/100
85260	Clotting; factor X (Stuart-Prower)	36.97	XXX	0/100
85270	Clotting; factor XI (PTA)	40.05	XXX	0/100
85280	Clotting; factor XII (Hageman)	40.05	XXX	0/100
85290	Clotting; factor XIII (fibrin stabilizing)	36.97	XXX	0/100
85291	Clotting; factor XIII (fibrin stabilizing), screen solubility	17.87	XXX	0/100
85292	Clotting; prekallikrein assay (Fletcher factor assay)	36.97	XXX	0/100
85293	Clotting; high molecular weight kininogen assay (Fitzgerald factor assay)	36.97	XXX	0/100
85300	Clotting inhibitors or anticoagulants; antithrombin III, activity	32.65	XXX	0/100
85301	Clotting inhibitors or anticoagulants; antithrombin III, antigen assay	30.81	XXX	0/100
85302	Clotting inhibitors or anticoagulants; protein C, antigen	33.89	XXX	0/100
85303	Clotting inhibitors or anticoagulants; protein C, activity	36.97	XXX	0/100
85305	Clotting inhibitors or anticoagulants; protein S, total	40.05	XXX	0/100
85306	Clotting inhibitors or anticoagulants; protein S, free	40.05	XXX	0/100
85307	Activated Protein C (APC) resistance assay	33.89	XXX	0/100
85335	Factor inhibitor test	16.63	XXX	0/100
85337	Thrombomodulin	30.81	XXX	0/100
85345	Coagulation time; Lee and White	6.16	XXX	0/100
85347	Coagulation time; activated	6.16	XXX	0/100
85348	Coagulation time; other methods	9.86	XXX	0/100
85360	Euglobulin lysis	19.72	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
85362	Fibrin(ogen) degradation (split) products (FDP) (FSP); agglutination slide, semiquantitative	13.55	XXX	0/100
85366	Fibrin(ogen) degradation (split) products (FDP) (FSP); paracoagulation	19.72	XXX	0/100
85370	Fibrin(ogen) degradation (split) products (FDP) (FSP); quantitative	19.72	XXX	0/100
85378	Fibrin degradation products, D-dimer; qualitative or semiquantitative	16.02	XXX	0/100
85379	Fibrin degradation products, D-dimer; quantitative	18.48	XXX	0/100
85380	Fibrin degradation products, D-dimer; ultrasensitive (eg, for evaluation for venous thromboembolism), qualitative or semiquantitative	18.48	XXX	0/100
85384	Fibrinogen; activity	12.32	XXX	0/100
85385	Fibrinogen; antigen	15.40	XXX	0/100
85390	Fibrinolysins or coagulopathy screen, interpretation and report	15.40	XXX	
85396	Coagulation/fibrinolysis assay, whole blood (eg, viscoelastic clot assessment), including use of any pharmacologic additive(s), as indicated, including interpretation and written report, per day	15.40	XXX	
85397	Coagulation and fibrinolysis, functional activity, not otherwise specified (eg, ADAMTS-13), each analyte	24.64	XXX	0/100
85400	Fibrinolytic factors and inhibitors; plasmin	29.57	XXX	0/100
85410	Fibrinolytic factors and inhibitors; alpha-2 antiplasmin	29.57	XXX	0/100
85415	Fibrinolytic factors and inhibitors; plasminogen activator	22.80	XXX	0/100
85420	Fibrinolytic factors and inhibitors; plasminogen, except antigenic assay	29.57	XXX	0/100
85421	Fibrinolytic factors and inhibitors; plasminogen, antigenic assay	36.97	XXX	0/100
85441	Heinz bodies; direct	5.54	XXX	0/100
85445	Heinz bodies; induced, acetyl phenylhydrazine	8.63	XXX	0/100
85460	Hemoglobin or RBCs, fetal, for fetomaternal hemorrhage; differential lysis (Kleihauer-Betke)	16.63	XXX	0/100
85461	Hemoglobin or RBCs, fetal, for fetomaternal hemorrhage; rosette	16.63	XXX	0/100
85475	Hemolysin, acid	20.95	XXX	0/100
85520	Heparin assay	24.64	XXX	0/100
85525	Heparin neutralization	24.64	XXX	0/100
85530	Heparin-protamine tolerance test	24.64	XXX	0/100
85536	Iron stain, peripheral blood	10.47	XXX	0/100
85540	Leukocyte alkaline phosphatase with count	15.40	XXX	0/100
85547	Mechanical fragility, RBC	14.17	XXX	0/100
85549	Muramidase	31.42	XXX	0/100
85555	Osmotic fragility, RBC; unincubated	15.40	XXX	0/100
85557	Osmotic fragility, RBC; incubated	30.81	XXX	0/100
85576	Platelet, aggregation (in vitro), each agent	30.81	XXX	20/80
85597	Phospholipid neutralization; platelet	21.56	XXX	0/100
85598	Phospholipid neutralization; hexagonal phospholipid	25.88	XXX	0/100
85610	Prothrombin time;	8.63	XXX	0/100
85611	Prothrombin time; substitution, plasma fractions, each	9.24	XXX	0/100

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

Code	Description	Relative Value	FUD	PC/TC Split
85612	Russell viper venom time (includes venom); undiluted	17.25	XXX	0/100
85613	Russell viper venom time (includes venom); diluted	20.33	XXX	0/100
85635	Reptilase test	12.32	XXX	0/100
85651	Sedimentation rate, erythrocyte; non-automated	7.70	XXX	0/100
85652	Sedimentation rate, erythrocyte; automated	7.70	XXX	0/100
85660	Sickling of RBC, reduction	8.63	XXX	0/100
85670	Thrombin time; plasma	11.71	XXX	0/100
85675	Thrombin time; titer	12.94	XXX	0/100
85705	Thromboplastin inhibition, tissue	23.41	XXX	0/100
85730	Thromboplastin time, partial (PTT); plasma or whole blood	10.47	XXX	0/100
85732	Thromboplastin time, partial (PTT); substitution, plasma fractions, each	12.32	XXX	0/100
85810	Viscosity	14.17	XXX	0/100
85999	Unlisted hematology and coagulation procedure	BR	XXX	
86000	Agglutinins, febrile (eg, Brucella, Francisella, Murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus), each antigen	14.17	XXX	0/100
86001	Allergen specific IgG quantitative or semiquantitative, each allergen	6.78	XXX	0/100
86003	Allergen specific IgE; quantitative or semiquantitative, crude allergen extract, each	6.78	XXX	0/100
86005	Allergen specific IgE; qualitative, multiallergen screen (eg, disk, sponge, card)	30.81	XXX	0/100
86008	Allergen specific IgE; quantitative or semiquantitative, recombinant or purified component, each	20.04	XXX	0/100
■ 86015	Actin (smooth muscle) antibody (ASMA), each	12.11	XXX	0/100
86021	Antibody identification; leukocyte antibodies	36.97	XXX	0/100
86022	Antibody identification; platelet antibodies	56.07	XXX	0/100
86023	Antibody identification; platelet associated immunoglobulin assay	30.81	XXX	0/100
■ 86036	Antineutrophil cytoplasmic antibody (ANCA); screen, each antibody	12.11	XXX	0/100
■ 86037	Antineutrophil cytoplasmic antibody (ANCA); titer, each antibody	12.11	XXX	0/100
86038	Antinuclear antibodies (ANA);	21.56	XXX	0/100
86039	Antinuclear antibodies (ANA); titer	21.56	XXX	0/100
■ 86041	Acetylcholine receptor (AChR); binding antibody	18.65	XXX	0/100
■ 86042	Acetylcholine receptor (AChR); blocking antibody	18.65	XXX	0/100
■ 86043	Acetylcholine receptor (AChR); modulating antibody	12.11	XXX	0/100
■ 86051	Aquaporin-4 (neuromyelitis optica [NMO]) antibody; enzyme-linked immunosorbent immunoassay (ELISA)	11.78	XXX	0/100
■ 86052	Aquaporin-4 (neuromyelitis optica [NMO]) antibody; cell-based immunofluorescence assay (CBA), each	12.11	XXX	0/100
■ 86053	Aquaporin-4 (neuromyelitis optica [NMO]) antibody; flow cytometry (ie, fluorescence-activated cell sorting [FACS]), each	38.28	XXX	0/100
86060	Antistreptolysin O; titer	14.79	XXX	0/100
86063	Antistreptolysin O; screen	11.09	XXX	0/100
86077	Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report	38.81	XXX	

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
86078	Blood bank physician services; investigation of transfusion reaction including suspicion of transmissible disease, interpretation and written report	44.98	XXX	
86079	Blood bank physician services; authorization for deviation from standard blood banking procedures (eg, use of outdated blood, transfusion of Rh incompatible units), with written report	27.72	XXX	
86140	C-reactive protein;	11.71	XXX	0/100
86141	C-reactive protein; high sensitivity (hsCRP)	14.79	XXX	0/100
86146	Beta 2 Glycoprotein I antibody, each	43.13	XXX	0/100
86147	Cardiolipin (phospholipid) antibody, each Ig class	43.13	XXX	0/100
86148	Anti-phosphatidylserine (phospholipid) antibody	21.07	XXX	0/100
86152	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood);	272.46	XXX	0/100
86153	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required	BR	XXX	
86155	Chemotaxis assay, specify method	16.63	XXX	0/100
86156	Cold agglutinin; screen	11.09	XXX	0/100
86157	Cold agglutinin; titer	14.17	XXX	0/100
86160	Complement; antigen, each component	27.11	XXX	0/100
86161	Complement; functional activity, each component	27.11	XXX	0/100
86162	Complement; total hemolytic (CH50)	38.20	XXX	0/100
86171	Complement fixation tests, each antigen	17.87	XXX	0/100
86200	Cyclic citrullinated peptide (CCP), antibody	24.64	XXX	0/100
86215	Deoxyribonuclease, antibody	24.03	XXX	0/100
86225	Deoxyribonucleic acid (DNA) antibody; native or double stranded	26.49	XXX	0/100
86226	Deoxyribonucleic acid (DNA) antibody; single stranded	26.49	XXX	0/100
■ 86231	Endomysial antibody (EMA), each immunoglobulin (Ig) class	12.11	XXX	0/100
86235	Extractable nuclear antigen, antibody to, any method (eg, nRNP, SS-A, SS-B, Sm, RNP, Scl70, J01), each antibody	23.41	XXX	0/100
86255	Fluorescent noninfectious agent antibody; screen, each antibody	21.56	XXX	0/100
86256	Fluorescent noninfectious agent antibody; titer, each antibody	26.49	XXX	0/100
■ 86258	Gliadin (deamidated) (DGP) antibody, each immunoglobulin (Ig) class	12.11	XXX	0/100
86277	Growth hormone, human (HGH), antibody	21.56	XXX	0/100
86280	Hemagglutination inhibition test (HAI)	17.87	XXX	0/100
86294	Immunoassay for tumor antigen, qualitative or semiquantitative (eg, bladder tumor antigen)	32.04	XXX	0/100
86300	Immunoassay for tumor antigen, quantitative; CA 15-3 (27.29)	32.04	XXX	0/100
86301	Immunoassay for tumor antigen, quantitative; CA 19-9	32.04	XXX	0/100
86304	Immunoassay for tumor antigen, quantitative; CA 125	32.04	XXX	0/100
86305	Human epididymis protein 4 (HE4)	27.36	XXX	0/100
86308	Heterophile antibodies; screening	10.47	XXX	0/100
86309	Heterophile antibodies; titer	13.55	XXX	0/100

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

Code	Description	Relative Value	FUD	PC/TC Split
86310	Heterophile antibodies; titers after absorption with beef cells and guinea pig kidney	15.40	XXX	0/100
86316	Immunoassay for tumor antigen, other antigen, quantitative (eg, CA 50, 72-4, 549), each	32.04	XXX	0/100
86317	Immunoassay for infectious agent antibody, quantitative, not otherwise specified	14.79	XXX	0/100
■ 86318	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single-step method (eg, reagent strip);	14.79	XXX	0/100
86320	Immunoelectrophoresis; serum	38.81	XXX	20/80
86325	Immunoelectrophoresis; other fluids (eg, urine, cerebrospinal fluid) with concentration	40.05	XXX	20/80
86327	Immunoelectrophoresis; crossed (2-dimensional assay)	30.81	XXX	20/80
■ 86328	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])	45.80	XXX	0/100
86329	Immunodiffusion; not elsewhere specified	29.57	XXX	0/100
86331	Immunodiffusion; gel diffusion, qualitative (Ouchterlony), each antigen or antibody	27.72	XXX	0/100
86332	Immune complex assay	35.12	XXX	0/100
86334	Immunofixation electrophoresis; serum	33.27	XXX	20/80
86335	Immunofixation electrophoresis; other fluids with concentration (eg, urine, CSF)	33.27	XXX	20/80
86336	Inhibin A	30.81	XXX	0/100
86337	Insulin antibodies	38.81	XXX	0/100
86340	Intrinsic factor antibodies	27.11	XXX	0/100
86341	Islet cell antibody	21.56	XXX	0/100
86343	Leukocyte histamine release test (LHR)	26.49	XXX	0/100
86344	Leukocyte phagocytosis	15.40	XXX	0/100
86352	Cellular function assay involving stimulation (eg, mitogen or antigen) and detection of biomarker (eg, ATP)	177.71	XXX	0/100
86353	Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis	86.25	XXX	0/100
86355	B cells, total count	40.05	XXX	0/100
86356	Mononuclear cell antigen, quantitative (eg, flow cytometry), not otherwise specified, each antigen	30.81	XXX	0/100
86357	Natural killer (NK) cells, total count	40.05	XXX	0/100
86359	T cells; total count	40.66	XXX	0/100
86360	T cells; absolute CD4 and CD8 count, including ratio	61.61	XXX	0/100
86361	T cells; absolute CD4 count	51.14	XXX	0/100
■ 86362	Myelin oligodendrocyte glycoprotein (MOG-IgG1) antibody; cell-based immunofluorescence assay (CBA), each	12.11	XXX	0/100
■ 86363	Myelin oligodendrocyte glycoprotein (MOG-IgG1) antibody; flow cytometry (ie, fluorescence-activated cell sorting [FACS]), each	38.28	XXX	0/100
■ 86364	Tissue transglutaminase, each immunoglobulin (Ig) class	11.78	XXX	0/100
■ 86366	Muscle-specific kinase (MuSK) antibody	18.65	XXX	0/100
86367	Stem cells (ie, CD34), total count	40.05	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	86376	Microsomal antibodies (eg, thyroid or liver-kidney), each	25.88	XXX	0/100
■	86381	Mitochondrial antibody (eg, M2), each	25.85	XXX	0/100
	86382	Neutralization test, viral	28.34	XXX	0/100
	86384	Nitroblue tetrazolium dye test (NTD)	21.56	XXX	0/100
	86386	Nuclear Matrix Protein 22 (NMP22), qualitative	20.76	XXX	0/100
	86403	Particle agglutination; screen, each antibody	9.86	XXX	0/100
	86406	Particle agglutination; titer, each antibody	11.40	XXX	0/100
■	86408	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); screen	42.53	XXX	0/100
■	86409	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); titer	80.49	XXX	0/100
■	86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) antibody, quantitative	52.02	XXX	0/100
	86430	Rheumatoid factor; qualitative	11.71	XXX	0/100
	86431	Rheumatoid factor; quantitative	13.55	XXX	0/100
	86480	Tuberculosis test, cell mediated immunity antigen response measurement; gamma interferon	20.33	XXX	0/100
	86481	Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon-producing T-cells in cell suspension	20.33	XXX	0/100
	86485	Skin test; candida	9.24	XXX	0/100
	86486	Skin test; unlisted antigen, each	6.16	XXX	0/100
	86490	Skin test; coccidioidomycosis	8.63	XXX	0/100
	86510	Skin test; histoplasmosis	9.24	XXX	0/100
	86580	Skin test; tuberculosis, intradermal	8.01	XXX	0/100
	86590	Streptokinase, antibody	11.09	XXX	0/100
	86592	Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)	8.01	XXX	0/100
	86593	Syphilis test, non-treponemal antibody; quantitative	8.63	XXX	0/100
■	86596	Voltage-gated calcium channel antibody, each	12.11	XXX	0/100
	86602	Antibody; actinomyces	24.64	XXX	0/100
	86603	Antibody; adenovirus	24.64	XXX	0/100
	86606	Antibody; Aspergillus	27.11	XXX	0/100
	86609	Antibody; bacterium, not elsewhere specified	33.89	XXX	0/100
	86611	Antibody; Bartonella	27.72	XXX	0/100
	86612	Antibody; Blastomyces	27.11	XXX	0/100
	86615	Antibody; Bordetella	30.81	XXX	0/100
	86617	Antibody; Borrelia burgdorferi (Lyme disease) confirmatory test (eg, Western Blot or immunoblot)	32.65	XXX	0/100
	86618	Antibody; Borrelia burgdorferi (Lyme disease)	30.81	XXX	0/100
	86619	Antibody; Borrelia (relapsing fever)	24.64	XXX	0/100
	86622	Antibody; Brucella	18.48	XXX	0/100
	86625	Antibody; Campylobacter	30.81	XXX	0/100

PATHOLOGY AND LABORATORY**80047-89398****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
86628	Antibody; Candida	29.57	XXX	0/100
86631	Antibody; Chlamydia	21.56	XXX	0/100
86632	Antibody; Chlamydia, IgM	24.03	XXX	0/100
86635	Antibody; Coccidioides	29.57	XXX	0/100
86638	Antibody; Coxiella burnetii (Q fever)	24.64	XXX	0/100
86641	Antibody; Cryptococcus	18.48	XXX	0/100
86644	Antibody; cytomegalovirus (CMV)	28.34	XXX	0/100
86645	Antibody; cytomegalovirus (CMV), IgM	31.42	XXX	0/100
86648	Antibody; Diphtheria	27.11	XXX	0/100
86651	Antibody; encephalitis, California (La Crosse)	24.64	XXX	0/100
86652	Antibody; encephalitis, Eastern equine	24.64	XXX	0/100
86653	Antibody; encephalitis, St. Louis	24.64	XXX	0/100
86654	Antibody; encephalitis, Western equine	24.64	XXX	0/100
86658	Antibody; enterovirus (eg, coxsackie, echo, polio)	24.64	XXX	0/100
86663	Antibody; Epstein-Barr (EB) virus, early antigen (EA)	29.57	XXX	0/100
86664	Antibody; Epstein-Barr (EB) virus, nuclear antigen (EBNA)	29.57	XXX	0/100
86665	Antibody; Epstein-Barr (EB) virus, viral capsid (VCA)	32.04	XXX	0/100
86666	Antibody; Ehrlichia	27.72	XXX	0/100
86668	Antibody; Francisella tularensis	18.48	XXX	0/100
86671	Antibody; fungus, not elsewhere specified	33.89	XXX	0/100
86674	Antibody; Giardia lamblia	24.64	XXX	0/100
86677	Antibody; Helicobacter pylori	33.27	XXX	0/100
86682	Antibody; helminth, not elsewhere specified	33.89	XXX	0/100
86684	Antibody; Haemophilus influenza	30.81	XXX	0/100
86687	Antibody; HTLV-I	24.64	XXX	0/100
86688	Antibody; HTLV-II	23.41	XXX	0/100
86689	Antibody; HTLV or HIV antibody, confirmatory test (eg, Western Blot)	32.65	XXX	0/100
86692	Antibody; hepatitis, delta agent	30.81	XXX	0/100
86694	Antibody; herpes simplex, non-specific type test	27.11	XXX	0/100
86695	Antibody; herpes simplex, type 1	27.11	XXX	0/100
86696	Antibody; herpes simplex, type 2	27.11	XXX	0/100
86698	Antibody; histoplasma	24.64	XXX	0/100
86701	Antibody; HIV-1	20.95	XXX	0/100
86702	Antibody; HIV-2	30.81	XXX	0/100
86703	Antibody; HIV-1 and HIV-2, single result	20.95	XXX	0/100
86704	Hepatitis B core antibody (HBcAb); total	21.56	XXX	0/100
86705	Hepatitis B core antibody (HBcAb); IgM antibody	23.41	XXX	0/100
86706	Hepatitis B surface antibody (HBsAb)	19.10	XXX	0/100
86707	Hepatitis Be antibody (HBeAb)	20.95	XXX	0/100
86708	Hepatitis A antibody (HAAb)	22.80	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
86709	Hepatitis A antibody (HAAb), IgM antibody	21.56	XXX	0/100
86710	Antibody; influenza virus	20.33	XXX	0/100
86711	Antibody; JC (John Cunningham) virus	15.84	XXX	0/100
86713	Antibody; Legionella	29.57	XXX	0/100
86717	Antibody; Leishmania	24.64	XXX	0/100
86720	Antibody; Leptospira	24.64	XXX	0/100
86723	Antibody; Listeria monocytogenes	24.64	XXX	0/100
86727	Antibody; lymphocytic choriomeningitis	24.64	XXX	0/100
86732	Antibody; mucormycosis	24.64	XXX	0/100
86735	Antibody; mumps	24.64	XXX	0/100
86738	Antibody; mycoplasma	24.64	XXX	0/100
86741	Antibody; Neisseria meningitidis	24.64	XXX	0/100
86744	Antibody; Nocardia	24.64	XXX	0/100
86747	Antibody; parvovirus	30.81	XXX	0/100
86750	Antibody; Plasmodium (malaria)	24.64	XXX	0/100
86753	Antibody; protozoa, not elsewhere specified	33.89	XXX	0/100
86756	Antibody; respiratory syncytial virus	24.64	XXX	0/100
86757	Antibody; Rickettsia	24.64	XXX	0/100
86759	Antibody; rotavirus	24.64	XXX	0/100
86762	Antibody; rubella	14.17	XXX	0/100
86765	Antibody; rubeola	30.81	XXX	0/100
86768	Antibody; Salmonella	24.64	XXX	0/100
■ 86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])	42.53	XXX	0/100
86771	Antibody; Shigella	24.64	XXX	0/100
86774	Antibody; tetanus	30.81	XXX	0/100
86777	Antibody; Toxoplasma	23.41	XXX	0/100
86778	Antibody; Toxoplasma, IgM	28.96	XXX	0/100
86780	Antibody; Treponema pallidum	20.95	XXX	0/100
86784	Antibody; Trichinella	24.64	XXX	0/100
86787	Antibody; varicella-zoster	27.11	XXX	0/100
86788	Antibody; West Nile virus, IgM	27.72	XXX	0/100
86789	Antibody; West Nile virus	27.72	XXX	0/100
86790	Antibody; virus, not elsewhere specified	33.89	XXX	0/100
86793	Antibody; Yersinia	24.64	XXX	0/100
86794	Antibody; Zika virus, IgM	18.75	XXX	0/100
86800	Thyroglobulin antibody	26.49	XXX	0/100
86803	Hepatitis C antibody;	30.19	XXX	0/100
86804	Hepatitis C antibody; confirmatory test (eg, immunoblot)	43.13	XXX	0/100
86805	Lymphocytotoxicity assay, visual crossmatch; with titration	91.18	XXX	0/100

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
	86806	Lymphocytotoxicity assay, visual crossmatch; without titration	30.19	XXX	0/100
	86807	Serum screening for cytotoxic percent reactive antibody (PRA); standard method	30.19	XXX	0/100
	86808	Serum screening for cytotoxic percent reactive antibody (PRA); quick method	33.89	XXX	0/100
	86812	HLA typing; A, B, or C (eg, A10, B7, B27), single antigen	43.13	XXX	0/100
	86813	HLA typing; A, B, or C, multiple antigens	61.61	XXX	0/100
	86816	HLA typing; DR/DQ, single antigen	58.53	XXX	0/100
	86817	HLA typing; DR/DQ, multiple antigens	168.20	XXX	0/100
	86821	HLA typing; lymphocyte culture, mixed (MLC)	131.23	XXX	0/100
	86825	Human leukocyte antigen (HLA) crossmatch, non-cytotoxic (eg, using flow cytometry); first serum sample or dilution	105.05	XXX	0/100
+	86826	Human leukocyte antigen (HLA) crossmatch, non-cytotoxic (eg, using flow cytometry); each additional serum sample or sample dilution (List separately in addition to primary procedure)	34.91	XXX	0/100
	86828	Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); qualitative assessment of the presence or absence of antibody(ies) to HLA Class I and Class II HLA antigens	57.53	XXX	0/100
	86829	Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); qualitative assessment of the presence or absence of antibody(ies) to HLA Class I or Class II HLA antigens	57.53	XXX	0/100
	86830	Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); antibody identification by qualitative panel using complete HLA phenotypes, HLA Class I	89.53	XXX	0/100
	86831	Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); antibody identification by qualitative panel using complete HLA phenotypes, HLA Class II	76.60	XXX	0/100
	86832	Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); high definition qualitative panel for identification of antibody specificities (eg, individual antigen per bead methodology), HLA Class I	290.56	XXX	0/100
	86833	Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); high definition qualitative panel for identification of antibody specificities (eg, individual antigen per bead methodology), HLA Class II	292.50	XXX	0/100
	86834	Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); semi-quantitative panel (eg, titer), HLA Class I	396.24	XXX	0/100
	86835	Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); semi-quantitative panel (eg, titer), HLA Class II	358.11	XXX	0/100
	86849	Unlisted immunology procedure	BR	XXX	
	86850	Antibody screen, RBC, each serum technique	12.32	XXX	0/100
	86860	Antibody elution (RBC), each elution	12.32	XXX	0/100
	86870	Antibody identification, RBC antibodies, each panel for each serum technique	21.56	XXX	0/100
	86880	Antihuman globulin test (Coombs test); direct, each antiserum	6.78	XXX	0/100
	86885	Antihuman globulin test (Coombs test); indirect, qualitative, each reagent red cell	8.63	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
86886	Antihuman globulin test (Coombs test); indirect, each antibody titer	11.09	XXX	0/100
86890	Autologous blood or component, collection processing and storage; predeposited	49.29	XXX	0/100
86891	Autologous blood or component, collection processing and storage; intra- or postoperative salvage	77.01	XXX	0/100
86900	Blood typing, serologic; ABO	6.78	XXX	0/100
86901	Blood typing, serologic; Rh (D)	6.16	XXX	0/100
86902	Blood typing, serologic; antigen testing of donor blood using reagent serum, each antigen test	6.78	XXX	0/100
86904	Blood typing, serologic; antigen screening for compatible unit using patient serum, per unit screened	9.24	XXX	0/100
86905	Blood typing, serologic; RBC antigens, other than ABO or Rh (D), each	7.39	XXX	0/100
86906	Blood typing, serologic; Rh phenotyping, complete	10.47	XXX	0/100
86910	Blood typing, for paternity testing, per individual; ABO, Rh and MN	13.55	XXX	0/100
86911	Blood typing, for paternity testing, per individual; each additional antigen system	10.47	XXX	0/100
86920	Compatibility test each unit; immediate spin technique	13.55	XXX	0/100
86921	Compatibility test each unit; incubation technique	12.32	XXX	0/100
86922	Compatibility test each unit; antiglobulin technique	7.39	XXX	0/100
86923	Compatibility test each unit; electronic	15.40	XXX	0/100
86927	Fresh frozen plasma, thawing, each unit	6.78	XXX	0/100
86930	Frozen blood, each unit; freezing (includes preparation)	61.61	XXX	0/100
86931	Frozen blood, each unit; thawing	67.77	XXX	0/100
86932	Frozen blood, each unit; freezing (includes preparation) and thawing	73.93	XXX	0/100
86940	Hemolysins and agglutinins; auto, screen, each	12.94	XXX	0/100
86941	Hemolysins and agglutinins; incubated	13.55	XXX	0/100
86945	Irradiation of blood product, each unit	18.48	XXX	0/100
86950	Leukocyte transfusion	33.89	XXX	0/100
86960	Volume reduction of blood or blood product (eg, red blood cells or platelets), each unit	12.32	XXX	0/100
86965	Pooling of platelets or other blood products	8.63	XXX	0/100
86970	Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing; incubation with chemical agents or drugs, each	9.86	XXX	0/100
86971	Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing; incubation with enzymes, each	9.86	XXX	0/100
86972	Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing; by density gradient separation	9.24	XXX	0/100
86975	Pretreatment of serum for use in RBC antibody identification; incubation with drugs, each	6.16	XXX	0/100
86976	Pretreatment of serum for use in RBC antibody identification; by dilution	4.93	XXX	0/100
86977	Pretreatment of serum for use in RBC antibody identification; incubation with inhibitors, each	6.16	XXX	0/100
86978	Pretreatment of serum for use in RBC antibody identification; by differential red cell absorption using patient RBCs or RBCs of known phenotype, each absorption	13.55	XXX	0/100

PATHOLOGY AND LABORATORY**80047-89398****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
86985	Splitting of blood or blood products, each unit	12.94	XXX	0/100
86999	Unlisted transfusion medicine procedure	BR	XXX	
87003	Animal inoculation, small animal, with observation and dissection	24.64	XXX	0/100
87015	Concentration (any type), for infectious agents	12.94	XXX	0/100
87040	Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)	17.25	XXX	0/100
87045	Culture, bacterial; stool, aerobic, with isolation and preliminary examination (eg, KIA, LIA), Salmonella and Shigella species	17.25	XXX	0/100
87046	Culture, bacterial; stool, aerobic, additional pathogens, isolation and presumptive identification of isolates, each plate	17.25	XXX	0/100
87070	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates	16.64	XXX	0/100
87071	Culture, bacterial; quantitative, aerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool	17.25	XXX	0/100
87073	Culture, bacterial; quantitative, anaerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool	19.10	XXX	0/100
87075	Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates	19.10	XXX	0/100
87076	Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate	19.10	XXX	0/100
87077	Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate	19.10	XXX	0/100
87081	Culture, presumptive, pathogenic organisms, screening only;	9.86	XXX	0/100
87084	Culture, presumptive, pathogenic organisms, screening only; with colony estimation from density chart	12.32	XXX	0/100
87086	Culture, bacterial; quantitative colony count, urine	15.40	XXX	0/100
87088	Culture, bacterial; with isolation and presumptive identification of each isolate, urine	14.79	XXX	0/100
87101	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail	12.94	XXX	0/100
87102	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; other source (except blood)	16.02	XXX	0/100
87103	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; blood	18.48	XXX	0/100
87106	Culture, fungi, definitive identification, each organism; yeast	16.63	XXX	0/100
87107	Culture, fungi, definitive identification, each organism; mold	16.63	XXX	0/100
87109	Culture, mycoplasma, any source	35.43	XXX	0/100
87110	Culture, chlamydia, any source	24.64	XXX	0/100
87116	Culture, tubercle or other acid-fast bacilli (eg, TB, AFB, mycobacteria) any source, with isolation and presumptive identification of isolates	19.72	XXX	0/100
87118	Culture, mycobacterial, definitive identification, each isolate	16.02	XXX	0/100
87140	Culture, typing; immunofluorescent method, each antiserum	9.86	XXX	0/100
87143	Culture, typing; gas liquid chromatography (GLC) or high pressure liquid chromatography (HPLC) method	23.41	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	87147	Culture, typing; immunologic method, other than immunofluorescence (eg, agglutination grouping), per antiserum	8.63	XXX	0/100
	87149	Culture, typing; identification by nucleic acid (DNA or RNA) probe, direct probe technique, per culture or isolate, each organism probed	24.64	XXX	0/100
	87150	Culture, typing; identification by nucleic acid (DNA or RNA) probe, amplified probe technique, per culture or isolate, each organism probed	24.64	XXX	0/100
	87152	Culture, typing; identification by pulse field gel typing	8.63	XXX	0/100
	87153	Culture, typing; identification by nucleic acid sequencing method, each isolate (eg, sequencing of the 16S rRNA gene)	25.88	XXX	0/100
■	87154	Culture, typing; identification of blood pathogen and resistance typing, when performed, by nucleic acid (DNA or RNA) probe, multiplexed amplified probe technique including multiplex reverse transcription, when performed, per culture or isolate, 6 or more targets	220.52	XXX	0/100
	87158	Culture, typing; other methods	8.32	XXX	0/100
	87164	Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection	18.48	XXX	80/20
	87166	Dark field examination, any source (eg, penile, vaginal, oral, skin); without collection	15.40	XXX	0/100
	87168	Macroscopic examination; arthropod	4.93	XXX	0/100
	87169	Macroscopic examination; parasite	4.93	XXX	0/100
	87172	Pinworm exam (eg, cellophane tape prep)	4.93	XXX	0/100
	87176	Homogenization, tissue, for culture	11.09	XXX	0/100
	87177	Ova and parasites, direct smears, concentration and identification	18.48	XXX	0/100
	87181	Susceptibility studies, antimicrobial agent; agar dilution method, per agent (eg, antibiotic gradient strip)	10.47	XXX	0/100
	87184	Susceptibility studies, antimicrobial agent; disk method, per plate (12 or fewer agents)	12.32	XXX	0/100
	87185	Susceptibility studies, antimicrobial agent; enzyme detection (eg, beta lactamase), per enzyme	12.32	XXX	0/100
	87186	Susceptibility studies, antimicrobial agent; microdilution or agar dilution (minimum inhibitory concentration [MIC] or breakpoint), each multi-antimicrobial, per plate	14.17	XXX	0/100
+	87187	Susceptibility studies, antimicrobial agent; microdilution or agar dilution, minimum lethal concentration (MLC), each plate (List separately in addition to code for primary procedure)	14.17	XXX	0/100
	87188	Susceptibility studies, antimicrobial agent; macrobroth dilution method, each agent	14.17	XXX	0/100
	87190	Susceptibility studies, antimicrobial agent; mycobacteria, proportion method, each agent	9.24	XXX	0/100
	87197	Serum bactericidal titer (Schlichter test)	19.72	XXX	0/100
	87205	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types	8.01	XXX	0/100
	87206	Smear, primary source with interpretation; fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types	14.17	XXX	0/100
	87207	Smear, primary source with interpretation; special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses)	16.02	XXX	0/100

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

Code	Description	Relative Value	FUD	PC/TC Split
87209	Smear, primary source with interpretation; complex special stain (eg, trichrome, iron hemotoxylin) for ova and parasites	8.01	XXX	0/100
87210	Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)	7.39	XXX	0/100
87220	Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (eg, scabies)	9.24	XXX	0/100
87230	Toxin or antitoxin assay, tissue culture (eg, Clostridium difficile toxin)	27.72	XXX	0/100
87250	Virus isolation; inoculation of embryonated eggs, or small animal, includes observation and dissection	33.27	XXX	0/100
87252	Virus isolation; tissue culture inoculation, observation, and presumptive identification by cytopathic effect	30.81	XXX	0/100
87253	Virus isolation; tissue culture, additional studies or definitive identification (eg, hemabsorption, neutralization, immunofluorescence stain), each isolate	30.81	XXX	0/100
87254	Virus isolation; centrifuge enhanced (shell vial) technique, includes identification with immunofluorescence stain, each virus	30.81	XXX	0/100
87255	Virus isolation; including identification by non-immunologic method, other than by cytopathic effect (eg, virus specific enzymatic activity)	30.81	XXX	0/100
87260	Infectious agent antigen detection by immunofluorescent technique; adenovirus	24.64	XXX	0/100
87265	Infectious agent antigen detection by immunofluorescent technique; Bordetella pertussis/parapertussis	24.64	XXX	0/100
87267	Infectious agent antigen detection by immunofluorescent technique; Enterovirus, direct fluorescent antibody (DFA)	24.64	XXX	0/100
87269	Infectious agent antigen detection by immunofluorescent technique; giardia	24.64	XXX	0/100
87270	Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis	24.64	XXX	0/100
87271	Infectious agent antigen detection by immunofluorescent technique; Cytomegalovirus, direct fluorescent antibody (DFA)	24.64	XXX	0/100
87272	Infectious agent antigen detection by immunofluorescent technique; cryptosporidium	24.64	XXX	0/100
87273	Infectious agent antigen detection by immunofluorescent technique; Herpes simplex virus type 2	24.64	XXX	0/100
87274	Infectious agent antigen detection by immunofluorescent technique; Herpes simplex virus type 1	24.64	XXX	0/100
87275	Infectious agent antigen detection by immunofluorescent technique; influenza B virus	24.64	XXX	0/100
87276	Infectious agent antigen detection by immunofluorescent technique; influenza A virus	24.64	XXX	0/100
87278	Infectious agent antigen detection by immunofluorescent technique; Legionella pneumophila	24.64	XXX	0/100
87279	Infectious agent antigen detection by immunofluorescent technique; Parainfluenza virus, each type	24.64	XXX	0/100
87280	Infectious agent antigen detection by immunofluorescent technique; respiratory syncytial virus	24.64	XXX	0/100
87281	Infectious agent antigen detection by immunofluorescent technique; Pneumocystis carinii	24.64	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
87283	Infectious agent antigen detection by immunofluorescent technique; Rubeola	24.64	XXX	0/100
87285	Infectious agent antigen detection by immunofluorescent technique; Treponema pallidum	24.64	XXX	0/100
87290	Infectious agent antigen detection by immunofluorescent technique; Varicella zoster virus	24.64	XXX	0/100
87299	Infectious agent antigen detection by immunofluorescent technique; not otherwise specified, each organism	24.64	XXX	0/100
87300	Infectious agent antigen detection by immunofluorescent technique, polyvalent for multiple organisms, each polyvalent antiserum	19.72	XXX	0/100
■ 87301	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; adenovirus enteric types 40/41	13.55	XXX	0/100
■ 87305	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Aspergillus	19.72	XXX	0/100
■ 87320	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Chlamydia trachomatis	13.55	XXX	0/100
■ 87324	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Clostridium difficile toxin(s)	13.55	XXX	0/100
■ 87327	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Cryptococcus neoformans	13.55	XXX	0/100
■ 87328	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; cryptosporidium	13.55	XXX	0/100
■ 87329	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; giardia	13.55	XXX	0/100
■ 87332	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; cytomegalovirus	13.55	XXX	0/100
■ 87335	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Escherichia coli 0157	13.55	XXX	0/100
■ 87336	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Entamoeba histolytica dispar group	13.55	XXX	0/100

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
■	87337	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Entamoeba histolytica group	13.55	XXX	0/100
■	87338	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Helicobacter pylori, stool	19.72	XXX	0/100
■	87339	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Helicobacter pylori	13.55	XXX	0/100
■	87340	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis B surface antigen (HBsAg)	17.87	XXX	0/100
■	87341	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis B surface antigen (HBsAg) neutralization	13.55	XXX	0/100
■	87350	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis Be antigen (HBeAg)	20.95	XXX	0/100
■	87380	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis, delta agent	23.41	XXX	0/100
■	87385	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Histoplasma capsulatum	13.55	XXX	0/100
■	87389	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result	31.45	XXX	0/100
■	87390	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV-1	28.96	XXX	0/100
■	87391	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV-2	28.96	XXX	0/100
■	87400	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Influenza, A or B, each	13.55	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	87420	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; respiratory syncytial virus	13.55	XXX	0/100
■	87425	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; rotavirus	13.55	XXX	0/100
■	87426	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19])	35.66	XXX	0/100
■	87427	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Shiga-like toxin	13.55	XXX	0/100
■	87428	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B	71.00	XXX	0/100
■	87430	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Streptococcus, group A	13.55	XXX	0/100
■	87449	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; not otherwise specified, each organism	13.55	XXX	0/100
■	87451	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; polyvalent for multiple organisms, each polyvalent antiserum	19.72	XXX	0/100
■	87467	Infectious agent antigen detection by immunoassay technique (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative; hepatitis B surface antigen (HBsAg), quantitative	25.52	XXX	
■	87468	Infectious agent detection by nucleic acid (DNA or RNA); Anaplasma phagocytophilum, amplified probe technique	35.33	XXX	0/100
■	87469	Infectious agent detection by nucleic acid (DNA or RNA); Babesia microti, amplified probe technique	35.33	XXX	0/100
	87471	Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, amplified probe technique	49.29	XXX	0/100
	87472	Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, quantification	49.60	XXX	0/100
	87475	Infectious agent detection by nucleic acid (DNA or RNA); Borrelia burgdorferi, direct probe technique	24.64	XXX	0/100

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
	87476	Infectious agent detection by nucleic acid (DNA or RNA); <i>Borrelia burgdorferi</i> , amplified probe technique	49.29	XXX	0/100
■	87478	Infectious agent detection by nucleic acid (DNA or RNA); <i>Borrelia miyamotoi</i> , amplified probe technique	35.33	XXX	0/100
	87480	Infectious agent detection by nucleic acid (DNA or RNA); <i>Candida</i> species, direct probe technique	24.64	XXX	0/100
	87481	Infectious agent detection by nucleic acid (DNA or RNA); <i>Candida</i> species, amplified probe technique	49.29	XXX	0/100
	87482	Infectious agent detection by nucleic acid (DNA or RNA); <i>Candida</i> species, quantification	49.60	XXX	0/100
	87483	Infectious agent detection by nucleic acid (DNA or RNA); central nervous system pathogen (eg, <i>Neisseria meningitidis</i> , <i>Streptococcus pneumoniae</i> , <i>Listeria</i> , <i>Haemophilus influenzae</i> , <i>E. coli</i> , <i>Streptococcus agalactiae</i> , enterovirus, human parechovirus, herpes simplex virus type 1 and 2, human herpesvirus 6, cytomegalovirus, varicella zoster virus, <i>Cryptococcus</i>), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets	461.85	XXX	0/100
■	87484	Infectious agent detection by nucleic acid (DNA or RNA); <i>Ehrlichia chaffeensis</i> , amplified probe technique	35.33	XXX	0/100
	87485	Infectious agent detection by nucleic acid (DNA or RNA); <i>Chlamydia pneumoniae</i> , direct probe technique	24.64	XXX	0/100
	87486	Infectious agent detection by nucleic acid (DNA or RNA); <i>Chlamydia pneumoniae</i> , amplified probe technique	49.29	XXX	0/100
	87487	Infectious agent detection by nucleic acid (DNA or RNA); <i>Chlamydia pneumoniae</i> , quantification	49.60	XXX	0/100
	87490	Infectious agent detection by nucleic acid (DNA or RNA); <i>Chlamydia trachomatis</i> , direct probe technique	24.64	XXX	0/100
	87491	Infectious agent detection by nucleic acid (DNA or RNA); <i>Chlamydia trachomatis</i> , amplified probe technique	49.29	XXX	0/100
	87492	Infectious agent detection by nucleic acid (DNA or RNA); <i>Chlamydia trachomatis</i> , quantification	49.60	XXX	0/100
	87493	Infectious agent detection by nucleic acid (DNA or RNA); <i>Clostridium difficile</i> , toxin gene(s), amplified probe technique	44.36	XXX	0/100
	87495	Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, direct probe technique	24.64	XXX	0/100
	87496	Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, amplified probe technique	49.29	XXX	0/100
	87497	Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, quantification	49.60	XXX	0/100
	87498	Infectious agent detection by nucleic acid (DNA or RNA); enterovirus, amplified probe technique, includes reverse transcription when performed	67.77	XXX	0/100
	87500	Infectious agent detection by nucleic acid (DNA or RNA); vancomycin resistance (eg, enterococcus species van A, van B), amplified probe technique	67.77	XXX	0/100
	87501	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, includes reverse transcription, when performed, and amplified probe technique, each type or subtype	67.77	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	87502	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, first 2 types or sub-types	67.77	XXX	0/100
+	87503	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, each additional influenza virus type or sub-type beyond 2 (List separately in addition to code for primary procedure)	67.77	XXX	0/100
	87505	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 3-5 targets	142.21	XXX	0/100
	87506	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 6-11 targets	236.58	XXX	0/100
	87507	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets	461.85	XXX	0/100
	87510	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, direct probe technique	24.64	XXX	0/100
	87511	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, amplified probe technique	49.29	XXX	0/100
	87512	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, quantification	49.60	XXX	0/100
	87516	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis B virus, amplified probe technique	49.29	XXX	0/100
	87517	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis B virus, quantification	49.60	XXX	0/100
	87520	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, direct probe technique	24.64	XXX	0/100
	87521	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, amplified probe technique, includes reverse transcription when performed	49.29	XXX	0/100
	87522	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, quantification, includes reverse transcription when performed	49.60	XXX	0/100
■	87523	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis D (delta), quantification, including reverse transcription, when performed	43.19	XXX	0/100
	87525	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, direct probe technique	24.64	XXX	0/100
	87526	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, amplified probe technique	49.29	XXX	0/100
	87527	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, quantification	49.60	XXX	0/100
	87528	Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, direct probe technique	24.64	XXX	0/100

PATHOLOGY AND LABORATORY**80047-89398****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
87529	Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, amplified probe technique	49.29	XXX	0/100
87530	Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, quantification	49.60	XXX	0/100
87531	Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, direct probe technique	24.64	XXX	0/100
87532	Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, amplified probe technique	49.29	XXX	0/100
87533	Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, quantification	49.60	XXX	0/100
87534	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique	24.64	XXX	0/100
87535	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique, includes reverse transcription when performed	49.29	XXX	0/100
87536	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification, includes reverse transcription when performed	49.60	XXX	0/100
87537	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique	24.64	XXX	0/100
87538	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, amplified probe technique, includes reverse transcription when performed	49.29	XXX	0/100
87539	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, quantification, includes reverse transcription when performed	49.60	XXX	0/100
87540	Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, direct probe technique	24.64	XXX	0/100
87541	Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, amplified probe technique	49.29	XXX	0/100
87542	Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, quantification	49.60	XXX	0/100
87550	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria species, direct probe technique	24.64	XXX	0/100
87551	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria species, amplified probe technique	49.29	XXX	0/100
87552	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria species, quantification	49.60	XXX	0/100
87555	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria tuberculosis, direct probe technique	24.64	XXX	0/100
87556	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria tuberculosis, amplified probe technique	49.29	XXX	0/100
87557	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria tuberculosis, quantification	49.60	XXX	0/100
87560	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria avium-intracellulare, direct probe technique	24.64	XXX	0/100
87561	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria avium-intracellulare, amplified probe technique	49.29	XXX	0/100
87562	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria avium-intracellulare, quantification	49.60	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	87563	Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma genitalium, amplified probe technique	35.33	XXX	0/100
	87580	Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, direct probe technique	24.64	XXX	0/100
	87581	Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, amplified probe technique	49.29	XXX	0/100
	87582	Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, quantification	49.60	XXX	0/100
	87590	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique	24.64	XXX	0/100
	87591	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique	49.29	XXX	0/100
	87592	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification	49.60	XXX	0/100
■	87593	Infectious agent detection by nucleic acid (DNA or RNA); orthopoxvirus (eg, monkeypox virus, cowpox virus, vaccinia virus), amplified probe technique, each	52.02	XXX	
	87623	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-risk types (eg, 6, 11, 42, 43, 44)	38.78	XXX	0/100
	87624	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)	38.78	XXX	0/100
	87625	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed	38.78	XXX	0/100
	87631	Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 3-5 targets	142.21	XXX	0/100
	87632	Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 6-11 targets	236.58	XXX	0/100
	87633	Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets	461.85	XXX	0/100
	87634	Infectious agent detection by nucleic acid (DNA or RNA); respiratory syncytial virus, amplified probe technique	77.89	XXX	0/100
■	87636	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique	144.28	XXX	0/100
■	87637	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique	144.28	XXX	0/100

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

Code	Description	Relative Value	FUD	PC/TC Split
87640	Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, amplified probe technique	49.29	XXX	0/100
87641	Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, methicillin resistant, amplified probe technique	49.29	XXX	0/100
87650	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, direct probe technique	24.64	XXX	0/100
87651	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, amplified probe technique	49.29	XXX	0/100
87652	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, quantification	49.60	XXX	0/100
87653	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group B, amplified probe technique	49.29	XXX	0/100
87660	Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique	24.64	XXX	0/100
87661	Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, amplified probe technique	38.78	XXX	0/100
87662	Infectious agent detection by nucleic acid (DNA or RNA); Zika virus, amplified probe technique	56.88	XXX	0/100
87797	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism	24.64	XXX	0/100
87798	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism	49.29	XXX	0/100
87799	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism	49.60	XXX	0/100
87800	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique	52.53	XXX	0/100
87801	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique	91.84	XXX	0/100
■ 87802	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Streptococcus, group B	21.56	XXX	0/100
■ 87803	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Clostridium difficile toxin A	21.56	XXX	0/100
■ 87804	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Influenza	21.56	XXX	0/100
■ 87806	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies	29.41	XXX	0/100
■ 87807	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; respiratory syncytial virus	21.56	XXX	0/100
■ 87808	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Trichomonas vaginalis	24.64	XXX	0/100
■ 87809	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; adenovirus	24.64	XXX	0/100
■ 87810	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Chlamydia trachomatis	21.56	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	87811	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])	41.88	XXX	0/100
■	87850	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Neisseria gonorrhoeae	21.56	XXX	0/100
■	87880	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Streptococcus, group A	21.56	XXX	0/100
■	87899	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; not otherwise specified	21.56	XXX	0/100
	87900	Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic bioinformatics	170.47	XXX	0/100
	87901	Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, reverse transcriptase and protease regions	273.55	XXX	0/100
	87902	Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis C virus	273.55	XXX	0/100
	87903	Infectious agent phenotype analysis by nucleic acid (DNA or RNA) with drug resistance tissue culture analysis, HIV 1; first through 10 drugs tested	492.88	XXX	0/100
+	87904	Infectious agent phenotype analysis by nucleic acid (DNA or RNA) with drug resistance tissue culture analysis, HIV 1; each additional drug tested (List separately in addition to code for primary procedure)	138.01	XXX	0/100
	87905	Infectious agent enzymatic activity other than virus (eg, sialidase activity in vaginal fluid)	30.81	XXX	0/100
	87906	Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, other region (eg, integrase, fusion)	30.81	XXX	0/100
	87910	Infectious agent genotype analysis by nucleic acid (DNA or RNA); cytomegalovirus	285.39	XXX	0/100
	87912	Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis B virus	285.39	XXX	0/100
■	87913	Infectious agent genotype analysis by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), mutation identification in targeted region(s)	260.43	XXX	0/100
	87999	Unlisted microbiology procedure	BR	XXX	
	88000	Necropsy (autopsy), gross examination only; without CNS	155.26	XXX	
	88005	Necropsy (autopsy), gross examination only; with brain	172.51	XXX	
	88007	Necropsy (autopsy), gross examination only; with brain and spinal cord	189.76	XXX	
	88012	Necropsy (autopsy), gross examination only; infant with brain	142.94	XXX	
	88014	Necropsy (autopsy), gross examination only; stillborn or newborn with brain	142.94	XXX	
	88016	Necropsy (autopsy), gross examination only; macerated stillborn	173.74	XXX	
	88020	Necropsy (autopsy), gross and microscopic; without CNS	223.03	XXX	
	88025	Necropsy (autopsy), gross and microscopic; with brain	240.28	XXX	
	88027	Necropsy (autopsy), gross and microscopic; with brain and spinal cord	257.53	XXX	
	88028	Necropsy (autopsy), gross and microscopic; infant with brain	142.94	XXX	
	88029	Necropsy (autopsy), gross and microscopic; stillborn or newborn with brain	142.94	XXX	
	88036	Necropsy (autopsy), limited, gross and/or microscopic; regional	92.42	XXX	

PATHOLOGY AND LABORATORY**80047-89398****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	88037	Necropsy (autopsy), limited, gross and/or microscopic; single organ	67.77	XXX	
	88040	Necropsy (autopsy); forensic examination	369.66	XXX	
	88045	Necropsy (autopsy); coroner's call	30.81	XXX	
	88099	Unlisted necropsy (autopsy) procedure	BR	XXX	
	88104	Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation	30.81	XXX	80/20
	88106	Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation	27.11	XXX	80/20
	88108	Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)	35.12	XXX	80/20
	88112	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal	73.93	XXX	80/20
	88120	Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual	252.60	XXX	11/89
	88121	Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology	215.64	XXX	11/89
	88125	Cytopathology, forensic (eg, sperm)	24.64	XXX	90/10
	88130	Sex chromatin identification; Barr bodies	15.40	XXX	10/90
	88140	Sex chromatin identification; peripheral blood smear, polymorphonuclear drumsticks	12.32	XXX	0/100
	88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician	15.40	XXX	
	88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	10.47	XXX	0/100
	88143	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision	11.52	XXX	0/100
	88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision	11.00	XXX	0/100
	88148	Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision	11.52	XXX	0/100
	88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision	10.47	XXX	0/100
	88152	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision	11.00	XXX	0/100
	88153	Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision	11.52	XXX	0/100
+	88155	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (eg, maturation index, karyopyknotic index, estrogenic index) (List separately in addition to code[s] for other technical and interpretation services)	11.55	XXX	0/100
	88160	Cytopathology, smears, any other source; screening and interpretation	21.56	XXX	80/20
	88161	Cytopathology, smears, any other source; preparation, screening and interpretation	24.64	XXX	70/30

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	88162	Cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains	41.28	XXX	70/30
	88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision	10.47	XXX	0/100
	88165	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision	11.52	XXX	0/100
	88166	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision	11.00	XXX	0/100
	88167	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision	12.04	XXX	0/100
	88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site	44.36	XXX	
	88173	Cytopathology, evaluation of fine needle aspirate; interpretation and report	57.91	XXX	85/15
	88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	11.09	XXX	0/100
	88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision	12.01	XXX	0/100
+	88177	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)	8.63	ZZZ	75/25
	88182	Flow cytometry, cell cycle or DNA analysis	156.49	XXX	20/80
	88184	Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker	67.16	XXX	0/100
+	88185	Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)	33.27	ZZZ	0/100
	88187	Flow cytometry, interpretation; 2 to 8 markers	49.29	XXX	
	88188	Flow cytometry, interpretation; 9 to 15 markers	61.61	XXX	
	88189	Flow cytometry, interpretation; 16 or more markers	81.33	XXX	
	88199	Unlisted cytopathology procedure	BR	XXX	
	88230	Tissue culture for non-neoplastic disorders; lymphocyte	66.54	XXX	0/100
	88233	Tissue culture for non-neoplastic disorders; skin or other solid tissue biopsy	25.26	XXX	0/100
	88235	Tissue culture for non-neoplastic disorders; amniotic fluid or chorionic villus cells	141.70	XXX	0/100
	88237	Tissue culture for neoplastic disorders; bone marrow, blood cells	109.05	XXX	0/100
	88239	Tissue culture for neoplastic disorders; solid tumor	43.13	XXX	0/100
	88240	Cryopreservation, freezing and storage of cells, each cell line	61.61	XXX	0/100
	88241	Thawing and expansion of frozen cells, each aliquot	67.77	XXX	0/100
	88245	Chromosome analysis for breakage syndromes; baseline Sister Chromatid Exchange (SCE), 20-25 cells	83.17	XXX	0/100
	88248	Chromosome analysis for breakage syndromes; baseline breakage, score 50-100 cells, count 20 cells, 2 karyotypes (eg, for ataxia telangiectasia, Fanconi anemia, fragile X)	166.35	XXX	0/100

PATHOLOGY AND LABORATORY**80047-89398****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
88249	Chromosome analysis for breakage syndromes; score 100 cells, clastogen stress (eg, diepoxybutane, mitomycin C, ionizing radiation, UV radiation)	184.83	XXX	0/100
88261	Chromosome analysis; count 5 cells, 1 karyotype, with banding	144.78	XXX	0/100
88262	Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding	215.64	XXX	0/100
88263	Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes, with banding	221.80	XXX	0/100
88264	Chromosome analysis; analyze 20-25 cells	184.83	XXX	0/100
88267	Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, 1 karyotype, with banding	243.36	XXX	0/100
88269	Chromosome analysis, in situ for amniotic fluid cells, count cells from 6-12 colonies, 1 karyotype, with banding	213.79	XXX	0/100
88271	Molecular cytogenetics; DNA probe, each (eg, FISH)	27.99	XXX	0/100
88272	Molecular cytogenetics; chromosomal in situ hybridization, analyze 3-5 cells (eg, for derivatives and markers)	34.91	XXX	0/100
88273	Molecular cytogenetics; chromosomal in situ hybridization, analyze 10-30 cells (eg, for microdeletions)	42.15	XXX	0/100
88274	Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells	45.61	XXX	0/100
88275	Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells	52.53	XXX	0/100
88280	Chromosome analysis; additional karyotypes, each study	70.24	XXX	0/100
88283	Chromosome analysis; additional specialized banding technique (eg, NOR, C-banding)	55.45	XXX	0/100
88285	Chromosome analysis; additional cells counted, each study	64.69	XXX	0/100
88289	Chromosome analysis; additional high resolution study	46.21	XXX	0/100
88291	Cytogenetics and molecular cytogenetics, interpretation and report	24.64	XXX	
88299	Unlisted cytogenetic study	BR	XXX	
88300	Level I - Surgical pathology, gross examination only	17.25	XXX	70/30
88302	Level II - Surgical pathology, gross and microscopic examination Appendix, incidental Fallopian tube, sterilization Fingers/toes, amputation, traumatic Foreskin, newborn Hernia sac, any location Hydrocele sac Nerve Skin, plastic repair Sympathetic ganglion Testis, castration Vaginal mucosa, incidental Vas deferens, sterilization	33.89	XXX	60/40
88304	Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologic fracture Bursa/synovial cyst Carpal tunnel tissue Cartilage, shavings Cholesteatoma Colon, colostomy stoma Conjunctiva - biopsy/pterygium Cornea Diverticulum - esophagus/small intestine Dupuytren's contracture tissue Femoral head, other than fracture Fissure/fistula Foreskin, other than newborn Gallbladder Ganglion cyst Hematoma Hemorrhoids Hydatid of Morgagni Intervertebral disc Joint, loose body Meniscus Mucocoele, salivary Neuroma - Morton's/traumatic Pilonidal cyst/sinus Polyps, inflammatory - nasal/sinusoidal Skin - cyst/tag/debridement Soft tissue, debridement Soft tissue, lipoma Spermatocoele Tendon/tendon sheath Testicular appendage Thrombus or embolus Tonsil and/or adenoids Varicocele Vas deferens, other than sterilization Vein, varicosity	44.36	XXX	60/40

80047-89398

PATHOLOGY AND LABORATORY

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
88305	Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed Artery, biopsy Bone marrow, biopsy Bone exostosis Brain/meninges, other than for tumor resection Breast, biopsy, not requiring microscopic evaluation of surgical margins Breast, reduction mammoplasty Bronchus, biopsy Cell block, any source Cervix, biopsy Colon, biopsy Duodenum, biopsy Endocervix, curettings/biopsy Endometrium, curettings/biopsy Esophagus, biopsy Extremity, amputation, traumatic Fallopian tube, biopsy Fallopian tube, ectopic pregnancy Femoral head, fracture Fingers/toes, amputation, non-traumatic Gingiva/oral mucosa, biopsy Heart valve Joint, resection Kidney, biopsy Larynx, biopsy Leiomyoma(s), uterine myomectomy - without uterus Lip, biopsy/wedge resection Lung, transbronchial biopsy Lymph node, biopsy Muscle, biopsy Nasal mucosa, biopsy Nasopharynx/oropharynx, biopsy Nerve, biopsy Odontogenic/dental cyst Omentum, biopsy Ovary with or without tube, non-neoplastic Ovary, biopsy/wedge resection Parathyroid gland Peritoneum, biopsy Pituitary tumor Placenta, other than third trimester Pleura/pericardium - biopsy/tissue Polyp, cervical/endometrial Polyp, colorectal Polyp, stomach/small intestine Prostate, needle biopsy Prostate, TUR Salivary gland, biopsy Sinus, paranasal biopsy Skin, other than cyst/tag/debridement/plastic repair Small intestine, biopsy Soft tissue, other than tumor/mass/lipoma/debridement Spleen Stomach, biopsy Synovium Testis, other than tumor/biopsy/castration Thyroglossal duct/brachial cleft cyst Tongue, biopsy Tonsil, biopsy Trachea, biopsy Ureter, biopsy Urethra, biopsy Urinary bladder, biopsy Uterus, with or without tubes and ovaries, for prolapse Vagina, biopsy Vulva/labia, biopsy	64.07	XXX	70/30
88307	Level V - Surgical pathology, gross and microscopic examination Adrenal, resection Bone - biopsy/curettings Bone fragment(s), pathologic fracture Brain, biopsy Brain/meninges, tumor resection Breast, excision of lesion, requiring microscopic evaluation of surgical margins Breast, mastectomy - partial/simple Cervix, conization Colon, segmental resection, other than for tumor Extremity, amputation, non-traumatic Eye, enucleation Kidney, partial/total nephrectomy Larynx, partial/total resection Liver, biopsy - needle/wedge Liver, partial resection Lung, wedge biopsy Lymph nodes, regional resection Mediastinum, mass Myocardium, biopsy Odontogenic tumor Ovary with or without tube, neoplastic Pancreas, biopsy Placenta, third trimester Prostate, except radical resection Salivary gland Sentinel lymph node Small intestine, resection, other than for tumor Soft tissue mass (except lipoma) - biopsy/simple excision Stomach - subtotal/total resection, other than for tumor Testis, biopsy Thymus, tumor Thyroid, total/lobe Ureter, resection Urinary bladder, TUR Uterus, with or without tubes and ovaries, other than neoplastic/prolapse	102.89	XXX	75/25
88309	Level VI - Surgical pathology, gross and microscopic examination Bone resection Breast, mastectomy - with regional lymph nodes Colon, segmental resection for tumor Colon, total resection Esophagus, partial/total resection Extremity, disarticulation Fetus, with dissection Larynx, partial/total resection - with regional lymph nodes Lung - total/lobe/segment resection Pancreas, total/subtotal resection Prostate, radical resection Small intestine, resection for tumor Soft tissue tumor, extensive resection Stomach - subtotal/total resection for tumor Testis, tumor Tongue/tonsil - resection for tumor Urinary bladder, partial/total resection Uterus, with or without tubes and ovaries, neoplastic Vulva, total/subtotal resection	142.94	XXX	75/25
+	88311 Decalcification procedure (List separately in addition to code for surgical pathology examination)	16.63	XXX	80/20
88312	Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)	24.64	XXX	80/20

PATHOLOGY AND LABORATORY

80047-89398

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
	88313	Special stain including interpretation and report; Group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry	18.48	XXX	80/20
+	88314	Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)	33.89	XXX	70/30
	88319	Special stain including interpretation and report; Group III, for enzyme constituents	41.89	XXX	80/20
	88321	Consultation and report on referred slides prepared elsewhere	55.45	XXX	
	88323	Consultation and report on referred material requiring preparation of slides	64.69	XXX	80/20
	88325	Consultation, comprehensive, with review of records and specimens, with report on referred material	86.25	XXX	
	88329	Pathology consultation during surgery;	40.66	XXX	
	88331	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen	78.24	XXX	75/25
+	88332	Pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)	46.82	XXX	75/25
	88333	Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site	49.29	XXX	75/25
+	88334	Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site (List separately in addition to code for primary procedure)	25.26	ZZZ	75/25
+	88341	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)	85.00	ZZZ	32/68
	88342	Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure	61.61	XXX	80/20
	88344	Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure	160.31	XXX	23/77
	88346	Immunofluorescence, per specimen; initial single antibody stain procedure	44.98	XXX	80/20
	88348	Electron microscopy, diagnostic	184.83	XXX	70/30
+	88350	Immunofluorescence, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)	66.26	ZZZ	41/59
	88355	Morphometric analysis; skeletal muscle	147.25	XXX	75/25
	88356	Morphometric analysis; nerve	135.54	XXX	75/25
	88358	Morphometric analysis; tumor (eg, DNA ploidy)	121.99	XXX	75/25
	88360	Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual	72.70	XXX	55/45
	88361	Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; using computer-assisted technology	78.25	XXX	80/20
	88362	Nerve teasing preparations	83.17	XXX	75/25
	88363	Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)	19.72	XXX	

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
+	88364	In situ hybridization (eg, FISH), per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)	121.20	ZZZ	27/73
	88365	In situ hybridization (eg, FISH), per specimen; initial single probe stain procedure	84.41	XXX	50/50
	88366	In situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure	240.78	XXX	24/76
	88367	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; initial single probe stain procedure	138.62	XXX	35/65
	88368	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; initial single probe stain procedure	125.68	XXX	40/60
+	88369	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)	100.19	ZZZ	30/70
	88371	Protein analysis of tissue by Western Blot, with interpretation and report;	36.97	XXX	20/80
	88372	Protein analysis of tissue by Western Blot, with interpretation and report; immunological probe for band identification, each	52.37	XXX	20/80
+	88373	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)	72.07	ZZZ	36/64
	88374	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each multiplex probe stain procedure	315.44	XXX	13/87
	88375	Optical endoscopic image(s), interpretation and report, real-time or referred, each endoscopic session	46.86	XXX	
	88377	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each multiplex probe stain procedure	374.91	XXX	16/84
	88380	Microdissection (ie, sample preparation of microscopically identified target); laser capture	86.25	XXX	41/59
	88381	Microdissection (ie, sample preparation of microscopically identified target); manual	120.14	XXX	27/73
	88387	Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)	19.72	XXX	80/20
+	88388	Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)	12.32	XXX	83/17
	88399	Unlisted surgical pathology procedure	BR	XXX	
	88720	Bilirubin, total, transcutaneous	6.16	XXX	
	88738	Hemoglobin (Hgb), quantitative, transcutaneous	6.16	XXX	
	88740	Hemoglobin, quantitative, transcutaneous, per day; carboxyhemoglobin	6.16	XXX	
	88741	Hemoglobin, quantitative, transcutaneous, per day; methemoglobin	6.16	XXX	
	88749	Unlisted in vivo (eg, transcutaneous) laboratory service	0.00	XXX	
	89049	Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report	75.16	XXX	

PATHOLOGY AND LABORATORY**80047-89398****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
89050	Cell count, miscellaneous body fluids (eg, cerebrospinal fluid, joint fluid), except blood;	9.86	XXX	0/100
89051	Cell count, miscellaneous body fluids (eg, cerebrospinal fluid, joint fluid), except blood; with differential count	11.71	XXX	0/100
89055	Leukocyte assessment, fecal, qualitative or semiquantitative	9.86	XXX	0/100
89060	Crystal identification by light microscopy with or without polarizing lens analysis, tissue or any body fluid (except urine)	11.71	XXX	0/100
89125	Fat stain, feces, urine, or respiratory secretions	9.24	XXX	0/100
89160	Meat fibers, feces	5.54	XXX	0/100
89190	Nasal smear for eosinophils	8.63	XXX	0/100
89220	Sputum, obtaining specimen, aerosol induced technique (separate procedure)	12.94	XXX	0/100
89230	Sweat collection by iontophoresis	24.64	XXX	0/100
89240	Unlisted miscellaneous pathology test	BR	XXX	0/100
89250	Culture of oocyte(s)/embryo(s), less than 4 days;	414.64	XXX	0/100
89251	Culture of oocyte(s)/embryo(s), less than 4 days; with co-culture of oocyte(s)/embryos	431.27	XXX	0/100
89253	Assisted embryo hatching, microtechniques (any method)	BR	XXX	0/100
89254	Oocyte identification from follicular fluid	BR	XXX	0/100
89255	Preparation of embryo for transfer (any method)	BR	XXX	0/100
89257	Sperm identification from aspiration (other than seminal fluid)	BR	XXX	0/100
89258	Cryopreservation; embryo(s)	BR	XXX	0/100
89259	Cryopreservation; sperm	BR	XXX	0/100
89260	Sperm isolation; simple prep (eg, sperm wash and swim-up) for insemination or diagnosis with semen analysis	BR	XXX	0/100
89261	Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis	BR	XXX	0/100
89264	Sperm identification from testis tissue, fresh or cryopreserved	BR	XXX	0/100
89268	Insemination of oocytes	BR	XXX	0/100
89272	Extended culture of oocyte(s)/embryo(s), 4-7 days	BR	XXX	0/100
89280	Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes	BR	XXX	0/100
89281	Assisted oocyte fertilization, microtechnique; greater than 10 oocytes	BR	XXX	0/100
89290	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos	BR	XXX	0/100
89291	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos	BR	XXX	0/100
89300	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)	21.56	XXX	0/100
89310	Semen analysis; motility and count (not including Huhner test)	20.33	XXX	0/100
89320	Semen analysis; volume, count, motility, and differential	30.81	XXX	0/100
89321	Semen analysis; sperm presence and motility of sperm, if performed	18.48	XXX	0/100
89322	Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)	43.13	XXX	0/100

80047-89398**PATHOLOGY AND LABORATORY**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
89325	Sperm antibodies	52.37	XXX	0/100
89329	Sperm evaluation; hamster penetration test	138.62	XXX	0/100
89330	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test	35.12	XXX	0/100
89331	Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology, as indicated)	25.48	XXX	0/100
89335	Cryopreservation, reproductive tissue, testicular	BR	XXX	0/100
89337	Cryopreservation, mature oocyte(s)	BR	XXX	
89342	Storage (per year); embryo(s)	BR	XXX	0/100
89343	Storage (per year); sperm/semen	BR	XXX	0/100
89344	Storage (per year); reproductive tissue, testicular/ovarian	BR	XXX	0/100
89346	Storage (per year); oocyte(s)	BR	XXX	0/100
89352	Thawing of cryopreserved; embryo(s)	BR	XXX	0/100
89353	Thawing of cryopreserved; sperm/semen, each aliquot	BR	XXX	0/100
89354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian	BR	XXX	0/100
89356	Thawing of cryopreserved; oocytes, each aliquot	BR	XXX	0/100
89398	Unlisted reproductive medicine laboratory procedure	BR	XXX	

7 Medicine

The relative value units in this section were determined uniquely for medicine services. Use the medicine conversion factor when determining fee amounts. The medicine conversion factor is not applicable to any other section.

The fee for a procedure or service in this section is determined by multiplying the relative value units by the medicine conversion factor, subject to the ground rules, instructions, and definitions of the schedule.

To ensure uniformity of billing when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately.

* Several Behavioral Health codes are retained from previous versions of the NYS WCB Fee Schedules. These codes are not listed here, but can be found in the NYS WCB Behavioral Health Fee Schedule.

CONVERSION FACTORS

Regional conversion factors for services rendered on or after TBD.

Section	Region I	Region II	Region III	Region IV
Medicine	\$8.91	\$8.91	\$10.19	\$11.07

MEDICINE GROUND RULES

Definitions and rules pertaining to medicine services are as follows:

Note: Rules used by all providers in reporting their services are presented in the General Ground Rules in the Introduction and General Guidelines section.

1A. NYS Medical Treatment Guidelines

Treatment of work-related injuries should be in accordance with any applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the

recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.

1B. Biofeedback

When more than one treatment is performed on the same day, reimbursement is limited to the highest single relative value unit.

2. Ophthalmology

These are integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. Itemization of service components (e.g., slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, tonometry, and motor evaluation) is not applicable.

Please see any applicable content in the WCB Medical Treatment Guideline for Eye Disorders.

3. Optometrists

Services provided by an optometrist should be billed in accordance with CPT codes and are subject to the *Official New York State Workers' Compensation Medical Fee Schedule*. Services must be billed utilizing the CMS1500 form and supported by a narrative report. These services are only covered for compensable work related injuries.

Please see any applicable content in the WCB Medical Treatment Guideline for Eye Disorders: see the most currently published information on the CMS1500 section on the NYS WCB webpage: <https://www.wcb.ny.gov/CMS-1500/>

4. Special Services and Reports

Adjunctive services are reported using codes 99000–99091 as illustrated in the code description. Charges for services generally provided as an adjunct to common medical services should be made only when circumstances clearly warrant an additional charge over and above the scheduled charges for basic services.

5. Pulmonary

- A. Ventilation codes (94002–94004) are not payable when billed on the same day as an E/M service. These services are considered an integral part of the E/M service.
- B. Noninvasive ear or pulse oximetry for oxygen saturation (94760–94762) should not be billed when billing for critical care management.

6. Osteopathic Manipulative Treatment

This form of manual treatment, performed by a licensed osteopathic physician (DO), is used to treat somatic dysfunction and related disorders. Codes are selected according to the number of body regions treated and are reported per treatment day.

Other services may be reported in addition to osteopathic manipulation codes if, and only if, the service exceeds that associated with the osteopathic manipulative treatment.

7. Moderate (Conscious) Sedation

Sedation with or without analgesia is used to achieve a state of depressed consciousness while maintaining the patient's ability to control their own breathing as well as respond to stimulation. The use of these codes requires the presence of an independent trained observer to assist the provider in monitoring the patient's level of consciousness and physiological status.

Conscious sedation includes pre- and post-sedation evaluations, administration of the sedation, and monitoring of cardiorespiratory function.

Codes 99151–99153 identify moderate (conscious) sedation services provided by the same provider performing the diagnostic or therapeutic service that the sedation supports. CPT codes 99155–99157 identify moderate (conscious) sedation services provided by a second provider other than the health care professional performing the diagnostic or therapeutic service. When moderate (conscious) sedation services are provided by a second provider in a facility setting or non-facility setting, the conscious sedation service may be billed separately.

See General Ground Rule 12 for additional guidelines related to reporting of moderate (conscious) sedation.

8. Cognitive and Sensory Testing Codes

See NYS WCB Behavioral Health Fee Schedule Ground Rules 2 and 7.

9. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code.

Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used with medicine procedures are as follows:

1B∞ Behavioral Health Provider Enhanced Reimbursement

- Provides a 20 percent reimbursement increase for certain E/M and psychotherapy services.
- The following types of codes may not be appended with modifier 1B: diagnostic testing codes, procedural codes, and E/M visit codes 99202–99205, and 99211–99215.
- Behavioral Health consultation codes may use modifier 1B.
- ** Modifier 1B may be used by psychologists and LCSWs with the appropriate telehealth codes.
- May only be used by the following WCB authorized Behavioral Health providers:
 - a. Licensed psychiatrist
 - b. Licensed physician with a specialty rating code from American Board of Psychiatry & Neurology as published on the WCB webpage
 - c. Board certified psychiatric nurse practitioner (NP)
 - d. Appropriately certified physician assistant (PA) with eligible supervising physician
 - e. Licensed psychologist
 - f. Licensed clinical social worker

** See current Telehealth Ground Rule and webpage: <https://www.wcb.ny.gov/telehealth/>

See **Appendix** for the Behavioral Health Provider Enhanced Rating Codes.

1R∞ Non-surgical services provided by residents and fellows.

Billed and payable at the same applicable rate as the WCB authorized, supervising physician.

1R can be used for E/M codes, such as office visits, as well as for standalone procedures not performed during a surgery i.e., injections.

This modifier is not used for assistance at surgery. See modifier 84.

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure

code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component

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

32 Mandated Services

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

52 Reduced Services

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

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Post-operative Period

The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

90 Reference (Outside) Laboratory

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

91 Repeat Clinical Diagnostic Laboratory Test

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

93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System.

Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous

telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

95° Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System.

Synchronous telemedicine service is defined as a **real-time** interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

10. Behavioral Health Provider Enhanced Reimbursement

In an effort to increase the number of Board authorized providers in the behavioral health to render care and treatment to injured workers, the WCB has established WCB specific modifier 1B. Reimbursement increase for E/M and Medicine services including psychotherapy visit codes but excluding diagnostic testing codes, procedural codes, and E/M visit codes 99202-99205, and 99211-99215 when rendered by providers that are New York State Workers' Compensation Board (NYS WCB) authorized (unless an exception applies) and are:

- A. Licensed Psychiatrist
- B. Licensed Physician with a specialty classification code for Psychiatry & Neurology from American Board of Psychiatry & Neurology as published on the WCB webpage
- C. Board Certified psychiatric nurse practitioner
- D. Appropriately certified Physician Assistant with eligible Supervising Physician
 - Provides a 20 percent reimbursement increase for certain E/M and psychotherapy services.

- The following types of codes may not be appended with modifier 1B: diagnostic testing codes, procedural codes, and E/M visit codes 99202-99205, and 99211-99215.
- Behavioral Health consultation codes may use modifier 1B.
- ** Modifier 1B may be used by psychologists and LCSWs with the appropriate telehealth codes.
- May only be used by the following WCB authorized Behavioral Health providers:
 - a. Licensed psychiatrist
 - b. Licensed physician with a specialty rating code from American Board of Psychiatry & Neurology as published on the WCB webpage
 - c. Board certified psychiatric nurse practitioner (NP)
 - d. Appropriately certified physician assistant (PA) with eligible supervising physician
 - e. Licensed psychologist
 - f. Licensed clinical social worker

** See current Telehealth Ground Rule and webpage: <https://www.wcb.ny.gov/telehealth/>

See **Appendix** for the Behavioral Health Provider Enhanced Rating Codes.

11. EDX (Codes 95907-95913)

EDX testing must comply with all applicable Medical Treatment Guidelines (unless there is an approved prior authorization request), including provider qualifications. When such testing is recommended and/or approved, the provider shall bill 1 unit of the single code that most closely represents the nerve(s) tested.

12. Telehealth

Effective July 11, 2023, the NYS Workers' Compensation Board adopted **permanent** regulations for telehealth appointments in certain situations. Telemedicine is not available to all provider types.

Treatment may be rendered by telehealth when medically appropriate and subject to the restrictions contained in the currently published regulations.

1. **Non Behavioral Health** Physicians, Nurse Practitioners, Physician Assistants, and Podiatrists may only bill:
 - E/M code **99212**

2. Behavioral Health Psychiatrists, Psych PAs, Psych NPs may bill:

- E/M codes **99202-99204, 99212**
- Psychotherapy/Combination/crisis codes: **90832-90834, 90836-90840**
- Group therapy: **90853**

3. See the *Behavioral Health* Fee Schedule for Psychologist and LCSW telehealth billing guidelines.

4. All eligible provider types should use:

- Modifier **95** for two-way *Audio and Visual* communication
- Modifier **93** for *Audio only*
- Place of service (POS) code **10** for patient located in their home
- POS code **02** for patient located in a *healthcare setting* that is not their home

5. Modifier **1B** may **not** be used with E/M codes but may be billed with applicable psychotherapy/group therapy telehealth codes.

Updates or modifications to WCB Telemedicine regulations may supersede the content published in this edition of the WCB Fee Schedule.

All current rules and restrictions for telehealth are found on the WCB webpage: <https://www.wcb.ny.gov/telehealth/>

13. Electronic Billing

Providers may offset the cost of using an electronic submission partner by using code 99080 as a "By Report" (BR) code, up to a maximum value of one dollar. The code should be placed on the same CMS1500 form for which the billable services payment and the electronic submission costs are being requested. The price listed by the provider for code 99080 should accurately reflect the actual cost incurred by the provider for the electronic submission of the individual bill, up to a maximum of one dollar. Please see any current guidance on the WCB webpage.

14. Narrative Reports

A detailed narrative report must be submitted with all services provided. Physicians & Nurse Practitioners narrative reports must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Physician Assistants must include Work Status & Temporary Impairment Percentages. Providers are strongly encouraged to use the narrative template format found on the WCB webpage [CMS-1500 Requirements](#).

Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/assessment of the patient.

Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed.

Any ordered medications, durable medical equipment, tests, or procedures should be thoroughly explained.

All entries in the medical record must be legible to another reader.

15. Category III Codes:

Category III codes are temporary codes identifying emerging technology and should be reported when available. The use of these codes supersedes reporting the service with an unlisted code. Because these codes are temporary, some of them may only be covered on a case-by-case review, and all require prior authorization. The temporary codes may be converted to permanent CPT codes or deleted during periodic updates of the code set. The Category III codes will utilize the *Medicine* conversion factor. Any currently published WCB Bulletins may supersede this Ground Rule if necessary.

For a complete explanation of this process refer to the guidelines in CPT 2024.

15A. Extracorporeal Shockwave Therapy

Please see all applicable Medical Treatment Guidelines (MTG). Extracorporeal Shockwave Therapy is only rarely, if ever, recommended in the MTGs. Therefore, use of extracorporeal shockwave therapy will generally require prior authorization. The Category III codes for shockwave treatments will utilize the *Medicine* Conversion factor. Any currently published WCB Bulletins may supersede this Ground Rule if necessary.

16. Psychological, Behavioral, and Neuro-cognitive Testing

Reimbursement for Psychological, Behavioral, and Neuro-cognitive testing is limited to 11 hours in any 12-month period.

Psychological, Behavioral, and Neuro-cognitive testing should not be used routinely. When appropriate, documentation should include the specific indication for each test and overlapping and/or duplicate testing should be avoided. Tests, when administered, must be used in correlation with clinical interview data to monitor a patient's condition and progress. Repeat testing is generally not necessary or indicated, particularly when the clinical documentation supports improved outcomes or stable condition. Ongoing documentation should include

updates to treatment plans, efficacy of medications and/or treatments, and overall progress towards expected goals. Qualifications of the “technicians” and “qualified health care professionals” referenced in these procedure codes must satisfy the requirements as provided for in Article 153 of the State Education Law. All applicable Medical Treatment Guidelines must be followed. Also see Ground Rules 2 and 7 in NYS WCB Behavioral Health Fee Schedule.

17. Billing for Residents and Fellows:

Treatment rendered by residents and fellows can only be billed by the Board authorized supervising physician.

Non-surgical service codes should be appended with modifier 1R.

Services with modifier 1R must be billed and reimbursed at the same amount payable to the authorized supervising physician.

- A. Physicians cannot additionally bill for supervision of the resident.
- B. All codes billed should accurately reflect work performed by the resident/fellow.
- C. Documentation in the operative/procedure report should include all details. Payment may be decided based on review of documentation, as well as the usual and customary standards of CPT/CMS billing guidelines for allowance of assistants at surgery.
- D. Non-authorized out-of-state physicians may not bill for residents/fellows.
- E. Physicians should not bill for services performed by a resident/fellow that would not normally be billed by another type of assistant at surgery. Payment shall not be made for observation, or for simple assistance, work typically performed by nursing/technical staff.
- F. The name of the resident/fellow does not need to be documented on the CMS1500 form.
- G. All CMS1500 Narrative requirements do apply to any bills submitted. <https://www.wcb.ny.gov/CMS-1500/>

18. Health and Behavior Assessment/Intervention

Assessment and intervention codes are reported for patients with physical health problems where the focus is not on mental health, but emotional and social factors contributing to the individual's well-being. When psychiatric services are performed during the same encounter, the dominating service should be reported, but not both services.

Information obtained through the assessment testing is interpreted and a written report is generated. The interpretation and report are included in the service.

For patients that require psychiatric services as well as health and behavior assessment/ intervention, report the predominant service performed. Do not report both services/code sets on the same date.

Evaluation and management services including counseling risk-factor reduction and behavior change services should not be reported on the same date of service when provided by the same provider.

19. Miscellaneous and By Report Codes

1. Providers should only use codes listed in the Fee Schedule. When billing a service or procedure, select the CPT code from the WCB Fee schedule that accurately identifies the service or procedure performed. If no such code is available, report the service or procedure using the closest appropriate **Miscellaneous** code in the Fee Schedule (often ending in -99). These codes may also be titled “Unlisted,” “Unspecified,” or “Not Otherwise Specified”.
2. By Report (BR) in the Relative Value (RVU) column represents services that too variable to permit assignment of RVUs. Fees for such procedures need to be justified with additional information.
 - The inclusion of a miscellaneous or by report code in this Fee Schedule does not guarantee reimbursement. All codes billed should be based on medical necessity and be in alignment with all applicable Medical Treatment Guidelines and Fee Schedule Ground Rules. Reimbursement may be dependent on multiple factors, including but not necessarily limited to, causal relationship, clinical necessity and appropriateness of the fees submitted.
 - It is the responsibility of the provider to ensure all information required to process a miscellaneous or by report procedure is included with the bill. If required information is missing, or if there is a valid code that describes the procedure, then the code may not be reimbursed.
 - Nearly all miscellaneous and by report codes, require prior authorization (PAR). If a procedure or item is not recommended or not addressed in an applicable WCB Medical Treatment Guideline (MTG), then prior authorization is always required. If the procedure or item involves a body part or condition for which there is no MTG and costs over \$1,000 then prior authorization must be obtained.
 - While emergency procedures/items do not require prior authorization, the circumstances must be identified and explained in the procedure record. The codes billed may be subject to review and non-payment.

- When a miscellaneous or by report code is used, the actual service/item should be identified on the bill, narrative note, and in an additional attached report.
- The price billed must be substantiated by indicating the closest comparable code found in the current fee schedule and/or with a manufacturer's invoice.
- Documentation should include: any decision making, medical necessity and explanation why an existing fee schedule code could not be used.
- Any PARs including identification numbers should also be submitted with bills.
- Miscellaneous and by report codes should not be billed merely to describe a proprietary product or procedure, when an existing fee schedule code adequately describes the procedure or item.
- Surgical miscellaneous or by report codes may require additional documentation including: time, skill, equipment necessary, diagnosis, pertinent history, and physical findings, size/ location number of lesions or procedures.

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
51	90281	Immune globulin (Ig), human, for intramuscular use	BR	XXX	
51	90283	Immune globulin (IgIV), human, for intravenous use	BR	XXX	
51	90284	Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each	BR	XXX	
51	90287	Botulinum antitoxin, equine, any route	BR	XXX	
51	90288	Botulism immune globulin, human, for intravenous use	BR	XXX	
51	90291	Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use	BR	XXX	
51	90296	Diphtheria antitoxin, equine, any route	BR	XXX	
51	90371	Hepatitis B immune globulin (HBIG), human, for intramuscular use	57.03	XXX	
51	90375	Rabies immune globulin (RIG), human, for intramuscular and/or subcutaneous use	74.66	XXX	
51	90376	Rabies immune globulin, heat-treated (RIG-HT), human, for intramuscular and/or subcutaneous use	74.66	XXX	
■	51 90377	Rabies immune globulin, heat- and solvent/detergent-treated (RIG-HT S/D), human, for intramuscular and/or subcutaneous use	48.54	XXX	
51	90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each	BR	XXX	
■	90380	Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use	BR	XXX	
■	90381	Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular use	BR	XXX	
51	90384	Rho(D) immune globulin (Rhlg), human, full-dose, for intramuscular use	11.84	XXX	
51	90385	Rho(D) immune globulin (Rhlg), human, mini-dose, for intramuscular use	5.41	XXX	
51	90386	Rho(D) immune globulin (RhlgIV), human, for intravenous use	12.68	XXX	
51	90389	Tetanus immune globulin (Tlg), human, for intramuscular use	6.55	XXX	
51	90393	Vaccinia immune globulin, human, for intramuscular use	BR	XXX	
51	90396	Varicella-zoster immune globulin, human, for intramuscular use	12.18	XXX	
51	90399	Unlisted immune globulin	BR	XXX	
	90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered	2.54	XXX	
+	90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)	1.52	ZZZ	
	90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)	2.20	XXX	
+	90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	2.20	ZZZ	
	90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)	2.20	XXX	

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	2.20	ZZZ	
Ⓢ1	90476	Adenovirus vaccine, type 4, live, for oral use	BR	XXX	
Ⓢ1	90477	Adenovirus vaccine, type 7, live, for oral use	BR	XXX	
Ⓢ1	90581	Anthrax vaccine, for subcutaneous or intramuscular use	14.08	XXX	
■	90584	Dengue vaccine, quadrivalent, live, 2 dose schedule, for subcutaneous use	BR	XXX	
Ⓢ1	90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use	16.28	XXX	
Ⓢ1	90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use	18.52	XXX	
Ⓢ1	90587	Dengue vaccine, quadrivalent, live, 3 dose schedule, for subcutaneous use	BR	XXX	
■	90589	Chikungunya virus vaccine, live attenuated, for intramuscular use	BR	XXX	
■	90611	Smallpox and monkeypox vaccine, attenuated vaccinia virus, live, non-replicating, preservative free, 0.5 mL dosage, suspension, for subcutaneous use	BR	XXX	
■ Ⓢ1	90619	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use	BR	XXX	
Ⓢ1	90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB-4C), 2 dose schedule, for intramuscular use	BR	XXX	
Ⓢ1	90621	Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp), 2 or 3 dose schedule, for intramuscular use	BR	XXX	
■	90622	Vaccinia (smallpox) virus vaccine, live, lyophilized, 0.3 mL dosage, for percutaneous use	BR	XXX	
■	90623	Meningococcal pentavalent vaccine, conjugated Men A, C, W, Y-tetanus toxoid carrier, and Men B-FHbp, for intramuscular use	BR	XXX	
Ⓢ1	90625	Cholera vaccine, live, adult dosage, 1 dose schedule, for oral use	BR	XXX	
■	90626	Tick-borne encephalitis virus vaccine, inactivated; 0.25 mL dosage, for intramuscular use	BR	XXX	
■	90627	Tick-borne encephalitis virus vaccine, inactivated; 0.5 mL dosage, for intramuscular use	BR	XXX	
Ⓢ1	90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	3.90	XXX	
Ⓢ1	90632	Hepatitis A vaccine (HepA), adult dosage, for intramuscular use	6.21	XXX	
Ⓢ1	90633	Hepatitis A vaccine (HepA), pediatric/adolescent dosage-2 dose schedule, for intramuscular use	3.00	XXX	
Ⓢ1	90634	Hepatitis A vaccine (HepA), pediatric/adolescent dosage-3 dose schedule, for intramuscular use	3.00	XXX	
Ⓢ1	90636	Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use	9.30	XXX	
Ⓢ1	90647	Haemophilus influenzae type b vaccine (Hib), PRP-OMP conjugate, 3 dose schedule, for intramuscular use	2.45	XXX	
Ⓢ1	90648	Haemophilus influenzae type b vaccine (Hib), PRP-T conjugate, 4 dose schedule, for intramuscular use	1.86	XXX	

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
51	90649	Human Papillomavirus vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3 dose schedule, for intramuscular use	12.85	XXX	
51	90650	Human Papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3 dose schedule, for intramuscular use	BR	XXX	
51	90651	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3 dose schedule, for intramuscular use	BR	XXX	
51	90653	Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use	9.51	XXX	
51	90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use	3.84	XXX	
51	90655	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use	1.56	XXX	
51	90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use	1.56	XXX	
51	90657	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use	1.14	XXX	
51	90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use	1.14	XXX	
51	90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use	2.03	XXX	
51	90661	Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	BR	XXX	
51	90662	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use	6.47	XXX	
51	90664	Influenza virus vaccine, live (LAIV), pandemic formulation, for intranasal use	BR	XXX	
51	90666	Influenza virus vaccine (IIV), pandemic formulation, split virus, preservative free, for intramuscular use	BR	XXX	
51	90667	Influenza virus vaccine (IIV), pandemic formulation, split virus, adjuvanted, for intramuscular use	BR	XXX	
51	90668	Influenza virus vaccine (IIV), pandemic formulation, split virus, for intramuscular use	BR	XXX	
51	90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use	10.52	XXX	
■	90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use	52.51	XXX	
51	90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use	BR	XXX	
51	90673	Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	7.73	XXX	
51	90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	4.58	XXX	
51	90675	Rabies vaccine, for intramuscular use	14.58	XXX	
51	90676	Rabies vaccine, for intradermal use	BR	XXX	
■	90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use	62.93	XXX	
■	90678	Respiratory syncytial virus vaccine, preF, subunit, bivalent, for intramuscular use	BR	XXX	
■	90679	Respiratory syncytial virus vaccine, preF, recombinant, subunit, adjuvanted, for intramuscular use	BR	XXX	

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
Ⓢ1	90680	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use	5.07	XXX	
Ⓢ1	90681	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use	7.61	XXX	
Ⓢ1	90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	8.82	XXX	
■	90683	Respiratory syncytial virus vaccine, mRNA lipid nanoparticles, for intramuscular use	BR	XXX	
Ⓢ1	90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL, for intramuscular use	4.04	XXX	
Ⓢ1	90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use	3.63	XXX	
Ⓢ1	90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use	1.78	XXX	
Ⓢ1	90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use	3.42	XXX	
■	Ⓢ1 90689	Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25 mL dosage, for intramuscular use	BR	XXX	
Ⓢ1	90690	Typhoid vaccine, live, oral	3.21	XXX	
Ⓢ1	90691	Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use	3.89	XXX	
■	Ⓢ1 90694	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use	BR	XXX	
Ⓢ1	90697	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use	BR	XXX	
Ⓢ1	90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenzae type b, and inactivated poliovirus vaccine, (DTaP-IPV/Hib), for intramuscular use	7.61	XXX	
Ⓢ1	90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use	4.86	XXX	
Ⓢ1	90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use	13.53	XXX	
Ⓢ1	90713	Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use	3.38	XXX	
Ⓢ1	90714	Tetanus and diphtheria toxoids adsorbed (Td), preservative free, when administered to individuals 7 years or older, for intramuscular use	2.54	XXX	
Ⓢ1	90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use	2.28	XXX	
Ⓢ1	90716	Varicella virus vaccine (VAR), live, for subcutaneous use	5.79	XXX	
Ⓢ1	90717	Yellow fever vaccine, live, for subcutaneous use	6.64	XXX	
Ⓢ1	90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine (DTaP-HepB-IPV), for intramuscular use	7.44	XXX	
Ⓢ1	90732	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use	2.41	XXX	
Ⓢ1	90733	Meningococcal polysaccharide vaccine, serogroups A, C, Y, W-135, quadrivalent (MPSV4), for subcutaneous use	10.10	XXX	

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	⑤1 90734	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diphtheria toxoid carrier (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use	9.64	XXX	
	⑤1 90736	Zoster (shingles) vaccine (HZV), live, for subcutaneous injection	16.23	XXX	
	⑤1 90738	Japanese encephalitis virus vaccine, inactivated, for intramuscular use	6.71	XXX	
■	⑤1 90739	Hepatitis B vaccine (HepB), CpG-adjuvanted, adult dosage, 2 dose or 4 dose schedule, for intramuscular use	24.90	XXX	
	⑤1 90740	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use	19.15	XXX	
	⑤1 90743	Hepatitis B vaccine (HepB), adolescent, 2 dose schedule, for intramuscular use	2.71	XXX	
	⑤1 90744	Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use	2.71	XXX	
	⑤1 90746	Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use	5.50	XXX	
	⑤1 90747	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use	19.15	XXX	
	⑤1 90748	Hepatitis B and Haemophilus influenzae type b vaccine (Hib-HepB), for intramuscular use	5.20	XXX	
	⑤1 90749	Unlisted vaccine/toxoid	BR	XXX	
	⑤1 90750	Zoster (shingles) vaccine (HZV), recombinant, subunit, adjuvanted, for intramuscular use	BR	XXX	
	⑤1 90756	Influenza virus vaccine, quadrivalent (ccIIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use	4.31	XXX	
■	90758	Zaire ebolavirus vaccine, live, for intramuscular use	BR	XXX	
■	90759	Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use	14.84	XXX	
+	90785	Interactive complexity (List separately in addition to the code for primary procedure)	2.80	ZZZ	
	90791	Psychiatric diagnostic evaluation	25.84	XXX	
	90792	Psychiatric diagnostic evaluation with medical services	27.75	XXX	
	90832	Psychotherapy, 30 minutes with patient	12.59	XXX	
+	90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	13.13	ZZZ	
	90834	Psychotherapy, 45 minutes with patient	16.83	XXX	
+	90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	16.55	ZZZ	
	90837	Psychotherapy, 60 minutes with patient	25.24	XXX	
+	90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	21.89	ZZZ	
	90839	Psychotherapy for crisis; first 60 minutes	26.34	XXX	
+	90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)	12.59	ZZZ	

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	90845	Psychoanalysis	16.43	XXX	
	90846	Family psychotherapy (without the patient present), 50 minutes	16.91	XXX	
	90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	20.42	XXX	
	90849	Multiple-family group psychotherapy	5.42	XXX	
	90853	Group psychotherapy (other than of a multiple-family group)	5.42	XXX	
+	90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)	5.06	XXX	
	90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital (Amytal) interview)	26.16	XXX	
	90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	37.94	000	
	90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	5.21	000	
	90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	25.29	000	
	90870	Electroconvulsive therapy (includes necessary monitoring)	26.72	000	
	90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 30 minutes	11.01	XXX	
	90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 45 minutes	17.55	XXX	
	90880	Hypnotherapy	20.26	XXX	
	90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	13.36	XXX	
	90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	8.93	XXX	
	90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	13.72	XXX	
	90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers	NC	XXX	
	90899	Unlisted psychiatric service or procedure	BR	XXX	
	90901	Biofeedback training by any modality	9.81	000	
		See NYS WCB Behavioral Health Fee Schedule for Biofeedback Behavioral Health code in this sequence			
■	90912	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient	15.62	000	

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■ +	90913	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)	6.31	ZZZ	
	90935	Hemodialysis procedure with single evaluation by a physician or other qualified health care professional	28.75	000	
	90937	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription	45.66	000	
	90940	Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator method	11.84	XXX	40/60
	90945	Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional	16.91	000	
	90947	Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluations by a physician or other qualified health care professional, with or without substantial revision of dialysis prescription	27.06	000	
	90957	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	84.55	XXX	
	90958	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month	56.65	XXX	
	90959	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month	37.20	XXX	
	90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	42.28	XXX	
	90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month	33.82	XXX	
	90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month	24.52	XXX	
	90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	56.65	XXX	
	90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older	29.59	XXX	
	90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age	1.52	XXX	
	90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	1.10	XXX	

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	90989	Dialysis training, patient, including helper where applicable, any mode, completed course	77.28	XXX	
	90993	Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session	13.02	XXX	
	90997	Hemoperfusion (eg, with activated charcoal or resin)	32.13	000	
	90999	Unlisted dialysis procedure, inpatient or outpatient	BR	XXX	
	91010	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report;	35.17	000	80/20
+	91013	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure)	3.04	ZZZ	39/61
	91020	Gastric motility (manometric) studies	29.59	000	80/20
	91022	Duodenal motility (manometric) study	22.15	000	35/65
	91030	Esophagus, acid perfusion (Bernstein) test for esophagitis	16.06	000	90/10
	91034	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation	37.20	000	20/80
	91035	Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation	73.90	000	20/80
	91037	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;	23.67	000	35/65
	91038	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)	20.29	000	45/55
	91040	Esophageal balloon distension study, diagnostic, with provocation when performed	72.21	000	10/90
	91065	Breath hydrogen or methane test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)	9.30	000	20/80
	91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report	28.24	XXX	15/85
	91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report	84.55	XXX	8/92
	91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	208.78	XXX	10/90
■	91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	166.20	XXX	13/87
	91117	Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report	19.78	000	
	91120	Rectal sensation, tone, and compliance test (ie, response to graded balloon distention)	45.83	XXX	10/90
	91122	Anorectal manometry	30.61	000	80/20
	91132	Electrogastrography, diagnostic, transcutaneous;	4.06	XXX	65/35
	91133	Electrogastrography, diagnostic, transcutaneous; with provocative testing	4.06	XXX	65/35

90281-99607**MEDICINE**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
91200	Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report	7.80	XXX	35/65
91299	Unlisted diagnostic gastroenterology procedure	BR	XXX	
■ 91304	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, 5 mcg/0.5 mL dosage, for intramuscular use	32.47	XXX	
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	6.93	XXX	
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits	9.13	XXX	
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient	6.59	XXX	
92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits	8.12	XXX	
92015	Determination of refractive state	2.28	XXX	
92018	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete	23.67	XXX	
92019	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; limited	10.99	XXX	
92020	Gonioscopy (separate procedure)	4.57	XXX	
92025	Computerized corneal topography, unilateral or bilateral, with interpretation and report	3.55	XXX	59/41
92060	Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)	6.76	XXX	
■ 92065	Orthoptic training; performed by a physician or other qualified health care professional	5.48	XXX	
92071	Fitting of contact lens for treatment of ocular surface disease	7.82	XXX	
92072	Fitting of contact lens for management of keratoconus, initial fitting	24.95	XXX	
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	4.57	XXX	20/80
92082	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)	7.78	XXX	20/80
92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)	11.84	XXX	20/80

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
92100	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)	4.23	XXX	
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	4.73	XXX	55/45
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	5.75	XXX	64/36
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	5.75	XXX	64/36
92136	Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation	8.96	XXX	20/80
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report	3.42	XXX	54/46
■ 92201	Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral	4.82	XXX	
■ 92202	Ophthalmoscopy, extended; with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral	2.99	XXX	
■ 92227	Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral	2.54	XXX	
■ 92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral	5.41	XXX	60/40
■ 92229	Imaging of retina for detection or monitoring of disease; point-of-care autonomous analysis and report, unilateral or bilateral	8.78	XXX	
92230	Fluorescein angiography with interpretation and report	8.79	XXX	
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral	23.00	XXX	30/70
92240	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral	23.00	XXX	30/70
92242	Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral	44.33	XXX	24/76
92250	Fundus photography with interpretation and report	7.27	XXX	30/70
92260	Ophthalmodynamometry	8.46	XXX	
92265	Needle oculoelectromyography, 1 or more extraocular muscles, 1 or both eyes, with interpretation and report	16.91	XXX	40/60
92270	Electro-oculography with interpretation and report	16.91	XXX	40/60
■ 92273	Electroretinography (ERG), with interpretation and report; full field (ie, ffERG, flash ERG, Ganzfeld ERG)	24.08	XXX	28/72
■ 92274	Electroretinography (ERG), with interpretation and report; multifocal (mfERG)	17.44	XXX	36/64
92283	Color vision examination, extended, eg, anomaloscope or equivalent	6.26	XXX	
■ 92284	Diagnostic dark adaptation examination with interpretation and report	8.96	XXX	

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
92285	External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniphotography, stereo-photography)	4.90	XXX	90/10
92286	Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis	23.67	XXX	20/80
92287	Anterior segment imaging with interpretation and report; with fluorescein angiography	29.59	XXX	30/70
92310	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	14.88	XXX	
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, 1 eye	12.85	XXX	
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes	16.91	XXX	
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal scleral lens	21.31	XXX	
92314	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia	15.22	XXX	
92315	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, 1 eye	14.20	XXX	
92316	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, both eyes	23.50	XXX	
92317	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal scleral lens	15.22	XXX	
92325	Modification of contact lens (separate procedure), with medical supervision of adaptation	8.03	XXX	
92326	Replacement of contact lens	8.79	XXX	
92340	Fitting of spectacles, except for aphakia; monofocal	8.71	XXX	
92341	Fitting of spectacles, except for aphakia; bifocal	9.47	XXX	
92342	Fitting of spectacles, except for aphakia; multifocal, other than bifocal	13.02	XXX	
92352	Fitting of spectacle prosthesis for aphakia; monofocal	3.89	XXX	
92353	Fitting of spectacle prosthesis for aphakia; multifocal	4.23	XXX	
92354	Fitting of spectacle mounted low vision aid; single element system	63.23	XXX	
92355	Fitting of spectacle mounted low vision aid; telescopic or other compound lens system	30.65	XXX	
92358	Prosthesis service for aphakia, temporary (disposable or loan, including materials)	7.18	XXX	
92370	Repair and refitting spectacles; except for aphakia	12.68	XXX	
92371	Repair and refitting spectacles; spectacle prosthesis for aphakia	20.97	XXX	
92499	Unlisted ophthalmological service or procedure	BR	XXX	
92502	Otolaryngologic examination under general anesthesia	29.09	000	

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
92504	Binocular microscopy (separate diagnostic procedure)	4.31	XXX	
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	7.78	XXX	
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	5.92	XXX	
92511	Nasopharyngoscopy with endoscope (separate procedure)	16.91	000	
92512	Nasal function studies (eg, rhinomanometry)	12.18	XXX	
92516	Facial nerve function studies (eg, electroneuronography)	13.36	XXX	
■ 92517	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)	14.77	XXX	
■ 92518	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; ocular (oVEMP)	14.84	XXX	
■ 92519	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP)	23.82	XXX	
92520	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)	26.21	XXX	
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	22.10	XXX	
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	17.79	XXX	
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)	38.31	XXX	
92524	Behavioral and qualitative analysis of voice and resonance	17.03	XXX	
92526	Treatment of swallowing dysfunction and/or oral function for feeding	12.60	XXX	
92531	Spontaneous nystagmus, including gaze	3.89	XXX	
92532	Positional nystagmus test	4.57	XXX	
92533	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests)	7.27	XXX	
92534	Optokinetic nystagmus test	3.21	XXX	
92537	Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)	7.87	XXX	78/22
92538	Caloric vestibular test with recording, bilateral; monothermal (ie, one irrigation in each ear for a total of two irrigations)	4.04	XXX	76/24
92540	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording	12.68	XXX	83/17
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	9.64	XXX	80/20
92542	Positional nystagmus test, minimum of 4 positions, with recording	8.62	XXX	80/20
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	5.24	XXX	80/20
92545	Oscillating tracking test, with recording	5.24	XXX	80/20
92546	Sinusoidal vertical axis rotational testing	8.29	XXX	80/20

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
+	92547	Use of vertical electrodes (List separately in addition to code for primary procedure)	5.07	ZZZ	80/20
■	92548	Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report;	16.91	XXX	70/30
■	92549	Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT)	12.62	XXX	68/32
	92550	Tympanometry and reflex threshold measurements	3.72	XXX	
	92551	Screening test, pure tone, air only	2.20	XXX	
	92552	Pure tone audiometry (threshold); air only	3.21	XXX	
	92553	Pure tone audiometry (threshold); air and bone	4.90	XXX	
	92555	Speech audiometry threshold;	2.54	XXX	
	92556	Speech audiometry threshold; with speech recognition	4.23	XXX	
	92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	8.62	XXX	
	92558	Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis	1.99	XXX	0/100
	92562	Loudness balance test, alternate binaural or monaural	2.11	XXX	
	92563	Tone decay test	3.72	XXX	
	92565	Stenger test, pure tone	3.04	XXX	
	92567	Tympanometry (impedance testing)	3.38	XXX	
	92568	Acoustic reflex testing, threshold	2.87	XXX	
	92570	Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing	5.58	XXX	
	92571	Filtered speech test	4.57	XXX	
	92572	Staggered spondaic word test	3.72	XXX	
	92575	Sensorineural acuity level test	3.72	XXX	
	92576	Synthetic sentence identification test	3.38	XXX	
	92577	Stenger test, speech	3.04	XXX	
	92579	Visual reinforcement audiometry (VRA)	5.92	XXX	
	92582	Conditioning play audiometry	6.43	XXX	
	92583	Select picture audiometry	4.23	XXX	
	92584	Electrocochleography	24.86	XXX	
	92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report	6.09	XXX	
	92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report	8.62	XXX	
	92590	Hearing aid examination and selection; monaural	NC	XXX	
	92591	Hearing aid examination and selection; binaural	NC	XXX	

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	92592	Hearing aid check; monaural	NC	XXX	
	92593	Hearing aid check; binaural	NC	XXX	
	92594	Electroacoustic evaluation for hearing aid; monaural	NC	XXX	
	92595	Electroacoustic evaluation for hearing aid; binaural	NC	XXX	
	92596	Ear protector attenuation measurements	NC	XXX	
	92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	NC	XXX	
	92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	16.91	XXX	
	92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	11.50	XXX	
	92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	18.98	XXX	
	92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification	16.92	XXX	
	92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	23.84	XXX	
+	92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)	4.90	ZZZ	
	92609	Therapeutic services for the use of speech-generating device, including programming and modification	12.34	XXX	
	92610	Evaluation of oral and pharyngeal swallowing function	25.03	XXX	
	92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	26.21	XXX	
	92612	Flexible endoscopic evaluation of swallowing by cine or video recording;	32.64	XXX	
	92613	Flexible endoscopic evaluation of swallowing by cine or video recording; interpretation and report only	8.54	XXX	
	92614	Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording;	28.75	XXX	
	92615	Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording; interpretation and report only	7.78	XXX	
	92616	Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording;	42.95	XXX	
	92617	Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; interpretation and report only	10.32	XXX	
+	92618	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)	6.82	ZZZ	
	92620	Evaluation of central auditory function, with report; initial 60 minutes	8.79	XXX	
+	92621	Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)	2.37	ZZZ	
■	92622	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes	15.42	XXX	
■ +	92623	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (List separately in addition to code for primary procedure)	3.97	ZZZ	

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	13.70	XXX	
■	92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour	4.23	XXX	
■ +	92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (List separately in addition to code for primary procedure)	4.23	ZZZ	
	92630	Auditory rehabilitation; prelingual hearing loss	BR	XXX	
	92633	Auditory rehabilitation; postlingual hearing loss	BR	XXX	
	92640	Diagnostic analysis with programming of auditory brainstem implant, per hour	10.82	XXX	
■	92650	Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis	5.14	XXX	
■	92651	Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report	15.42	XXX	
■	92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report	21.15	XXX	
■	92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report	15.81	XXX	
	92700	Unlisted otorhinolaryngological service or procedure	BR	XXX	
	92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	110.72	000	
+	92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	BR	ZZZ	
	92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	131.98	000	
+	92925	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	BR	ZZZ	
	92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	123.17	000	
+	92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	BR	ZZZ	
	92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	138.06	000	
+	92934	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	BR	ZZZ	
	92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	123.03	000	
+	92938	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)	BR	ZZZ	

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	92941	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel	138.34	000	
	92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	138.34	000	
+	92944	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)	BR	ZZZ	
	92950	Cardiopulmonary resuscitation (eg, in cardiac arrest)	45.66	000	
	92953	Temporary transcutaneous pacing	12.68	000	
	92960	Cardioversion, elective, electrical conversion of arrhythmia; external	38.05	000	
	92961	Cardioversion, elective, electrical conversion of arrhythmia; internal (separate procedure)	118.37	000	
	92970	Cardioassist-method of circulatory assist; internal	42.28	000	
	92971	Cardioassist-method of circulatory assist; external	12.68	000	
■ +	92972	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)	29.66	ZZZ	
+	92973	Percutaneous transluminal coronary thrombectomy mechanical (List separately in addition to code for primary procedure)	150.08	ZZZ	
+	92974	Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to code for primary procedure)	168.68	ZZZ	
	92975	Thrombolysis, coronary; by intracoronary infusion, including selective coronary angiography	139.00	000	
	92977	Thrombolysis, coronary; by intravenous infusion	70.51	XXX	
+	92978	Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)	143.27	ZZZ	
+	92979	Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)	63.24	ZZZ	46/54
	92986	Percutaneous balloon valvuloplasty; aortic valve	287.47	090	
	92987	Percutaneous balloon valvuloplasty; mitral valve	316.22	090	
	92990	Percutaneous balloon valvuloplasty; pulmonary valve	236.74	090	
	92997	Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel	300.15	000	
+	92998	Percutaneous transluminal pulmonary artery balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)	150.08	ZZZ	
	93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	6.59	XXX	40/60

90281-99607**MEDICINE**

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
93005	Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report	4.90	XXX	0/100
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only	3.30	XXX	
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report	38.05	XXX	
93016	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report	9.51	XXX	
93017	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report	19.02	XXX	0/100
93018	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only	9.51	XXX	
93024	Ergonovine provocation test	35.34	XXX	60/40
93025	Microvolt T-wave alternans for assessment of ventricular arrhythmias	45.66	XXX	
93040	Rhythm ECG, 1-3 leads; with interpretation and report	4.06	XXX	65/35
93041	Rhythm ECG, 1-3 leads; tracing only without interpretation and report	2.03	XXX	0/100
93042	Rhythm ECG, 1-3 leads; interpretation and report only	2.71	XXX	
93050	Arterial pressure waveform analysis for assessment of central arterial pressures, includes obtaining waveform(s), digitization and application of nonlinear mathematical transformations to determine central arterial pressures and augmentation index, with interpretation and report, upper extremity artery, non-invasive	3.22	XXX	51/49
■ 93150	Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming	19.72	XXX	
■ 93151	Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system	17.24	XXX	
■ 93152	Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography	27.46	XXX	
■ 93153	Interrogation without programming of implanted phrenic nerve stimulator system	10.28	XXX	
93224	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional	42.11	XXX	40/60
93225	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; recording (includes connection, recording, and disconnection)	13.70	XXX	0/100
93226	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; scanning analysis with report	15.22	XXX	0/100
93227	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional	16.06	XXX	

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	7.27	XXX	
93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	144.92	XXX	
■ 93241	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation	52.25	XXX	
■ 93242	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	2.28	XXX	
■ 93243	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; scanning analysis with report	45.55	XXX	
■ 93244	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; review and interpretation	4.42	XXX	
■ 93245	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation	54.40	XXX	
■ 93246	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	2.28	XXX	
■ 93247	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; scanning analysis with report	47.24	XXX	
■ 93248	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; review and interpretation	4.88	XXX	
93260	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable subcutaneous lead defibrillator system	12.66	XXX	66/34
93261	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system	11.49	XXX	64/36
■ 93264	Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional	10.09	XXX	

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
93268	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional	36.69	XXX	
93270	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection)	7.27	XXX	0/100
93271	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; transmission and analysis	14.71	XXX	0/100
93272	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; review and interpretation by a physician or other qualified health care professional	14.71	XXX	
93278	Signal-averaged electrocardiography (SAECG), with or without ECG	21.48	XXX	40/60
■ 93279	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system or leadless pacemaker system in one cardiac chamber	16.06	XXX	65/35
93280	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system	18.94	XXX	66/34
93281	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system	22.32	XXX	65/35
93282	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system	20.63	XXX	66/34
93283	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system	25.03	XXX	68/32
93284	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead transvenous implantable defibrillator system	31.28	XXX	70/30

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
■	93285	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; subcutaneous cardiac rhythm monitor system	14.04	XXX	61/39
■	93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system, or leadless pacemaker system	7.27	XXX	55/45
	93287	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system	11.84	XXX	61/39
■	93288	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system, or leadless pacemaker system	12.51	XXX	56/44
	93289	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements	19.11	XXX	66/34
■	93290	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors	10.15	XXX	66/34
■	93291	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis	12.01	XXX	59/41
	93292	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	12.34	XXX	64/36
	93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days	17.25	XXX	28/72
■	93294	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, or leadless pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	12.18	XXX	
	93295	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	19.11	XXX	
■	93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	12.01	XXX	

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional	7.10	XXX	
■	93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	9.64	XXX	
	93303	Transthoracic echocardiography for congenital cardiac anomalies; complete	48.02	XXX	40/60
	93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	26.80	XXX	40/60
	93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	71.02	XXX	27/73
	93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	43.63	XXX	40/60
	93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	24.35	XXX	40/60
	93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	62.57	XXX	45/55
	93313	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only	21.64	XXX	
	93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only	44.47	XXX	40/60
	93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	68.82	XXX	45/55
	93316	Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only	23.84	XXX	
	93317	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only	48.95	XXX	40/60
	93318	Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis	62.57	XXX	45/55
■ +	93319	3D echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging)	10.48	ZZZ	
+	93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete	26.72	ZZZ	40/60

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging)	16.03	ZZZ	40/60
+	93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	18.94	ZZZ	40/60
	93350	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report;	77.79	XXX	40/60
	93351	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional	71.02	XXX	
+	93352	Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to code for primary procedure)	10.15	ZZZ	
	93355	Echocardiography, transesophageal (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (eg, TAVR, transcatheter pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair, left atrial appendage occlusion/closure, ventricular septal defect closure) (peri- and intra-procedural), real-time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation, and report, including diagnostic transesophageal echocardiography and, when performed, administration of ultrasound contrast, Doppler, color flow, and 3D	46.45	XXX	
■ +	93356	Myocardial strain imaging using speckle tracking-derived assessment of myocardial mechanics (List separately in addition to codes for echocardiography imaging)	7.09	ZZZ	
■	93451	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed	93.01	000	18/82
	93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	103.32	000	29/71
	93453	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	135.28	000	29/71
	93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	103.32	000	28/72
	93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography	123.95	000	28/72
■	93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	133.59	000	29/71

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	148.81	000	29/71
	93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	128.01	000	29/71
	93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	142.04	000	29/71
	93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	152.19	000	31/69
	93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	174.00	000	29/71
+	93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)	24.69	ZZZ	
+	93463	Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure)	13.02	ZZZ	
+	93464	Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)	30.61	ZZZ	35/65
■	93503	Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes	57.83	000	
	93505	Endomyocardial biopsy	93.01	000	55/45
+	93563	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)	6.76	ZZZ	
+	93564	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (List separately in addition to code for primary procedure)	6.76	ZZZ	

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	93565	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)	5.24	ZZZ	
+	93566	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)	20.63	ZZZ	
+	93567	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supraaortic aortography (List separately in addition to code for primary procedure)	16.91	ZZZ	
■ +	93568	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for nonselective pulmonary arterial angiography (List separately in addition to code for primary procedure)	18.60	ZZZ	
■ +	93569	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, unilateral (List separately in addition to code for primary procedure)	7.16	ZZZ	
+	93571	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)	32.81	ZZZ	35/65
+	93572	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)	20.12	ZZZ	47/53
■ +	93573	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, bilateral (List separately in addition to code for primary procedure)	11.91	ZZZ	
■ +	93574	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary venous angiography of each distinct pulmonary vein during cardiac catheterization (List separately in addition to code for primary procedure)	13.27	ZZZ	
■ +	93575	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its systemic branches, during cardiac catheterization for congenital heart defects, each distinct vessel (List separately in addition to code for primary procedure)	17.63	ZZZ	
	93580	Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant	489.04	000	
	93581	Percutaneous transcatheter closure of a congenital ventricular septal defect with implant	489.04	000	
	93582	Percutaneous transcatheter closure of patent ductus arteriosus	138.56	000	
	93583	Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed	154.66	000	
■ +	93584	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; anomalous or persistent superior vena cava when it exists as a second contralateral superior vena cava, with native drainage to heart (List separately in addition to code for primary procedure)	11.90	ZZZ	

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■ +	93585	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; azygos/hemiazygos venous system (List separately in addition to code for primary procedure)	11.22	ZZZ	
■ +	93586	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; coronary sinus (List separately in addition to code for primary procedure)	14.24	ZZZ	
■ +	93587	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; venovenous collaterals originating at or above the heart (eg, from innominate vein) (List separately in addition to code for primary procedure)	20.85	ZZZ	
■ +	93588	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; venovenous collaterals originating below the heart (eg, from the inferior vena cava) (List separately in addition to code for primary procedure)	21.12	ZZZ	
	93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	222.37	000	
	93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	184.65	000	
+	93592	Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)	81.23	ZZZ	
■	93593	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections	36.05	000	100/0
■	93594	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; abnormal native connections	55.38	000	100/0
■	93595	Left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone, normal or abnormal native connections	49.39	000	100/0
■	93596	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); normal native connections	245.98	000	25/75
■	93597	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); abnormal native connections	399.55	000	20/80
■ +	93598	Cardiac output measurement(s), thermodilution or other indicator dilution method, performed during cardiac catheterization for the evaluation of congenital heart defects (List separately in addition to code for primary procedure)	12.56	ZZZ	100/0
⊖	93600	Bundle of His recording	63.58	000	55/45
⊖	93602	Intra-atrial recording	36.19	000	55/45
⊖	93603	Right ventricular recording	41.09	000	55/45
+	93609	Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)	142.89	ZZZ	55/45
⊖	93610	Intra-atrial pacing	45.66	000	55/45
⊖	93612	Intraventricular pacing	53.60	000	55/45

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	93613	Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)	145.09	ZZZ	72/28
⊖	93615	Esophageal recording of atrial electrogram with or without ventricular electrogram(s);	5.92	000	55/45
⊖	93616	Esophageal recording of atrial electrogram with or without ventricular electrogram(s); with pacing	26.21	000	55/45
⊖	93618	Induction of arrhythmia by electrical pacing	152.19	000	55/45
	93619	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia	247.90	000	55/45
	93620	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording	315.88	000	55/45
+	93621	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)	89.83	ZZZ	55/45
+	93622	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left ventricular pacing and recording (List separately in addition to code for primary procedure)	89.83	ZZZ	55/45
+	93623	Programmed stimulation and pacing after intravenous drug infusion (List separately in addition to code for primary procedure)	81.51	ZZZ	55/45
	93624	Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia	199.03	000	55/45
■	93631	Intra-operative epicardial and endocardial pacing and mapping to localize the site of tachycardia or zone of slow conduction for surgical correction	152.45	000	55/45
	93640	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement;	167.92	000	55/45
	93641	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement; with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator	207.15	000	55/45
	93642	Electrophysiologic evaluation of single or dual chamber transvenous pacing cardioverter-defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	249.59	000	55/45
	93644	Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	39.74	000	73/27

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	93650	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	389.78	000	55/45
■	93653	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry	174.13	000	
■	93654	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed	233.25	000	
+	93655	Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)	88.75	ZZZ	
■	93656	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/ recording, right ventricular pacing/recording, and His bundle recording, when performed	233.89	000	
+	93657	Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)	88.68	ZZZ	
	93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention	50.73	000	60/40
+	93662	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)	172.48	ZZZ	55/45
	93668	Peripheral arterial disease (PAD) rehabilitation, per session	19.02	XXX	0/100
	93701	Bioimpedance-derived physiologic cardiovascular analysis	10.99	XXX	28/72
	93702	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s)	23.94	XXX	
	93724	Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)	106.87	000	60/40

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
93740	Temperature gradient studies	16.91	XXX	75/25
93745	Initial set-up and programming by a physician or other qualified health care professional of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problems or events	BR	XXX	65/35
93750	Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report	12.68	XXX	
93770	Determination of venous pressure	2.54	XXX	90/10
■ 93784	Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; including recording, scanning analysis, interpretation and report	41.43	XXX	40/60
■ 93786	Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; recording only	6.17	XXX	0/100
■ 93788	Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; scanning analysis with report	18.60	XXX	0/100
■ 93790	Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; review with interpretation and report	18.09	XXX	
93792	Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results	10.47	XXX	
93793	Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed	2.33	XXX	
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	6.76	000	
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)	8.62	000	
93799	Unlisted cardiovascular service or procedure	BR	XXX	
93880	Duplex scan of extracranial arteries; complete bilateral study	41.43	XXX	40/60
93882	Duplex scan of extracranial arteries; unilateral or limited study	29.76	XXX	40/60
93886	Transcranial Doppler study of the intracranial arteries; complete study	45.83	XXX	40/60
93888	Transcranial Doppler study of the intracranial arteries; limited study	27.39	XXX	40/60
93890	Transcranial Doppler study of the intracranial arteries; vasoreactivity study	49.72	XXX	25/75
93892	Transcranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection	52.76	XXX	25/75
93893	Transcranial Doppler study of the intracranial arteries; emboli detection with intravenous microbubble injection	49.38	XXX	25/75
93895	Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral	BR	XXX	

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
93922	Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)	26.21	XXX	40/60
93923	Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)	30.44	XXX	40/60
93924	Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study	28.75	XXX	40/60
93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study	39.06	XXX	40/60
93926	Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study	23.34	XXX	40/60
93930	Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study	38.39	XXX	40/60
93931	Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study	19.95	XXX	40/60
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	37.54	XXX	40/60
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	23.34	XXX	40/60
93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study	33.31	XXX	40/60
93976	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study	21.48	XXX	40/60
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study	35.51	XXX	40/60
93979	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study	21.31	XXX	40/60
93980	Duplex scan of arterial inflow and venous outflow of penile vessels; complete study	31.79	XXX	40/60

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	93981	Duplex scan of arterial inflow and venous outflow of penile vessels; follow-up or limited study	20.97	XXX	40/60
■	93985	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study	48.02	XXX	15/85
■	93986	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study	28.18	XXX	16/84
	93990	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)	19.45	XXX	40/60
	93998	Unlisted noninvasive vascular diagnostic study	0.00	XXX	
	94002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day	24.18	XXX	
	94003	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day	17.42	XXX	
	94004	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day	12.68	XXX	
	94005	Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more	22.32	XXX	
	94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	8.54	XXX	40/60
	94014	Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional	11.84	XXX	40/60
	94015	Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)	5.92	XXX	0/100
	94016	Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional	7.44	XXX	
	94060	Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration	13.11	XXX	40/60
	94070	Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010, with administered agents (eg, antigen[s], cold air, methacholine)	27.06	XXX	40/60
	94150	Vital capacity, total (separate procedure)	2.79	XXX	40/60
	94200	Maximum breathing capacity, maximal voluntary ventilation	6.59	XXX	20/80
	94375	Respiratory flow volume loop	10.15	XXX	20/80
	94450	Breathing response to hypoxia (hypoxia response curve)	16.23	XXX	20/80
	94452	High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional;	20.46	XXX	30/70
	94453	High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional; with supplemental oxygen titration	29.25	XXX	30/70
⊖	94610	Intrapulmonary surfactant administration by a physician or other qualified health care professional through endotracheal tube	17.59	XXX	

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	94617	Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry; with electrocardiographic recording(s)	18.47	XXX	35/65
	94618	Pulmonary stress testing (eg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed	32.38	XXX	20/80
■	94619	Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry; without electrocardiographic recording(s)	12.75	XXX	32/68
	94621	Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings	38.05	XXX	20/80
	94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device	3.55	XXX	
	94642	Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis	15.81	XXX	
	94644	Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour	9.30	XXX	
+	94645	Continuous inhalation treatment with aerosol medication for acute airway obstruction; each additional hour (List separately in addition to code for primary procedure)	3.55	XXX	
	94660	Continuous positive airway pressure ventilation (CPAP), initiation and management	19.45	XXX	
	94662	Continuous negative pressure ventilation (CNP), initiation and management	12.68	XXX	
	94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device	4.23	XXX	
	94667	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation	5.07	XXX	
	94668	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent	4.06	XXX	
	94669	Mechanical chest wall oscillation to facilitate lung function, per session	6.36	XXX	
	94680	Oxygen uptake, expired gas analysis; rest and exercise, direct, simple	13.53	XXX	40/60
	94681	Oxygen uptake, expired gas analysis; including CO2 output, percentage oxygen extracted	25.37	XXX	40/60
	94690	Oxygen uptake, expired gas analysis; rest, indirect (separate procedure)	5.07	XXX	40/60
	94726	Plethysmography for determination of lung volumes and, when performed, airway resistance	11.23	XXX	23/77
	94727	Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes	8.81	XXX	29/71
■	94728	Airway resistance by oscillometry	8.81	XXX	29/71
+	94729	Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure)	11.16	ZZZ	15/85
	94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination	3.55	XXX	0/100
	94761	Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)	5.92	XXX	0/100
	94762	Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)	7.44	XXX	0/100

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
94799	Unlisted pulmonary service or procedure	BR	XXX	
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests	0.42	XXX	
95012	Nitric oxide expired gas determination	3.21	XXX	
95017	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests	0.64	XXX	
95018	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests	1.18	XXX	
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests	0.72	XXX	
95027	Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests	0.72	XXX	
95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests	1.23	XXX	
95044	Patch or application test(s) (specify number of tests)	1.65	XXX	
95052	Photo patch test(s) (specify number of tests)	2.20	XXX	
95056	Photo tests	0.59	XXX	
95060	Ophthalmic mucous membrane tests	2.54	XXX	
95065	Direct nasal mucous membrane test	2.11	XXX	
■ 95070	Inhalation bronchial challenge testing (not including necessary pulmonary function tests), with histamine, methacholine, or similar compounds	16.91	XXX	
95076	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes of testing	23.19	XXX	
+ 95079	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); each additional 60 minutes of testing (List separately in addition to code for primary procedure)	16.28	ZZZ	
95115	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection	1.35	XXX	
95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections	2.03	XXX	
95120	Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; single injection	1.86	XXX	
95125	Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; 2 or more injections	2.28	XXX	
95130	Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; single stinging insect venom	3.21	XXX	

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
95131	Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; 2 stinging insect venoms	4.06	XXX	
95132	Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; 3 stinging insect venoms	4.90	XXX	
95133	Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; 4 stinging insect venoms	5.92	XXX	
95134	Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; 5 stinging insect venoms	7.10	XXX	
95144	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)	4.90	XXX	
95145	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom	3.72	XXX	
95146	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 2 single stinging insect venoms	4.57	XXX	
95147	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 3 single stinging insect venoms	5.41	XXX	
95148	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms	6.43	XXX	
95149	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 5 single stinging insect venoms	7.61	XXX	
95165	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)	2.70	XXX	
95170	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses)	1.99	XXX	
95180	Rapid desensitization procedure, each hour (eg, insulin, penicillin, equine serum)	18.26	XXX	
95199	Unlisted allergy/clinical immunologic service or procedure	BR	XXX	
95249	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording	10.67	XXX	
95250	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording	23.67	XXX	0/100
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report	4.23	XXX	

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
■	95700	Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels	50.11	XXX	
■	95705	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored	37.87	XXX	
■	95706	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	77.57	XXX	
■	95707	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	91.62	XXX	
■	95708	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	49.98	XXX	
■	95709	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	149.08	XXX	
■	95710	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	187.93	XXX	
■	95711	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored	41.00	XXX	
■	95712	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	93.90	XXX	
■	95713	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	120.71	XXX	
■	95714	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	54.47	XXX	
■	95715	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	173.68	XXX	
■	95716	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	230.55	XXX	
■	95717	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without video	20.89	XXX	
■	95718	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)	26.29	XXX	
■	95719	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video	31.43	XXX	
■	95720	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)	40.35	XXX	

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	95721	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video	40.35	XXX	
■	95722	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG)	49.00	XXX	
■	95723	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, without video	49.59	XXX	
■	95724	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)	62.14	XXX	
■	95725	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, without video	56.94	XXX	
■	95726	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, with video (VEEG)	79.13	XXX	
	95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	175.02	XXX	31/69
	95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)	296.09	XXX	56/44
	95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	34.16	XXX	27/73
	95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	60.03	XXX	40/60
	95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)	67.64	XXX	50/50
	95807	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist	84.89	XXX	40/60
	95808	Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist	53.44	XXX	40/60
	95810	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	57.32	XXX	40/60
	95811	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist	105.01	XXX	40/60
	95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes	32.97	XXX	40/60
■	95813	Electroencephalogram (EEG) extended monitoring; 61-119 minutes	45.41	XXX	40/60
	95816	Electroencephalogram (EEG); including recording awake and drowsy	26.38	XXX	40/60

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	95819	Electroencephalogram (EEG); including recording awake and asleep	26.38	XXX	40/60
	95822	Electroencephalogram (EEG); recording in coma or sleep only	26.38	XXX	40/60
	95824	Electroencephalogram (EEG); cerebral death evaluation only	37.50	XXX	40/60
	95829	Electrocorticogram at surgery (separate procedure)	54.96	XXX	95/05
	95830	Insertion by physician or other qualified health care professional of sphenoidal electrodes for electroencephalographic (EEG) recording	19.62	XXX	
■	95836	Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and written report, up to 30 days	20.50	XXX	
	For codes 95851-95852, please see the Physical Medicine section				
	95857	Cholinesterase inhibitor challenge test for myasthenia gravis	10.99	XXX	
	95860	Needle electromyography; 1 extremity with or without related paraspinal areas	21.98	XXX	80/20
	95861	Needle electromyography; 2 extremities with or without related paraspinal areas	28.58	XXX	80/20
	95863	Needle electromyography; 3 extremities with or without related paraspinal areas	37.20	XXX	80/20
	95864	Needle electromyography; 4 extremities with or without related paraspinal areas	48.36	XXX	80/20
	95865	Needle electromyography; larynx	32.97	XXX	75/25
	95866	Needle electromyography; hemidiaphragm	22.83	XXX	90/10
	95867	Needle electromyography; cranial nerve supplied muscle(s), unilateral	22.83	XXX	80/20
	95868	Needle electromyography; cranial nerve supplied muscles, bilateral	39.91	XXX	80/20
	95869	Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)	16.91	XXX	80/20
	95870	Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters	16.91	XXX	80/20
	95872	Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied	39.06	XXX	80/20
+	95873	Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)	9.13	ZZZ	71/29
+	95874	Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)	9.30	ZZZ	72/28
	95875	Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)	7.78	XXX	70/30
+	95885	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)	11.66	ZZZ	32/68
+	95886	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)	18.27	ZZZ	54/46
+	95887	Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)	16.28	ZZZ	48/52

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
⊖	95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report	24.52	XXX	4/96
	95907	Nerve conduction studies; 1-2 studies	19.02	XXX	55/45
	95908	Nerve conduction studies; 3-4 studies	24.63	XXX	54/46
	95909	Nerve conduction studies; 5-6 studies	29.35	XXX	54/46
	95910	Nerve conduction studies; 7-8 studies	38.65	XXX	54/46
	95911	Nerve conduction studies; 9-10 studies	46.11	XXX	57/43
	95912	Nerve conduction studies; 11-12 studies	51.17	XXX	61/39
	95913	Nerve conduction studies; 13 or more studies	59.03	XXX	62/38
	95921	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio	NC	XXX	53/47
	95922	Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt	NC	XXX	45/55
	95923	Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential	20.29	XXX	29/71
	95924	Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt	29.35	XXX	59/41
	95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	35.76	XXX	80/20
	95926	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs	35.76	XXX	80/20
	95927	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head	35.76	XXX	80/20
	95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs	92.67	XXX	50/50
	95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs	96.56	XXX	45/55
	95930	Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report	16.91	XXX	50/50
	95933	Orbicularis oculi (blink) reflex, by electrodiagnostic testing	14.37	XXX	80/20
	95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method	13.36	XXX	80/20
	95938	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs	61.77	XXX	15/85
	95939	Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs	96.66	XXX	25/75
+	95940	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)	6.66	XXX	

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)	BR	XXX	
	95954	Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test)	16.91	XXX	90/10
	95955	Electroencephalogram (EEG) during nonintracranial surgery (eg, carotid surgery)	30.44	XXX	95/05
	95957	Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)	32.65	XXX	0/100
	95958	Wada activation test for hemispheric function, including electroencephalographic (EEG) monitoring	48.19	XXX	80/20
	95961	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of attendance by a physician or other qualified health care professional	50.73	XXX	80/20
+	95962	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of attendance by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	33.82	ZZZ	80/20
	95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	432.85	XXX	20/80
	95966	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)	216.07	XXX	20/80
+	95967	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)	188.35	ZZZ	20/80
■	95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	10.91	XXX	
■	95971	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	16.40	XXX	

90281-99607**MEDICINE**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	95972	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	32.72	XXX	
■	95976	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	7.35	XXX	
■	95977	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	9.83	XXX	
	95980	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	14.37	XXX	
	95981	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	10.15	XXX	
	95982	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	14.88	XXX	
■	95983	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional	9.63	XXX	

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
■ +	95984	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)	8.39	ZZZ	
	95990	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed;	7.61	XXX	
	95991	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional	7.61	XXX	
	95992	Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day	14.37	XXX	
	95999	Unlisted neurological or neuromuscular diagnostic procedure	BR	XXX	
	96000	Comprehensive computer-based motion analysis by video-taping and 3D kinematics;	0.00	XXX	0/100
	96001	Comprehensive computer-based motion analysis by video-taping and 3D kinematics; with dynamic plantar pressure measurements during walking	0.00	XXX	0/100
	96002	Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles	0.00	XXX	0/100
	96003	Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle	0.00	XXX	0/100
	96004	Review and interpretation by physician or other qualified health care professional of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report	0.00	XXX	
	96020	Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or other qualified health care professional (ie, psychologist), with review of test results and report	BR	XXX	0/100
■	96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family See NYS WCB Behavioral Health Fee Schedule for Behavioral Health codes 961XX- in this sequence	NC	XXX	
	96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	18.50	XXX	
	96110	Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument See NYS WCB Behavioral Health Fee Schedule for Behavioral Health codes 961XX in this sequence	17.00	XXX	

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

Code	Description	Relative Value	FUD	PC/TC Split
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	23.84	XXX	
96127	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	1.23	XXX	
	See NYS WCB Behavioral Health Fee Schedule for Behavioral Health codes in this sequence			
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	0.75	ZZZ	
96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument	0.75	ZZZ	
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	9.64	XXX	
+ 96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	4.06	ZZZ	
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	10.99	XXX	
+ 96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	5.07	ZZZ	
+ 96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)	7.27	ZZZ	
+ 96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)	4.23	ZZZ	
96369	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)	24.52	XXX	
+ 96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	2.87	ZZZ	
+ 96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)	10.15	ZZZ	
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	2.71	XXX	
96373	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arterial	2.54	XXX	
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	7.78	XXX	
+ 96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	4.73	ZZZ	

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	96376	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)	2.03	ZZZ	
	96377	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection	3.97	XXX	
	96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion	BR	XXX	
	96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	5.58	XXX	
	96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic	3.04	XXX	
	96405	Chemotherapy administration; intralesional, up to and including 7 lesions	10.65	000	
	96406	Chemotherapy administration; intralesional, more than 7 lesions	12.68	000	
	96409	Chemotherapy administration; intravenous, push technique, single or initial substance/drug	10.32	XXX	
+	96411	Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)	5.92	ZZZ	
	96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	14.88	XXX	
+	96415	Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)	3.38	ZZZ	
	96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	15.90	XXX	
+	96417	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)	7.10	ZZZ	
	96420	Chemotherapy administration, intra-arterial; push technique	11.33	XXX	
	96422	Chemotherapy administration, intra-arterial; infusion technique, up to 1 hour	16.74	XXX	
+	96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure)	6.76	ZZZ	
	96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	20.12	XXX	
	96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	29.59	000	
■	96446	Chemotherapy administration into the peritoneal cavity via implanted port or catheter	21.98	XXX	
	96450	Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture	26.13	000	
	96521	Refilling and maintenance of portable pump	13.02	XXX	
	96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)	9.47	XXX	
	96523	Irrigation of implanted venous access device for drug delivery systems	2.37	XXX	
	96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	18.60	XXX	

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■ +	96547	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure)	74.66	ZZZ	
■ +	96548	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure)	34.20	ZZZ	
	96549	Unlisted chemotherapy procedure	BR	XXX	
	96567	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day	52.42	XXX	
+	96570	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)	26.21	ZZZ	
+	96571	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)	13.11	ZZZ	
	96573	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day	36.73	000	
	96574	Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day	47.34	000	
	96900	Actinotherapy (ultraviolet light)	3.21	XXX	
	96902	Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality	3.89	XXX	
	96904	Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	15.22	XXX	
	96910	Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B	3.72	XXX	
	96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)	4.31	XXX	
	96913	Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)	10.29	XXX	
■	96920	Excimer laser treatment for psoriasis; total area less than 250 sq cm	42.28	000	
■	96921	Excimer laser treatment for psoriasis; 250 sq cm to 500 sq cm	63.41	000	
■	96922	Excimer laser treatment for psoriasis; over 500 sq cm	46.50	000	
	96931	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion	32.70	XXX	
	96932	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, first lesion	23.74	XXX	

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
	96933	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, first lesion	8.30	XXX	
+	96934	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, each additional lesion (List separately in addition to code for primary procedure)	14.37	ZZZ	
+	96935	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, each additional lesion (List separately in addition to code for primary procedure)	6.77	ZZZ	
+	96936	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, each additional lesion (List separately in addition to code for primary procedure)	7.94	ZZZ	
	96999	Unlisted special dermatological service or procedure	BR	XXX	
		For codes 97010-97124, please see the Physical Medicine section			
		See NYS WCB Behavioral Health Fee Schedule for Behavioral Health codes in this sequence			
		For codes 97139-97530, please see the Physical Medicine section			
Ⓢ1	97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes	5.55	XXX	
		For codes 97535-97546, please see the Physical Medicine section			
Ⓢ1	97597	Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less	2.71	000	
+	Ⓢ1 97598	Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	3.21	ZZZ	
Ⓢ1	97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session	2.07	XXX	
Ⓢ1	97605	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	4.40	XXX	
Ⓢ1	97606	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	7.61	XXX	

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
51	97607	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	9.92	XXX	
51	97608	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	11.01	XXX	
51	97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	25.93	XXX	
	For codes 97750-∞ 97800, please see the Physical Medicine section				
	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	1.86	XXX	
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	1.86	XXX	
	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes	0.68	XXX	
	97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	3.55	XXX	
+	97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)	3.04	ZZZ	
	97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	3.89	XXX	
+	97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)	3.38	ZZZ	
	98925	Osteopathic manipulative treatment (OMT); 1-2 body regions involved	4.57	000	
	98926	Osteopathic manipulative treatment (OMT); 3-4 body regions involved	6.00	000	
	98927	Osteopathic manipulative treatment (OMT); 5-6 body regions involved	7.10	000	
	98928	Osteopathic manipulative treatment (OMT); 7-8 body regions involved	7.78	000	
	98929	Osteopathic manipulative treatment (OMT); 9-10 body regions involved	8.12	000	
	98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions	NC	000	
	98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions	NC	000	
	98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions	NC	000	
	98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions	NC	XXX	
	98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	3.38	XXX	
	98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	4.06	XXX	

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

Code	Description	Relative Value	FUD	PC/TC Split
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	4.40	XXX	
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	5.07	XXX	
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	8.62	XXX	
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	10.99	XXX	
99000	Handling and/or conveyance of specimen for transfer from the office to a laboratory	NC	XXX	
99001	Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)	NC	XXX	
99002	Handling, conveyance, and/or any other service in connection with the implementation of an order involving devices (eg, designing, fitting, packaging, handling, delivery or mailing) when devices such as orthotics, protectives, prosthetics are fabricated by an outside laboratory or shop but which items have been designed, and are to be fitted and adjusted by the attending physician or other qualified health care professional	NC	XXX	
99024	Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure	BR	XXX	
99026	Hospital mandated on call service; in-hospital, each hour	BR	XXX	
99027	Hospital mandated on call service; out-of-hospital, each hour	BR	XXX	
⑤1 99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service	3.55	XXX	
⑤1 99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	BR	XXX	
⑤1 99053	Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service	BR	XXX	
⑤1 99056	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service	3.38	XXX	
⑤1 99058	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service	4.23	XXX	

90281-99607

MEDICINE

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
⑤1	99060	Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service	4.73	XXX	
	99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	Refer to Rules	XXX	
	99071	Educational supplies, such as books, tapes, and pamphlets, for the patient's education at cost to physician or other qualified health care professional	NC	XXX	
	99075	Medical testimony	Refer to Rules	XXX	
	99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)	NC	XXX	
■	99080	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form	BR	XXX	
	99082	Unusual travel (eg, transportation and escort of patient)	NC	XXX	
■	99091	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days	NC	XXX	
	For codes 99100-99140, please see the Anesthesia section				
⊖	99151	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age	15.05	XXX	
⊖	99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older	9.99	XXX	
+	99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	2.12	ZZZ	
	99155	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age	19.61	XXX	
	99156	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older	15.39	XXX	

MEDICINE**90281-99607****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD	PC/TC Split
+	99157	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	11.74	ZZZ	
	99172	Visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision (may include all or some screening of the determination[s] for contrast sensitivity, vision under glare)	4.57	XXX	20/80
	99173	Screening test of visual acuity, quantitative, bilateral	2.28	XXX	
	99174	Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with remote analysis and report	2.54	XXX	
	99175	Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison	6.43	XXX	
	99177	Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with on-site analysis	0.96	XXX	
	99183	Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session	37.20	XXX	
	99184	Initiation of selective head or total body hypothermia in the critically ill neonate, includes appropriate patient selection by review of clinical, imaging and laboratory data, confirmation of esophageal temperature probe location, evaluation of amplitude EEG, supervision of controlled hypothermia, and assessment of patient tolerance of cooling	45.23	XXX	
	99188	Application of topical fluoride varnish by a physician or other qualified health care professional	2.39	XXX	
	99190	Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); each hour	NC	XXX	0/100
	99191	Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); 45 minutes	NC	XXX	0/100
	99192	Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); 30 minutes	NC	XXX	0/100
	99195	Phlebotomy, therapeutic (separate procedure)	6.76	XXX	
	99199	Unlisted special service, procedure or report	BR	XXX	
	For codes 99202-99499, please see the Evaluation and Management section				
	99500	Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring	NC	XXX	
	99501	Home visit for postnatal assessment and follow-up care	NC	XXX	
	99502	Home visit for newborn care and assessment	NC	XXX	
	99503	Home visit for respiratory therapy care (eg, bronchodilator, oxygen therapy, respiratory assessment, apnea evaluation)	NC	XXX	
	99504	Home visit for mechanical ventilation care	NC	XXX	
	99505	Home visit for stoma care and maintenance including colostomy and cystostomy	NC	XXX	
	99506	Home visit for intramuscular injections	NC	XXX	
	99507	Home visit for care and maintenance of catheter(s) (eg, urinary, drainage, and enteral)	NC	XXX	
	99509	Home visit for assistance with activities of daily living and personal care	NC	XXX	

90281-99607**MEDICINE**

Effective TBD

Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	99510	Home visit for individual, family, or marriage counseling	NC	XXX	
	99511	Home visit for fecal impaction management and enema administration	NC	XXX	
	99512	Home visit for hemodialysis	NC	XXX	
	99600	Unlisted home visit service or procedure	NC	XXX	
	99601	Home infusion/specialty drug administration, per visit (up to 2 hours);	NC	XXX	
+	99602	Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code for primary procedure)	NC	XXX	
	99605	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient	BR	XXX	
	99606	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient	BR	XXX	
+	99607	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes (List separately in addition to code for primary service)	BR	XXX	

8 Physical Medicine

The relative value units in this section were determined uniquely for physical medicine services. Use the physical medicine conversion factor when determining fee amounts. The physical medicine conversion factor is not applicable to any other section. Physical and Occupational Therapists may not bill from this section of the fee schedule. Please see the *separate* fee schedule for Physical and Occupational Therapy.

The fee for a procedure or service in this section is determined by multiplying the relative value unit by the physical medicine conversion factor, subject to the ground rules, instructions, and definitions of the schedule.

To ensure uniformity of billing when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately. After which, charges for products may be added.

CONVERSION FACTORS

Regional conversion factors for services rendered on or after TBD.

Section	Region I	Region II	Region III	Region IV
Physical Medicine	\$8.43	\$8.43	\$9.65	\$10.48

PHYSICAL MEDICINE GROUND RULES

The fees for physical medicine and physical or occupational therapy services are payable when services are rendered by a physician/NP/PA. When physical medicine treatment is rendered in the follow-up period of surgical or fracture care procedures, the treatment is not considered part of the global surgical fee. Physical medicine services are separately covered procedures when rendered during the follow-up period of any surgical service. When a patient is seen by a provider other than the surgeon prior to and during the implementation of a physical medicine program, and a history and physical examination is performed, a fee for an office visit is permitted. Definitions and rules pertaining to physical medicine services are as follows:

Note: Rules used by all providers in reporting their services are presented in the General Ground Rules in the Introduction and General Guidelines section.

1A. NYS Medical Treatment Guidelines

Treatment of work-related injuries should be in accordance with any applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.

1B. Referral and Prescription by Physician, Nurse Practitioner, Physician Assistant or Podiatrist

Occupational and physical therapy services must be rendered only upon the prescription or referral of an authorized physician, nurse practitioner, physician assistant or podiatrist. The referring or prescribing provider should also oversee the written instructions for treatment for a given diagnosis. Written instructions should include precautions, goals, frequency, and modalities to be used.

2. Physical Medicine Utilization

Physical medicine services in excess of 12 treatments or after 45 days from the first treatment, require documentation that includes provider certification of medical necessity for continued treatment, progress notes, and treatment plans. This documentation should be submitted to the insurance carrier as part of the claim.

3. Physical Medicine and Rehabilitation Program

If the provider deems that the patient's condition warrants a physical medicine and rehabilitation program and the referral is made during the post operative follow-up period, such treatment must be consistent with the Medical Treatment Guidelines or be subject to prior authorization.

4. Home Treatment

When treatment is rendered in a patient's home by a provider or a therapist, add 50 percent to the listed value. Documentation explaining the necessity of home treatment

instead of an office or outpatient treatment setting is required with the bill to the insurance carrier.

5. Referral and Authorization

A provider referring patients to a duly licensed and registered physical therapist (PT) or occupational therapist (OT) may include a directive indicating the treatment plan and duration but should not exceed 12.0 RVUs per patient per day.

6. Narrative Reports

A detailed narrative report must be submitted with all services provided. Physicians & Nurse Practitioners narrative reports must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Physician Assistants must include Work Status & Temporary Impairment Percentages. Providers are strongly encouraged to use the narrative template format found on the WCB webpage [CMS-1500 Requirements](#).

Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/assessment of the patient.

Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed.

Any ordered medications, durable medical equipment, tests, or procedures should be thoroughly explained.

All entries in the medical record must be legible to another reader.

7. Post-operative Procedures by a Physical Therapist or Occupational Therapist

Physical or occupational therapists that render therapy during the follow-up period for fractures, dislocations, or other post-operative procedures shall be reimbursed for therapy during and after the follow-up period in accordance with any applicable Medical Treatment Guidelines and the Physical and Occupational Therapy Fee Schedules.

8. Initial Evaluation and Re-evaluation by a Physician, Nurse Practitioner, or Physician Assistant

Physicians, nurse practitioners, and physician assistants may bill for an initial evaluation using CPT codes 97161–97163 and 97165–97167, respectively. The maximum number of RVUs (including treatment) per patient per day per WCB case number when billing for an initial evaluation shall be limited to 18.0. The following codes represent the treatments subject to this rule:

97010	97012	97014	97016	97018	97022
97024	97026	97028	97032	97033	97034
97035	97036	97039	97110	97112	97113
97116	97124	97139	97140	97150	97530
97535	97537	97542	97760	97761	97763

Evaluations may include the following elements: history, examination, clinical testing, interpretation of data, clinical presentation, clinical decision making, and development of the plan of care with defined goals, appropriate interventions, and recommendations.

The maximum number of RVUs (including treatment) per person per day per WCB case number when billing for a re-evaluation shall be limited to 15.0. Re-evaluations using CPT codes 97164 (PT) and 97168 (OT) may be billed when any of the following applies:

- A. If following discharge (for whatever reason), the patient is referred again for treatment with the same or similar condition of the same body part.
- B. If there is a significant change in the patient's condition that warrants a revision of the treatment goals, intervention and/or the plan of care.
- C. If it is medically necessary to provide re-evaluation services over and above those normally included during therapeutic treatment.
- D. If the patient's status becomes stationary and it is not likely that significant improvement will occur with further treatment.
- E. If at the conclusion of the current episode of therapy care, re-evaluation is indicated for any of the following reasons:
 - Satisfactory goal achievement with present functional status defined including a home program and follow-up services, as necessary.
 - Patient declines to continue care.
 - The patient is unable to continue to work toward goals due to medical or psychosocial complications.

Please note, however, that re-evaluations may be billed only in instances where such evaluation is therapeutically necessary, and in any event, not more than once in a 30-day period.

9. Physical and Occupational Therapists Billing

All providers who can be authorized by the NYS Workers' Compensation Board, must be Board-authorized in order to treat injured workers, with limited exceptions for out-of-state providers.

All Physical and Occupational Therapists, whether self-employed or part of a physician practice, must bill using the NYS WCB Physical and Occupational Therapy

Fee Schedule and submit their own medical reports and bill independently in their own name, not through a supervising physician. Some exceptions may include:

- PT/OT performed in a hospital inpatient setting or ambulatory surgery setting may be billed by the facility. See WCB webpage for more information on Expanded Provider Law: www.wcb.ny.gov
- Physicians may not bill for (incident to) physical/occupational therapists that are performing the patient's therapy.

10. Hospital-based EMG

When electro-diagnostic testing is performed in a hospital setting using hospital-owned equipment and hospital-employed technicians, the hospital may bill for the technical portion of the service, provided that the studies are conducted according to the requirements set forth in the Medical Treatment Guidelines.

11. Multiple Physical Medicine Procedures and Modalities

When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 12.0 RVUs per patient per WCB case number or the amount billed, whichever is less. **Note:** When a patient receives physical medicine procedures and/or modalities from more than one provider, the patient may not receive more than 12.0 RVUs per day per WCB case number from all providers combined. The following codes represent the physical medicine procedures and modalities subject to this rule:

97010	97012	97014	97016	97018	97022
97024	97026	97028	97032	97033	97034
97035	97036	97039	97110	97112	97113
97116	97124	97139	97140	97150	97530
97535	97537	97542	97760	97761	97763

12. Tests and Measurements

Codes 97760–97763 training and management for orthotic/prosthetic use, shall not be billed on the same day as an office visit.

13. Work Hardening Rules

Work hardening programs are interdisciplinary, goal-specific, vocationally-driven treatment programs designed to maximize the likelihood of return to work through functional, behavioral, and vocational management.

Not all claimants require these programs to reach a level of function that will allow successful return to work.

Only those programs that meet all of the specific guidelines will be defined as work hardening programs.

Programs will be reimbursed per the fee schedule after meeting all other requirements.

Pre-Admission Criteria

All claimants must complete a preprogram assessment including a Functional Capacity Evaluation (FCE) and Vocational Evaluation.

The goal of the program is return to work, therefore, for all anticipated returns to previous employment or placement with a new employer, the following must be provided:

- Specific written critical job demands and/or job site analysis
- Verified written employment opportunities

Evaluation Process

Initial screening evaluation is performed by the treatment team consisting of:

- Physical Therapy and/or Occupational Therapy
PLUS
- Psychology/Psychiatry and/or Vocational Rehabilitation, Chiropractor, or other providers suitable by scope of practice as determined in the State Education Law

The outcome of this evaluation will be:

- Recommendation of release to return to work
- Acceptance into the program with an Individual Written Rehabilitation Plan stating specific goals and recommended services
- Rejection from program for specific reasons
- Referral back to provider for medical evaluation
- Recommendation of vocational rehabilitation, either by referral to and acceptance by Adult Career and Continuing Education Services—Vocational Rehabilitation (ACCES-VR), or by other providers if approved by the carrier

Claimants must be referred by a physician, nurse practitioner, physician assistant or podiatrist authorized by the NYSWCB to provide care to injured claimants, who will provide a written referral for evaluation and treatment.

Programs and Providers

Claimants will be provided with the availability of the following providers as determined by the needs of the claimant:

- A minimum of two (2) of the following: Physical Therapist, Occupational Therapist, Vocational Rehabilitation Counselor, Psychologist/Psychiatrist,

Licensed Clinical Social Worker, Chiropractor, or other provider suitable by scope of practice as determined in the State Education Law; in addition to a Case Manager, either internal or external to the program.

- B. Providers who can provide initial medical evaluation, participation in the development of the treatment plan, and coordination of work restrictions and discharge planning with the recommendation of specialists in Physical Medicine and Rehabilitation.

Discharge Criteria

Discharge criteria must be provided to all claimants in writing prior to initiation of treatment at the time program goals are determined.

Voluntary discharge is achieved by:

- A. Meeting program goals
- B. Early return to work
- C. Acute or worsening medical conditions
- D. The claimant declining further treatment

Non-voluntary discharge may be necessary in cases of:

- A. Failure to comply with program policies
- B. Absenteeism
- C. Lack of demonstrable benefit from treatment

Non-voluntary discharge requires written documentation of prior and repeated counseling of the claimant, and immediate notification of the employer, insurer, case manager, and referring and attending (if different) provider.

Under all circumstances of voluntary and non-voluntary discharge, the claimant will return to the referring attending provider for release from the program.

The attending provider must sign a release to return to work when the program goals are achieved.

Program Evaluation

Programs are subject to disclosure and evaluation as permitted by local and state health care agencies and other appropriate individuals or groups in the State of New York, including issues of:

- A. Written policies and procedures
- B. Program implementation
- C. Maintenance of medical records
- D. Outcomes achieved
- E. Site design and equipment
- F. Affiliations with non-site-based providers

- G. Admission and discharge criteria

Programs must provide insurers and referring providers with:

- A. Initial interdisciplinary team evaluation report
- B. Proposed treatment plan
- C. Progress reports at weekly intervals
- D. Opportunity to attend team meetings
- E. Final discharge summary report
- F. Any information described in sections above

Integration of Vocation Rehabilitation Services

Work hardening programs are vocationally directed and driven rehabilitation services. The vocational rehabilitation counselor serves to:

- A. Coordinate efforts between the claimant, program, and employer
- B. Obtain job descriptions and critical job demands from the employer
- C. Gather and provide information to the treatment team
- D. Educate employers toward work tasks and work-site design
- E. Assist claimants toward appropriate employment opportunities within their safe maximal capabilities

Programs that do not retain the services of vocational rehabilitation counselors on a full time basis may utilize private rehabilitation agencies, specialists provided by insurance carriers, or ACCES-VR. These individuals are required to make continuous on-site contact with claimants and program providers, including participation in team meetings.

The qualifications for serving as a vocational rehabilitation counselor with respect to work hardening programs shall be determined by the Chair of the State of New York, Workers' Compensation Board, in consultation with the Medical Director's Office of the State of New York Workers' Compensation Board. Vocational rehabilitation counselors should be reimbursed at the usual and customary rate currently paid by insurers in each region.

Program Duration

Work hardening programs will be provided on the following time schedule:

- A. Daily treatment, full or partial days, with fee differential
- B. Minimum of ten (10) treatment days and maximum of thirty (30) treatment days subject to carrier prior approval

- C. Treatment to be completed within six (6) consecutive weeks
- D. Any additional treatment days beyond thirty (30) upon approval by the carrier

Fee Schedule

Fees for work hardening programs will be paid in accordance with the medical fee schedule, with written prior approval by the carrier, utilizing the following guidelines:

- A. In all cases, for both voluntary and non-voluntary discharge, payment is for the actual duration of treatment provided.
- B. Payment differential for partial and full day program.
- C. CPT codes 97545 and 97546 will be reimbursed for work hardening programs only as described above.
- D. Non-multidisciplinary "work conditioning" programs will be reimbursed utilizing existing PT, OT, and physical medicine codes.
- E. Behavioral health services as requested in the Individual Written Rehabilitation Plan and approved by the carrier will be billed separately from codes 97545 and 97546, in accordance with the appropriate fee schedules.
- F. Payment for external case managers and vocational rehabilitation counselors will be the responsibility of the carrier, exclusive of program codes 97545 and 97546.
- G. Billing will not exceed eight (8) hours for any given treatment day.

14. Functional Capacity Evaluations (FCE)

Indications

The FCE is utilized for the following purposes:

- A. To determine the level of safe maximal function at the time of maximal medical improvement.
- B. To provide a prevocational baseline of functional capabilities to assist in the vocational rehabilitation process.
- C. To objectively set restrictions and guidelines for return to work.
- D. To determine whether specific job tasks can be safely performed by modification of technique, equipment, or by further training.
- E. To determine whether additional treatment or referral to a work hardening program is indicated.

- F. To assess outcome at the conclusion of a work hardening program.

General Requirements

- A. The FCE may be prescribed only by an authorized physician, nurse practitioner, physician assistant, or podiatrist, or may be requested by the carrier when indicated.
- B. The FCE does not require prior authorization by the carrier.
- C. The prescribing provider must justify the indication for each at the request of the carrier (see Eligibility Criteria).
- D. The FCE shall be performed by a physical or occupational therapist currently holding a valid license in New York state, or other licensed provider qualified by scope of practice. Constant supervision by the licensed provider is required.

Specific Requirements

- A. The FCE, when medically necessary and indicated, may be performed only at the point of maximum medical improvement in the opinion of the attending provider.
- B. The FCE should not be prescribed prior to three (3) months post-injury unless there is a significant documented change in the claimant's status which justifies earlier utilization.
- C. At least one of the following eligibility criteria is required for all claimants:
 1. Claimant is preparing to return to previous job.
 2. Claimant has been offered a new job (verified).
 3. Claimant is working with a rehabilitation provider and a vocational objective is established.
 4. Claimant is expected to be classified with a non-schedule permanent partial disability.
- D. Reports will include the following information:
 1. Patient demographics including work history.
 2. Indication for evaluation.
 3. Type of evaluation performed.
 4. Raw and tabulated data.
 5. Normative data values.
 6. Narrative cover sheet with recommendations.
- E. The bill for services provided must be attached to the report to be processed by the carrier.

- E. All evaluation tools must be standardized, and normative data and interpretive guidelines must be attached to the report.

NYS Allowable for FCE

∞97800 Functional Capacity Evaluation:

Region I	\$496.00	Region II	\$496.00
Region III	\$564.00	Region IV	\$614.00

15. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used with physical medicine procedures are as follows:

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

51 Multiple Procedures

When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

96 Habilitative Services

When a service or procedure that may be either habilitative or rehabilitative in nature is provided for habilitative purposes, the physician or other qualified health care professional may add modifier 96 to the service or procedure code to indicate that the service or procedure provided was a habilitative service. Habilitative services help an individual learn skills and functioning for daily living that the individual has not yet developed, and then keep and/or improve those learned skills. Habilitative services also help an individual keep, learn, or improve skills and functioning for daily living.

97 Rehabilitative Services

When a service or procedure that may be either habilitative or rehabilitative in nature is provided for rehabilitative purposes, the physician or other qualified health care professional may add modifier 97 to the service or procedure code to indicate that the service or procedure provided was a rehabilitative service. Rehabilitative services help an individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt, or disabled.

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

16. Supplies and Materials: Durable Medical Equipment

All durable medical equipment (DME) supplied shall be billed and paid using the current published WCB Durable Medical Equipment Fee Schedule. The WCB Durable Medical Equipment Fee Schedule is/will be available on the Board's website. Any item identified as requiring prior authorization in the WCB Durable Medical Equipment Fee Schedule or not listed in the WCB Durable Medical Equipment Fee Schedule, may not be billed without such prior authorization.

Medical necessity should be documented for all prescribed DME. Prescription or order form must be completed by the provider and accurately describe the item needed. Appropriate HCPCS codes should be billed for items. All miscellaneous/unspecified codes, or codes without a listed price require prior authorization (PAR) and manufacturer's invoice. Also see Surgery Ground Rules regarding post procedure casting/splinting DME.

Do not bill for or report supplies that are customarily included in surgical packages, such as gauze, sponges, Steri-strips, and dressings; drug screening supplies; and hot and cold packs. These items are included in the fee for the medical services in which such supplies are used.

17. Miscellaneous and By Report Codes

- Providers should only use codes listed in the Fee Schedule. When billing a service or procedure, select the CPT code from the WCB Fee schedule that accurately identifies the service or procedure performed. If no such code is available, report the service or procedure using the closest appropriate **Miscellaneous** code in the Fee Schedule (often ending in -99). These codes may also be titled "Unlisted," "Unspecified," or "Not Otherwise Specified".

2. By Report (BR) in the Relative Value (RVU) column represents services that too variable to permit assignment of RVUs. Fees for such procedures need to be justified with additional information.
- The inclusion of a miscellaneous or by report code in this Fee Schedule does not guarantee reimbursement. All codes billed should be based on medical necessity and be in alignment with all applicable Medical Treatment Guidelines and Fee Schedule Ground Rules. Reimbursement may be dependent on multiple factors, including but not necessarily limited to, causal relationship, clinical necessity and appropriateness of the fees submitted.
 - It is the responsibility of the provider to ensure all information required to process a miscellaneous or by report procedure is included with the bill. If required information is missing, or if there is a valid code that describes the procedure, then the code may not be reimbursed.
 - Nearly all miscellaneous and by report codes, require prior authorization (PAR). If a procedure or item is not recommended or not addressed in an applicable WCB Medical Treatment Guideline (MTG), then prior authorization is always required. If the procedure or item involves a body part or condition for which there is no MTG and costs over \$1,000 then prior authorization must be obtained.
 - While emergency procedures/items do not require prior authorization, the circumstances must be identified and explained in the procedure record. The codes billed may be subject to review and non-payment.
 - When a miscellaneous or by report code is used, the actual service/item should be identified on the bill, narrative note, and in an additional attached report.
 - The price billed must be substantiated by indicating the closest comparable code found in the current fee schedule and/or with a manufacturer's invoice.
 - Documentation should include: any decision making, medical necessity and explanation why an existing fee schedule code could not be used.
 - Any PARs including identification numbers should also be submitted with bills.
 - Miscellaneous and by report codes should not be billed merely to describe a proprietary product or procedure, when an existing fee schedule code adequately describes the procedure or item.
- Surgical miscellaneous or by report codes may require additional documentation including: time, skill, equipment necessary, diagnosis, pertinent history, and physical findings, size/ location/ number of lesions or procedures.

95851-97800

Effective TBD

PHYSICAL MEDICINE**Medical Fee Schedule**

	Code	Description	Relative Value	FUD
	95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)	0.00	XXX
	95852	Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side	0.00	XXX
Ⓢ1	97010	Application of a modality to 1 or more areas; hot or cold packs	0.55	XXX
Ⓢ1	97012	Application of a modality to 1 or more areas; traction, mechanical	2.71	XXX
Ⓢ1	97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)	2.66	XXX
Ⓢ1	97016	Application of a modality to 1 or more areas; vasopneumatic devices	3.30	XXX
Ⓢ1	97018	Application of a modality to 1 or more areas; paraffin bath	2.71	XXX
Ⓢ1	97022	Application of a modality to 1 or more areas; whirlpool	2.62	XXX
Ⓢ1	97024	Application of a modality to 1 or more areas; diathermy (eg, microwave)	2.71	XXX
Ⓢ1	97026	Application of a modality to 1 or more areas; infrared	2.54	XXX
Ⓢ1	97028	Application of a modality to 1 or more areas; ultraviolet	2.54	XXX
Ⓢ1	97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	2.45	XXX
Ⓢ1	97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	3.55	XXX
Ⓢ1	97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes	2.37	XXX
Ⓢ1	97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes	2.41	XXX
Ⓢ1	97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes	3.89	XXX
■	97037	Application of a modality to 1 or more areas; low-level laser therapy (ie, nonthermal and non-ablative) for post-operative pain reduction	BR	XXX
	97039	Unlisted modality (specify type and time if constant attendance)	BR	XXX
Ⓢ1	97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	3.97	XXX
Ⓢ1	97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	3.89	XXX
Ⓢ1	97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	4.40	XXX
Ⓢ1	97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	3.51	XXX
Ⓢ1	97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	2.62	XXX
	97139	Unlisted therapeutic procedure (specify)	2.89	XXX
Ⓢ1	97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	4.23	XXX
Ⓢ1	97150	Therapeutic procedure(s), group (2 or more individuals)	3.63	XXX

PHYSICAL MEDICINE
Medical Fee Schedule
95851-97800
Effective TBD

	Code	Description	Relative Value	FUD
■	(51) 97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.	9.47	XXX
■	(51) 97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.	9.47	XXX
■	(51) 97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.	9.47	XXX
■	(51) 97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.	4.00	XXX
■	(51) 97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.	9.47	XXX
■	(51) 97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.	9.47	XXX

95851-97800

Effective TBD

PHYSICAL MEDICINE

Medical Fee Schedule

	Code	Description	Relative Value	FUD
■	⑤1 97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.	9.47	XXX
■	⑤1 97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.	4.00	XXX
■	⑤1 97169	Athletic training evaluation, low complexity, requiring these components: A history and physical activity profile with no comorbidities that affect physical activity; An examination of affected body area and other symptomatic or related systems addressing 1-2 elements from any of the following: body structures, physical activity, and/or participation deficiencies; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 15 minutes are spent face-to-face with the patient and/or family.	10.60	XXX
■	⑤1 97170	Athletic training evaluation, moderate complexity, requiring these components: A medical history and physical activity profile with 1-2 comorbidities that affect physical activity; An examination of affected body area and other symptomatic or related systems addressing a total of 3 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.	10.60	XXX
■	⑤1 97171	Athletic training evaluation, high complexity, requiring these components: A medical history and physical activity profile, with 3 or more comorbidities that affect physical activity; A comprehensive examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; Clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.	10.60	XXX
■	⑤1 97172	Re-evaluation of athletic training established plan of care requiring these components: An assessment of patient's current functional status when there is a documented change; and A revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome with an update in management options, goals, and interventions. Typically, 20 minutes are spent face-to-face with the patient and/or family.	5.20	XXX
	⑤1 97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	2.87	XXX
	⑤1 97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes	3.38	XXX

PHYSICAL MEDICINE**95851-97800****Medical Fee Schedule****Effective TBD**

	Code	Description	Relative Value	FUD
Ⓢ1	97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes	3.38	XXX
Ⓢ1	97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	2.37	XXX
Ⓢ1	® 97545	Work hardening/conditioning; initial 2 hours	28.00	XXX
+ Ⓢ1	® 97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)	3.30	ZZZ
Ⓢ1	97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	0.00	XXX
Ⓢ1	97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes	NC	XXX
Ⓢ1	97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes	4.23	XXX
Ⓢ1	97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	4.23	XXX
Ⓢ1	97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	3.55	XXX
	97799	Unlisted physical medicine/rehabilitation service or procedure	BR	XXX
∞	97800	Functional Capacity Evaluation-See Rules	Refer to Rules	

9 Category III Codes

CATEGORY III CODES

Category III codes are temporary codes identifying emerging technology and should be reported when available. The use of these codes supersedes reporting the service with an unlisted code. Because these codes are temporary, some of them may only be covered on a case-by-case review and **all require prior authorization**. The temporary codes may be converted to permanent CPT codes or deleted during a semiannual update of the code set.

For a complete explanation of this process refer to the guidelines in *CPT 2024*.

Because Category III codes represent new and emerging technology, a limited number of these codes have been assigned relative value units. Codes without an assigned relative value are by report (BR) procedures. See Ground Rule 10 in the Surgery section for the complete rule related to BR procedures.

CATEGORY III GROUND RULES

1A. NYS Medical Treatment Guidelines

Treatment of work-related injuries should be in accordance with any applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.

2. Conversion Factor

The Category III codes will utilize the **Medicine conversion factor**. Any currently published WCB Bulletins may supersede this Ground Rule if necessary.

3. Authorization

Since Cat III codes may only be covered on a case-by-case review ALL codes require prior authorization.

0042T-0866T

Effective TBD

CATEGORY III CODES**Medical Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
	0042T	Cerebral perfusion analysis using computed tomography with contrast administration, including post-processing of parametric maps with determination of cerebral blood flow, cerebral blood volume, and mean transit time	15.44	XXX	
+	0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)	2.47	XXX	
+	0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)	3.23	XXX	
	0071T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue	BR	XXX	
	0072T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue	BR	XXX	
	0075T	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel	18.68	XXX	
+	0076T	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; each additional vessel (List separately in addition to code for primary procedure)	17.50	XXX	
+	0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)	BR	XXX	
+	0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)	BR	XXX	
	0100T	Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intra-ocular retinal electrode array, with vitrectomy	16.22	XXX	
■	0101T	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified	2.78	XXX	
■	0102T	Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving the lateral humeral epicondyle	2.78	XXX	
	0106T	Quantitative sensory testing (QST), testing and interpretation per extremity; using touch pressure stimuli to assess large diameter sensation	BR	XXX	
	0107T	Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration stimuli to assess large diameter fiber sensation	BR	XXX	
	0108T	Quantitative sensory testing (QST), testing and interpretation per extremity; using cooling stimuli to assess small nerve fiber sensation and hyperalgesia	BR	XXX	
	0109T	Quantitative sensory testing (QST), testing and interpretation per extremity; using heat-pain stimuli to assess small nerve fiber sensation and hyperalgesia	BR	XXX	
	0110T	Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli to assess sensation	BR	XXX	
+	0164T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)	3.25	YYY	
+	0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)	3.61	YYY	

CATEGORY III CODES

0042T-0866T

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
+	0174T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed concurrent with primary interpretation (List separately in addition to code for primary procedure)	0.60	XXX	
	0175T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed remote from primary interpretation	0.60	XXX	
	0184T	Excision of rectal tumor, transanal endoscopic microsurgical approach (ie, TEMS), including muscularis propria (ie, full thickness)	6.22	XXX	
	0198T	Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report	9.99	XXX	
	0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed	8.70	XXX	
	0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed	11.98	XXX	
	0202T	Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine	15.40	XXX	
	0207T	Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral	3.76	XXX	
	0208T	Pure tone audiometry (threshold), automated; air only	5.20	XXX	
	0209T	Pure tone audiometry (threshold), automated; air and bone	9.65	XXX	
	0210T	Speech audiometry threshold, automated;	6.43	XXX	
	0211T	Speech audiometry threshold, automated; with speech recognition	BR	XXX	
	0212T	Comprehensive audiometry threshold evaluation and speech recognition (0209T, 0211T combined), automated	8.14	XXX	
	0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level	1.19	XXX	
+	0214T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; second level (List separately in addition to code for primary procedure)	0.60	ZZZ	
+	0215T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)	0.61	ZZZ	
	0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level	1.07	XXX	
+	0217T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level (List separately in addition to code for primary procedure)	0.54	ZZZ	

0042T-0866T

Effective TBD

CATEGORY III CODES**Medical Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
+	0218T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)	0.55	ZZZ	
	0219T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical	BR	XXX	
	0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic	BR	XXX	
	0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar	BR	XXX	
+	0222T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure)	BR	ZZZ	
	0232T	Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed	0.37	XXX	
	0234T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; renal artery	11.12	YYY	
	0235T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; visceral artery (except renal), each vessel	10.84	YYY	
	0236T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; abdominal aorta	9.27	YYY	
	0237T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; brachiocephalic trunk and branches, each vessel	4.62	YYY	
	0238T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel	6.28	YYY	
	0253T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space	7.12	YYY	
	0263T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest	2.67	XXX	
	0264T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest	1.19	XXX	
	0265T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy	0.19	XXX	
	0266T	Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	BR	YYY	
	0267T	Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	BR	YYY	

CATEGORY III CODES

0042T-0866T

Medical Fee Schedule

Effective TBD

Code	Description	Relative Value	FUD	PC/TC Split
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	BR	YYY	
0269T	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	BR	XXX	
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	BR	XXX	
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	BR	XXX	
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day);	BR	XXX	
0273T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); with programming	BR	XXX	
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic	BR	YYY	
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar	BR	YYY	
0278T	Transcutaneous electrical modulation pain reprocessing (eg, scrambler therapy), each treatment session (includes placement of electrodes)	BR	XXX	
0308T	Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis	11.74	YYY	
0329T	Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report	BR	YYY	
0330T	Tear film imaging, unilateral or bilateral, with interpretation and report	BR	YYY	
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;	BR	YYY	
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	BR	YYY	
0333T	Visual evoked potential, screening of visual acuity, automated, with report	BR	YYY	
■ 0335T	Insertion of sinus tarsi implant	BR	YYY	

0042T-0866T

Effective TBD

CATEGORY III CODES**Medical Fee Schedule**

Code	Description	Relative Value	FUD	PC/TC Split
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral	8.33	YYY	
0339T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral	10.02	YYY	
0342T	Therapeutic apheresis with selective HDL delipidation and plasma reinfusion	BR	YYY	
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus	11.59	YYY	
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	BR	YYY	
0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic and lumbosacral, when performed)	BR	YYY	
0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow, and wrist, when performed)	BR	YYY	
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and ankle, when performed)	BR	YYY	
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real-time intraoperative	BR	YYY	
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real-time or referred	BR	YYY	
0353T	Optical coherence tomography of breast, surgical cavity; real-time intraoperative	BR	YYY	
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real-time or referred	BR	YYY	
0358T	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report	BR	YYY	
■ 0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	BR	YYY	
■ 0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	BR	YYY	
0378T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	BR	XXX	
0379T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; technical support and patient instructions, surveillance, analysis, and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	14.84	XXX	

CATEGORY III CODES

0042T-0866T

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
	0394T	High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed	9.14	XXX	
	0395T	High dose rate electronic brachytherapy, interstitial or intracavitary treatment, per fraction, includes basic dosimetry, when performed	33.94	XXX	
+	0397T	Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure)	BR	XXX	
	0398T	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed	BR	XXX	
■	0402T	Collagen cross-linking of cornea, including removal of the corneal epithelium, when performed, and intraoperative pachymetry, when performed	BR	XXX	
	0403T	Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day	BR	XXX	
	0408T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes	BR	XXX	
	0409T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only	BR	XXX	
	0410T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only	BR	XXX	
	0411T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only	BR	XXX	
	0412T	Removal of permanent cardiac contractility modulation system; pulse generator only	BR	XXX	
	0413T	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)	BR	XXX	
	0414T	Removal and replacement of permanent cardiac contractility modulation system pulse generator only	BR	XXX	
	0415T	Repositioning of previously implanted cardiac contractility modulation transvenous electrode, (atrial or ventricular lead)	BR	XXX	
	0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator	BR	XXX	
	0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation system	BR	XXX	
	0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system	BR	XXX	
	0419T	Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibromas	BR	XXX	
	0420T	Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); trunk and extremities, extensive, greater than 100 neurofibromas	BR	XXX	

0042T-0866T

Effective TBD

CATEGORY III CODES**Medical Fee Schedule**

Code	Description	Relative Value	FUD	PC/TC Split
0421T	Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)	BR	XXX	
0422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral	BR	XXX	
+	0437T Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)	BR	ZZZ	
+	0439T Myocardial contrast perfusion echocardiography, at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)	BR	ZZZ	
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve	BR	YYY	
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve	BR	YYY	
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)	BR	YYY	
+	0443T Real-time spectral analysis of prostate tissue by fluorescence spectroscopy, including imaging guidance (List separately in addition to code for primary procedure)	BR	ZZZ	
0444T	Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral	BR	YYY	
0445T	Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral	BR	YYY	
0446T	Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training	BR	000	
0447T	Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision	BR	000	
0448T	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation	BR	000	
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device	BR	YYY	
+	0450T Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure)	BR	YYY	
0464T	Visual evoked potential, testing for glaucoma, with interpretation and report	BR	YYY	
0469T	Retinal polarization scan, ocular screening with on-site automated results, bilateral	BR	XXX	
0472T	Device evaluation, interrogation, and initial programming of intraocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional	9.44	XXX	
0473T	Device evaluation and interrogation of intraocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional	7.39	XXX	

CATEGORY III CODES

0042T-0866T

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
	0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space	3.34	XXX	
	0479T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm2 or part thereof, or 1% of body surface area of infants and children	1.01	000	
+	0480T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm2, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)	0.48	ZZZ	
	0481T	Injection(s), autologous white blood cell concentrate (autologous protein solution), any site, including image guidance, harvesting and preparation, when performed	BR	000	
	0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed	11.75	000	
	0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)	16.69	000	
	0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral	BR	XXX	
	0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral	BR	XXX	
	0488T	Preventive behavior change, online/electronic structured intensive program for prevention of diabetes using a standardized diabetes prevention program curriculum, provided to an individual, per 30 days	BR	XXX	
	0489T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and debris, determination of concentration and dilution of regenerative cells	BR	000	
	0490T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; multiple injections in one or both hands	BR	000	
	0494T	Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to implantation, when performed	BR	XXX	
	0495T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; first two hours in sterile field	BR	XXX	
+	0496T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; each additional hour (List separately in addition to code for primary procedure)	BR	ZZZ	

0042T-0866T

Effective TBD

CATEGORY III CODES**Medical Fee Schedule**

Code	Description	Relative Value	FUD	PC/TC Split
0500T	Infectious agent detection by nucleic acid (DNA or RNA), human papillomavirus (HPV) for five or more separately reported high-risk HPV types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) (ie, genotyping)	BR	XXX	
■ 0505T	Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion	BR	YYY	
■ 0506T	Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report	BR	XXX	60/40
■ 0507T	Near-infrared dual imaging (ie, simultaneous reflective and trans-illuminated light) of meibomian glands, unilateral or bilateral, with interpretation and report	BR	XXX	14/86
■ 0509T	Electroretinography (ERG) with interpretation and report, pattern (PERG)	BR	XXX	27/73
■ 0510T	Removal of sinus tarsi implant	BR	YYY	
■ 0511T	Removal and reinsertion of sinus tarsi implant	BR	YYY	
■ 0512T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; initial wound	BR	YYY	
■ + 0513T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; each additional wound (List separately in addition to code for primary procedure)	BR	ZZZ	
■ 0515T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery])	BR	YYY	
■ 0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only	BR	YYY	
■ 0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; both components of pulse generator (battery and transmitter) only	BR	YYY	
■ 0518T	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; battery component only	BR	YYY	
■ 0519T	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; both components (battery and transmitter)	BR	YYY	
■ 0520T	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only	BR	YYY	
■ 0521T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording, and disconnection per patient encounter, wireless cardiac stimulator for left ventricular pacing	BR	XXX	49/51
■ 0522T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, wireless cardiac stimulator for left ventricular pacing	BR	XXX	59/41

CATEGORY III CODES

0042T-0866T

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
■ +	0523T	Intraprocedural coronary fractional flow reserve (FFR) with 3D functional mapping of color-coded FFR values for the coronary tree, derived from coronary angiogram data, for real-time review and interpretation of possible atherosclerotic stenosis(es) intervention (List separately in addition to code for primary procedure)	BR	ZZZ	
■	0524T	Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein, open or percutaneous, including all vascular access, catheter manipulation, diagnostic imaging, imaging guidance and monitoring	BR	YYY	
■	0525T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; complete system (electrode and implantable monitor)	BR	YYY	
■	0526T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; electrode only	BR	YYY	
■	0527T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; implantable monitor only	BR	YYY	
■	0528T	Programming device evaluation (in person) of intracardiac ischemia monitoring system with iterative adjustment of programmed values, with analysis, review, and report	BR	XXX	38/62
■	0529T	Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report	BR	XXX	38/62
■	0530T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; complete system (electrode and implantable monitor)	BR	YYY	
■	0531T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; electrode only	BR	YYY	
■	0532T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; implantable monitor only	BR	YYY	
■	0537T	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day	BR	XXX	
■	0538T	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (eg, cryopreservation, storage)	BR	XXX	
■	0539T	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration	BR	XXX	
■	0540T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous	BR	YYY	
■	0541T	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia, by signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles, machine learning-derived clinical scoring, and automated report generation, single study;	BR	XXX	
■	0542T	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia, by signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles, machine learning-derived clinical scoring, and automated report generation, single study; interpretation and report	BR	XXX	

0042T-0866T

Effective TBD

CATEGORY III CODES**Medical Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
■	0543T	Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae	BR	YYY	
■	0544T	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture	BR	YYY	
■	0545T	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach	BR	YYY	
■	0546T	Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report	BR	YYY	
■	0547T	Bone-material quality testing by microindentation(s) of the tibia(s), with results reported as a score	BR	XXX	
■	0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional	BR	YYY	
■	0553T	Percutaneous transcatheter placement of iliac arteriovenous anastomosis implant, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention	BR	YYY	
■	0554T	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data, assessment of bone strength and fracture risk and bone mineral density, interpretation and report	BR	XXX	
■	0555T	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data	BR	XXX	
■	0556T	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone mineral density	BR	XXX	
■	0557T	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; interpretation and report	BR	XXX	
■	0558T	Computed tomography scan taken for the purpose of biomechanical computed tomography analysis	BR	XXX	
■	0559T	Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure	BR	XXX	
■ +	0560T	Anatomic model 3D-printed from image data set(s); each additional individually prepared and processed component of an anatomic structure (List separately in addition to code for primary procedure)	BR	ZZZ	
■	0561T	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide	BR	XXX	
■ +	0562T	Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in addition to code for primary procedure)	BR	ZZZ	
■	0563T	Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral	BR	YYY	
■	0564T	Oncology, chemotherapeutic drug cytotoxicity assay of cancer stem cells (CSCs), from cultured CSCs and primary tumor cells, categorical drug response reported based on percent of cytotoxicity observed, a minimum of 14 drugs or drug combinations	BR	YYY	

CATEGORY III CODES

0042T-0866T

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
■	0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation	BR	YYY	
■	0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral	BR	YYY	
■	0567T	Permanent fallopian tube occlusion with degradable biopolymer implant, transcervical approach, including transvaginal ultrasound	BR	YYY	
■	0568T	Introduction of mixture of saline and air for sonosalpingography to confirm occlusion of fallopian tubes, transcervical approach, including transvaginal ultrasound and pelvic ultrasound	BR	YYY	
■	0569T	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis	BR	YYY	
■ +	0570T	Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (List separately in addition to code for primary procedure)	BR	ZZZ	
■	0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters), when performed	BR	YYY	
■	0572T	Insertion of substernal implantable defibrillator electrode	BR	YYY	
■	0573T	Removal of substernal implantable defibrillator electrode	BR	YYY	
■	0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode	BR	YYY	
■	0575T	Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional	BR	YYY	
■	0576T	Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter	BR	YYY	
	0577T	Electrophysiologic evaluation of implantable cardioverter-defibrillator system with substernal electrode (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	BR	YYY	
■	0578T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	BR	YYY	
■	0579T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	BR	YYY	
■	0580T	Removal of substernal implantable defibrillator pulse generator only	BR	YYY	
■	0581T	Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral	BR	YYY	

0042T-0866T

Effective TBD

CATEGORY III CODES**Medical Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
■	0582T	Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative imaging and needle guidance	BR	YYY	
■	0583T	Tympanostomy (requiring insertion of ventilating tube), using an automated tube delivery system, iontophoresis local anesthesia	BR	YYY	
■	0584T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; percutaneous	BR	YYY	
■	0585T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; laparoscopic	BR	YYY	
■	0586T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; open	BR	YYY	
■	0587T	Percutaneous implantation or replacement of integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve	BR	YYY	
■	0588T	Revision or removal of percutaneously placed integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve	BR	YYY	
■	0589T	Electronic analysis with simple programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 1-3 parameters	BR	YYY	
■	0590T	Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 4 or more parameters	BR	YYY	
■	0591T	Health and well-being coaching face-to-face; individual, initial assessment	BR	YYY	
	0592T	Health and well-being coaching face-to-face; individual, follow-up session, at least 30 minutes	BR	YYY	
■	0593T	Health and well-being coaching face-to-face; group (2 or more individuals), at least 30 minutes	BR	YYY	
■	0594T	Osteotomy, humerus, with insertion of an externally controlled intramedullary lengthening device, including intraoperative imaging, initial and subsequent alignment assessments, computations of adjustment schedules, and management of the intramedullary lengthening device	BR	YYY	
■	0596T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement	BR	YYY	
■	0597T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement	BR	YYY	

CATEGORY III CODES

0042T-0866T

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
■	0598T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; first anatomic site (eg, lower extremity)	BR	YYY	
■ +	0599T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; each additional anatomic site (eg, upper extremity) (List separately in addition to code for primary procedure)	BR	ZZZ	
■	0600T	Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous	BR	YYY	
■	0601T	Ablation, irreversible electroporation; 1 or more tumors, including fluoroscopic and ultrasound guidance, when performed, open	BR	YYY	
■	0602T	Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent	BR	YYY	
■	0603T	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours	BR	YYY	
■	0604T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center unilateral or bilateral; initial device provision, set-up and patient education on use of equipment	BR	YYY	
■	0605T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center unilateral or bilateral; remote surveillance center technical support, data analyses and reports, with a minimum of 8 daily recordings, each 30 days	BR	YYY	
■	0606T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center unilateral or bilateral; review, interpretation and report by the prescribing physician or other qualified health care professional of remote surveillance center data analyses, each 30 days	BR	YYY	
■	0607T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (eg, ECG data), transmitted to a remote 24-hour attended surveillance center; set-up and patient education on use of equipment	BR	YYY	
■	0608T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (eg, ECG data), transmitted to a remote 24-hour attended surveillance center; analysis of data received and transmission of reports to the physician or other qualified health care professional	BR	YYY	
■	0609T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); acquisition of single voxel data, per disc, on biomarkers (ie, lactic acid, carbohydrate, alanine, laal, propionic acid, proteoglycan, and collagen) in at least 3 discs	BR	YYY	
■	0610T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); transmission of biomarker data for software analysis	BR	YYY	
■	0611T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); postprocessing for algorithmic analysis of biomarker data for determination of relative chemical differences between discs	BR	YYY	

0042T-0866T

Effective TBD

CATEGORY III CODES**Medical Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
■	0612T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); interpretation and report	BR	YYY	
■	0613T	Percutaneous transcatheter implantation of interatrial septal shunt device, including right and left heart catheterization, intracardiac echocardiography, and imaging guidance by the proceduralist, when performed	BR	YYY	
■	0614T	Removal and replacement of substernal implantable defibrillator pulse generator	BR	YYY	
■	0615T	Eye-movement analysis without spatial calibration, with interpretation and report	BR	YYY	
■	0616T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; without removal of crystalline lens or intraocular lens, without insertion of intraocular lens	BR	YYY	
■	0617T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with removal of crystalline lens and insertion of intraocular lens	BR	YYY	
■	0618T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with secondary intraocular lens placement or intraocular lens exchange	BR	YYY	
■	0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed	BR	YYY	
■	0620T	Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed	BR	YYY	
■	0621T	Trabeculostomy ab interno by laser	BR	YYY	
■	0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope	BR	YYY	
■	0623T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission, computerized analysis of data, with review of computerized analysis output to reconcile discordant data, interpretation and report	BR	XXX	
■	0624T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission	BR	XXX	
■	0625T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography	BR	XXX	
■	0626T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; review of computerized analysis output to reconcile discordant data, interpretation and report	BR	XXX	
■	0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level	BR	YYY	
■ +	0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	BR	ZZZ	

CATEGORY III CODES

0042T-0866T

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
■	0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level	BR	YYY	
■ +	0630T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	BR	ZZZ	
■	0631T	Transcutaneous visible light hyperspectral imaging measurement of oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with interpretation and report, per extremity	BR	XXX	
■	0632T	Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	BR	YYY	
■	0633T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast material	BR	XXX	37/63
■	0634T	Computed tomography, breast, including 3D rendering, when performed, unilateral; with contrast material(s)	BR	XXX	32/68
■	0635T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast, followed by contrast material(s)	BR	XXX	29/71
■	0636T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast material(s)	BR	XXX	37/63
■	0637T	Computed tomography, breast, including 3D rendering, when performed, bilateral; with contrast material(s)	BR	XXX	32/68
■	0638T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast material(s)	BR	XXX	29/71
■	0639T	Wireless skin sensor thermal anisotropy measurement(s) and assessment of flow in cerebrospinal fluid shunt, including ultrasound guidance, when performed	BR	XXX	
■	0640T	Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; first anatomic site	BR	XXX	
■	0643T	Transcatheter left ventricular restoration device implantation including right and left heart catheterization and left ventriculography when performed, arterial approach	BR	YYY	
■	0644T	Transcatheter removal or debulking of intracardiac mass (eg, vegetations, thrombus) via suction (eg, vacuum, aspiration) device, percutaneous approach, with intraoperative reinfusion of aspirated blood, including imaging guidance, when performed	BR	YYY	
■	0645T	Transcatheter implantation of coronary sinus reduction device including vascular access and closure, right heart catheterization, venous angiography, coronary sinus angiography, imaging guidance, and supervision and interpretation, when performed	BR	YYY	
■	0646T	Transcatheter tricuspid valve implantation (TTVI)/replacement with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed	BR	YYY	
■	0647T	Insertion of gastrostomy tube, percutaneous, with magnetic gastropexy, under ultrasound guidance, image documentation and report	BR	YYY	

0042T-0866T

Effective TBD

CATEGORY III CODES**Medical Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
■	0648T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; single organ	BR	XXX	70/30
■ +	0649T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure); single organ (List separately in addition to code for primary procedure)	BR	ZZZ	70/30
■	0650T	Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis, review and report by a physician or other qualified health care professional	BR	XXX	65/35
■	0651T	Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report	BR	XXX	
■	0652T	Esophagogastroduodenoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	BR	YYY	
■	0653T	Esophagogastroduodenoscopy, flexible, transnasal; with biopsy, single or multiple	BR	YYY	
■	0654T	Esophagogastroduodenoscopy, flexible, transnasal; with insertion of intraluminal tube or catheter	BR	YYY	
■	0655T	Transperineal focal laser ablation of malignant prostate tissue, including transrectal imaging guidance, with MR-fused images or other enhanced ultrasound imaging	BR	YYY	
■	0656T	Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments	BR	YYY	
■	0657T	Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more vertebral segments	BR	YYY	
■	0658T	Electrical impedance spectroscopy of 1 or more skin lesions for automated melanoma risk score	BR	XXX	
■	0659T	Transcatheter intracoronary infusion of supersaturated oxygen in conjunction with percutaneous coronary revascularization during acute myocardial infarction, including catheter placement, imaging guidance (eg, fluoroscopy), angiography, and radiologic supervision and interpretation	BR	YYY	
■	0660T	Implantation of anterior segment intraocular nonbiodegradable drug-eluting system, internal approach	BR	YYY	
■	0661T	Removal and reimplantation of anterior segment intraocular nonbiodegradable drug-eluting implant	BR	YYY	
■	0662T	Scalp cooling, mechanical; initial measurement and calibration of cap	BR	XXX	
■ +	0663T	Scalp cooling, mechanical; placement of device, monitoring, and removal of device (List separately in addition to code for primary procedure)	BR	ZZZ	
■	0664T	Donor hysterectomy (including cold preservation); open, from cadaver donor	BR	XXX	
■	0665T	Donor hysterectomy (including cold preservation); open, from living donor	BR	XXX	
■	0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor	BR	XXX	

CATEGORY III CODES

0042T-0866T

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
■	0667T	Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor	BR	XXX	
■	0668T	Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation, including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies), as necessary	BR	YYY	
■	0669T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each	BR	YYY	
■	0670T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each	BR	YYY	
■	0671T	Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more	BR	YYY	
■	0672T	Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the tissues surrounding the female bladder neck and proximal urethra for urinary incontinence	BR	YYY	
■	0673T	Ablation, benign thyroid nodule(s), percutaneous, laser, including imaging guidance	BR	YYY	
■	0674T	Laparoscopic insertion of new or replacement of permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including an implantable pulse generator and diaphragmatic lead(s)	BR	YYY	
■	0675T	Laparoscopic insertion of new or replacement of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; first lead	BR	YYY	
■ +	0676T	Laparoscopic insertion of new or replacement of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; each additional lead (List separately in addition to code for primary procedure)	BR	ZZZ	
■	0677T	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; first repositioned lead	BR	YYY	
■ +	0678T	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; each additional repositioned lead (List separately in addition to code for primary procedure)	BR	ZZZ	
■	0679T	Laparoscopic removal of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	BR	YYY	
■	0680T	Insertion or replacement of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, with connection to existing lead(s)	BR	YYY	
■	0681T	Relocation of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, with connection to existing dual leads	BR	YYY	
■	0682T	Removal of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	BR	YYY	

0042T-0866T

Effective TBD

CATEGORY III CODES**Medical Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
■	0683T	Programming device evaluation (in-person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	BR	XXX	
■	0684T	Peri-procedural device evaluation (in-person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review, and report by a physician or other qualified health care professional, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	BR	XXX	
■	0685T	Interrogation device evaluation (in-person) with analysis, review and report by a physician or other qualified health care professional, including connection, recording and disconnection per patient encounter, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	BR	XXX	
■	0686T	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance	BR	YYY	
■	0687T	Treatment of amblyopia using an online digital program; device supply, educational set-up, and initial session	BR	XXX	
■	0688T	Treatment of amblyopia using an online digital program; assessment of patient performance and program data by physician or other qualified health care professional, with report, per calendar month	BR	XXX	
■	0689T	Quantitative ultrasound tissue characterization (non-elastographic), including interpretation and report, obtained without diagnostic ultrasound examination of the same anatomy (eg, organ, gland, tissue, target structure)	BR	XXX	
■ +	0690T	Quantitative ultrasound tissue characterization (non-elastographic), including interpretation and report, obtained with diagnostic ultrasound examination of the same anatomy (eg, organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)	BR	ZZZ	30/70
■	0691T	Automated analysis of an existing computed tomography study for vertebral fracture(s), including assessment of bone density when performed, data preparation, interpretation, and report	BR	XXX	0/100
■	0692T	Therapeutic ultrafiltration	BR	YYY	
■	0693T	Comprehensive full body computer-based markerless 3D kinematic and kinetic motion analysis and report	BR	XXX	
■	0694T	3-dimensional volumetric imaging and reconstruction of breast or axillary lymph node tissue, each excised specimen, 3-dimensional automatic specimen reorientation, interpretation and report, real-time intraoperative	BR	XXX	20/80
■	0695T	Body surface-activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to optimize electrical synchrony, cardiac resynchronization therapy device, including connection, recording, disconnection, review, and report; at time of implant or replacement	BR	XXX	
■	0696T	Body surface-activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to optimize electrical synchrony, cardiac resynchronization therapy device, including connection, recording, disconnection, review, and report; at time of follow-up interrogation or programming device evaluation	BR	XXX	

CATEGORY III CODES

0042T-0866T

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
■	0697T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; multiple organs	BR	XXX	
■ +	0698T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure); multiple organs (List separately in addition to code for primary procedure)	BR	ZZZ	70/30
■	0699T	Injection, posterior chamber of eye, medication	BR	YYY	
■	0700T	Molecular fluorescent imaging of suspicious nevus; first lesion	BR	XXX	25/75
■ +	0701T	Molecular fluorescent imaging of suspicious nevus; each additional lesion (List separately in addition to code for primary procedure)	BR	ZZZ	27/73
■	0704T	Remote treatment of amblyopia using an eye tracking device; device supply with initial set-up and patient education on use of equipment	BR	XXX	
■	0705T	Remote treatment of amblyopia using an eye tracking device; surveillance center technical support including data transmission with analysis, with a minimum of 18 training hours, each 30 days	BR	XXX	
■	0706T	Remote treatment of amblyopia using an eye tracking device; interpretation and report by physician or other qualified health care professional, per calendar month	BR	XXX	
■	0707T	Injection(s), bone substitute material (eg, calcium phosphate) into subchondral bone defect (ie, bone marrow lesion, bone bruise, stress injury, microtrabecular fracture), including imaging guidance and arthroscopic assistance for joint visualization	BR	YYY	
■	0708T	Intradermal cancer immunotherapy; preparation and initial injection	BR	XXX	
■ +	0709T	Intradermal cancer immunotherapy; each additional injection (List separately in addition to code for primary procedure)	BR	ZZZ	
■	0710T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; including data preparation and transmission, quantification of the structure and composition of the vessel wall and assessment for lipid-rich necrotic core plaque to assess atherosclerotic plaque stability, data review, interpretation and report	BR	XXX	
■	0711T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; data preparation and transmission	BR	XXX	
■	0712T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; quantification of the structure and composition of the vessel wall and assessment for lipid-rich necrotic core plaque to assess atherosclerotic plaque stability	BR	XXX	
■	0713T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; data review, interpretation and report	BR	XXX	
■	0714T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance	BR	YYY	
■	0716T	Cardiac acoustic waveform recording with automated analysis and generation of coronary artery disease risk score	BR	XXX	

0042T-0866T

Effective TBD

CATEGORY III CODES**Medical Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
■	0717T	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; adipose tissue harvesting, isolation and preparation of harvested cells, including incubation with cell dissociation enzymes, filtration, washing and concentration of ADRCs	BR	YYY	
■	0718T	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; injection into supraspinatus tendon including ultrasound guidance, unilateral	BR	YYY	
■	0719T	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment	BR	YYY	
■	0720T	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation	BR	XXX	
■	0721T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	BR	XXX	
■ +	0722T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset (List separately in addition to code for primary procedure)	BR	ZZZ	
■	0723T	Quantitative magnetic resonance cholangiopancreatography (QMRC) including data preparation and transmission, interpretation and report, obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session	BR	XXX	
■ +	0724T	Quantitative magnetic resonance cholangiopancreatography (QMRC) including data preparation and transmission, interpretation and report, obtained with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)	BR	ZZZ	
■	0725T	Vestibular device implantation, unilateral	BR	YYY	
■	0726T	Removal of implanted vestibular device, unilateral	BR	YYY	
■	0727T	Removal and replacement of implanted vestibular device, unilateral	BR	YYY	
■	0728T	Diagnostic analysis of vestibular implant, unilateral; with initial programming	BR	XXX	
■	0729T	Diagnostic analysis of vestibular implant, unilateral; with subsequent programming	BR	XXX	
■	0730T	Trabeculotomy by laser, including optical coherence tomography (OCT) guidance	BR	YYY	
■	0731T	Augmentative AI-based facial phenotype analysis with report	BR	XXX	
■	0732T	Immunotherapy administration with electroporation, intramuscular	BR	XXX	
■	0733T	Remote real-time, motion capture-based neurorehabilitative therapy ordered by a physician or other qualified health care professional; supply and technical support, per 30 days	BR	XXX	
■	0734T	Remote real-time, motion capture-based neurorehabilitative therapy ordered by a physician or other qualified health care professional; treatment management services by a physician or other qualified health care professional, per calendar month	BR	XXX	
■ +	0735T	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with primary craniotomy (List separately in addition to code for primary procedure)	BR	ZZZ	

CATEGORY III CODES

0042T-0866T

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
■	0736T	Colonic lavage, 35 or more liters of water, gravity-fed, with induced defecation, including insertion of rectal catheter	BR	XXX	
■	0737T	Xenograft implantation into the articular surface	BR	YYY	
■	0738T	Treatment planning for magnetic field induction ablation of malignant prostate tissue, using data from previously performed magnetic resonance imaging (MRI) examination	BR	XXX	
■	0739T	Ablation of malignant prostate tissue by magnetic field induction, including all intraprocedural, transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring, thermal dosimetry, bladder irrigation, and magnetic field nanoparticle activation	BR	YYY	
■	0740T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education	BR	XXX	
■	0741T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; provision of software, data collection, transmission, and storage, each 30 days	BR	XXX	
■ +	0742T	Absolute quantitation of myocardial blood flow (AQMBF), single-photon emission computed tomography (SPECT), with exercise or pharmacologic stress, and at rest, when performed (List separately in addition to code for primary procedure)	BR	ZZZ	20/80
■	0743T	Bone strength and fracture risk using finite element analysis of functional data and bone mineral density (BMD), with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and BMD and classification of any vertebral fractures, with overall fracture-risk assessment, interpretation and report	BR	XXX	
■	0744T	Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium), when performed	BR	YYY	
■	0745T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization and mapping of arrhythmia site (nidus), derived from anatomical image data (eg, CT, MRI, or myocardial perfusion scan) and electrical data (eg, 12-lead ECG data), and identification of areas of avoidance	BR	YYY	
■	0746T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan	BR	XXX	
■	0747T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy, arrhythmia	BR	XXX	
■	0748T	Injections of stem cell product into perianal perifistular soft tissue, including fistula preparation (eg, removal of setons, fistula curettage, closure of internal openings)	BR	YYY	
■	0749T	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone strength and fracture risk and BMD, interpretation and report;	BR	XXX	
■	0750T	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone strength and fracture risk and BMD, interpretation and report; with single-view digital X-ray examination of the hand taken for the purpose of DXR-BMD	BR	XXX	

0042T-0866T

Effective TBD

CATEGORY III CODES**Medical Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
■ +	0751T	Digitization of glass microscope slides for level II, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0752T	Digitization of glass microscope slides for level III, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0753T	Digitization of glass microscope slides for level IV, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0754T	Digitization of glass microscope slides for level V, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0755T	Digitization of glass microscope slides for level VI, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0756T	Digitization of glass microscope slides for special stain, including interpretation and report, group I, for microorganisms (eg, acid fast, methenamine silver) (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0757T	Digitization of glass microscope slides for special stain, including interpretation and report, group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0758T	Digitization of glass microscope slides for special stain, including interpretation and report, histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0759T	Digitization of glass microscope slides for special stain, including interpretation and report, group III, for enzyme constituents (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0760T	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, initial single antibody stain procedure (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0761T	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, each additional single antibody stain procedure (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0762T	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, each multiplex antibody stain procedure (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0763T	Digitization of glass microscope slides for morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure, manual (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0764T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to concurrently performed electrocardiogram (List separately in addition to code for primary procedure)	BR	ZZZ	
■	0765T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to previously performed electrocardiogram	BR	XXX	

CATEGORY III CODES

0042T-0866T

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
■	0766T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve	BR	XXX	
■ +	0767T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0770T	Virtual reality technology to assist therapy (List separately in addition to code for primary procedure)	BR	ZZZ	
■	0771T	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older	BR	XXX	
■ +	0772T	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	BR	ZZZ	
■	0773T	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time, patient age 5 years or older	BR	XXX	
■ +	0774T	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	BR	ZZZ	
■	0776T	Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (eg, vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment	BR	XXX	
■ +	0777T	Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure)	BR	ZZZ	39/61
■	0778T	Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function	BR	XXX	
■	0779T	Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report	BR	XXX	65/35
■	0780T	Instillation of fecal microbiota suspension via rectal enema into lower gastrointestinal tract	BR	000	
■	0781T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi	BR	YYY	

0042T-0866T

Effective TBD

CATEGORY III CODES**Medical Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
■	0782T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; unilateral mainstem bronchus	BR	YYY	
■	0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment	BR	XXX	
■	0784T	Insertion or replacement of percutaneous electrode array, spinal, with integrated neurostimulator, including imaging guidance, when performed	BR	YYY	
■	0785T	Revision or removal of neurostimulator electrode array, spinal, with integrated neurostimulator	BR	YYY	
■	0786T	Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed	BR	YYY	
■	0787T	Revision or removal of neurostimulator electrode array, sacral, with integrated neurostimulator	BR	YYY	
■	0788T	Electronic analysis with simple programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 1-3 parameters	BR	XXX	
■	0789T	Electronic analysis with complex programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 4 or more parameters	BR	XXX	
■	0790T	Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed	BR	YYY	
■ +	0791T	Motor-cognitive, semi-immersive virtual reality-facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)	BR	ZZZ	
■	0792T	Application of silver diamine fluoride 38%, by a physician or other qualified health care professional	BR	XXX	
■	0793T	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	BR	YYY	
■	0794T	Patient-specific, assistive, rules-based algorithm for ranking pharmacologic treatment options based on the patient's tumor-specific cancer marker information obtained from prior molecular pathology, immunohistochemical, or other pathology results which have been previously interpreted and reported separately	BR	XXX	
■	0795T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; complete system (ie, right atrial and right ventricular pacemaker components)	BR	YYY	

CATEGORY III CODES

0042T-0866T

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
■	0796T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)	BR	YYY	
■	0797T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	BR	YYY	
■	0798T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (ie, right atrial and right ventricular pacemaker components)	BR	YYY	
■	0799T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right atrial pacemaker component	BR	YYY	
■	0800T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	BR	YYY	
■	0801T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; dual-chamber system (ie, right atrial and right ventricular pacemaker components)	BR	YYY	
■	0802T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component	BR	YYY	
■	0803T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	BR	YYY	
■	0804T	Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers	BR	XXX	
■	0805T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); percutaneous femoral vein approach	BR	YYY	
■	0806T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); open femoral vein approach	BR	YYY	

0042T-0866T

Effective TBD

CATEGORY III CODES**Medical Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
■	0807T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report	BR	XXX	35/65
■	0808T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with computed tomography (CT) images taken for the purpose of pulmonary tissue ventilation analysis, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report	BR	XXX	35/65
■	0810T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies	BR	YYY	
■	0811T	Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); set-up and patient education on use of equipment	BR	XXX	
■	0812T	Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); device supply with automated report generation, up to 10 days	BR	XXX	
■	0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon	BR	YYY	
■	0814T	Percutaneous injection of calcium-based biodegradable osteoconductive material, proximal femur, including imaging guidance, unilateral	BR	YYY	
■	0815T	Ultrasound-based radiofrequency echographic multi-spectrometry (REMS), bone-density study and fracture-risk assessment, 1 or more sites, hips, pelvis, or spine	BR	XXX	
■	0816T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous	BR	YYY	
■	0817T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subfascial	BR	YYY	
■	0818T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous	BR	YYY	
■	0819T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subfascial	BR	YYY	
■	0820T	Continuous in-person monitoring and intervention (eg, psychotherapy, crisis intervention), as needed, during psychedelic medication therapy; first physician or other qualified health care professional, each hour	BR	XXX	
■ +	0821T	Continuous in-person monitoring and intervention (eg, psychotherapy, crisis intervention), as needed, during psychedelic medication therapy; second physician or other qualified health care professional, concurrent with first physician or other qualified health care professional, each hour (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0822T	Continuous in-person monitoring and intervention (eg, psychotherapy, crisis intervention), as needed, during psychedelic medication therapy; clinical staff under the direction of a physician or other qualified health care professional, concurrent with first physician or other qualified health care professional, each hour (List separately in addition to code for primary procedure)	BR	ZZZ	

CATEGORY III CODES

0042T-0866T

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
■	0823T	Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed	BR	YYY	
■	0824T	Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed	BR	YYY	
■	0825T	Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed	BR	YYY	
■	0826T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, leadless pacemaker system in single-cardiac chamber	BR	XXX	
■ +	0827T	Digitization of glass microscope slides for cytopathology, fluids, washings, or brushings, except cervical or vaginal; smears with interpretation (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0828T	Digitization of glass microscope slides for cytopathology, fluids, washings, or brushings, except cervical or vaginal; simple filter method with interpretation (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0829T	Digitization of glass microscope slides for cytopathology, concentration technique, smears, and interpretation (eg, Saccomanno technique) (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0830T	Digitization of glass microscope slides for cytopathology, selective-cellular enhancement technique with interpretation (eg, liquid-based slide preparation method), except cervical or vaginal (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0831T	Digitization of glass microscope slides for cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0832T	Digitization of glass microscope slides for cytopathology, smears, any other source; screening and interpretation (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0833T	Digitization of glass microscope slides for cytopathology, smears, any other source; preparation, screening and interpretation (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0834T	Digitization of glass microscope slides for cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0835T	Digitization of glass microscope slides for cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site (List separately in addition to code for primary procedure)	BR	ZZZ	

0042T-0866T

Effective TBD

CATEGORY III CODES**Medical Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
■ +	0836T	Digitization of glass microscope slides for cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0837T	Digitization of glass microscope slides for cytopathology, evaluation of fine needle aspirate; interpretation and report (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0838T	Digitization of glass microscope slides for consultation and report on referred slides prepared elsewhere (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0839T	Digitization of glass microscope slides for consultation and report on referred material requiring preparation of slides (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0840T	Digitization of glass microscope slides for consultation, comprehensive, with review of records and specimens, with report on referred material (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0841T	Digitization of glass microscope slides for pathology consultation during surgery; first tissue block, with frozen section(s), single specimen (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0842T	Digitization of glass microscope slides for pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0843T	Digitization of glass microscope slides for pathology consultation during surgery; cytologic examination (eg, touch preparation, squash preparation), initial site (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0844T	Digitization of glass microscope slides for pathology consultation during surgery; cytologic examination (eg, touch preparation, squash preparation), each additional site (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0845T	Digitization of glass microscope slides for immunofluorescence, per specimen; initial single antibody stain procedure (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0846T	Digitization of glass microscope slides for immunofluorescence, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0847T	Digitization of glass microscope slides for examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis) (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0848T	Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; initial single probe stain procedure (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0849T	Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0850T	Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure (List separately in addition to code for primary procedure)	BR	ZZZ	

CATEGORY III CODES

0042T-0866T

Medical Fee Schedule

Effective TBD

	Code	Description	Relative Value	FUD	PC/TC Split
■ +	0851T	Digitization of glass microscope slides for morphometric analysis, in situ hybridization (quantitative or semiquantitative), manual, per specimen; initial single probe stain procedure (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0852T	Digitization of glass microscope slides for morphometric analysis, in situ hybridization (quantitative or semiquantitative), manual, per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0853T	Digitization of glass microscope slides for morphometric analysis, in situ hybridization (quantitative or semiquantitative), manual, per specimen; each multiplex probe stain procedure (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0854T	Digitization of glass microscope slides for blood smear, peripheral, interpretation by physician with written report (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0855T	Digitization of glass microscope slides for bone marrow, smear interpretation (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0856T	Digitization of glass microscope slides for electron microscopy, diagnostic (List separately in addition to code for primary procedure)	BR	ZZZ	
■ +	0857T	Opto-acoustic imaging, breast, unilateral, including axilla when performed, real-time with image documentation, augmentative analysis and report (List separately in addition to code for primary procedure)	BR	ZZZ	34/66
■	0858T	Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report	BR	XXX	
■ +	0859T	Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; each additional anatomic site (List separately in addition to code for primary procedure)	BR	ZZZ	
■	0860T	Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), for screening for peripheral arterial disease, including provocative maneuvers, image acquisition, interpretation, and report, one or both lower extremities	BR	XXX	
■	0861T	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter)	BR	YYY	
■	0862T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only	BR	YYY	
■	0863T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only	BR	YYY	
■	0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy	BR	XXX	
■	0865T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion identification, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the brain during the same session	BR	XXX	

0042T-0866T

Effective TBD

CATEGORY III CODES**Medical Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
■ +	0866T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion detection, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the brain (List separately in addition to code for primary procedure)	BR	ZZZ	

Appendix

NEW CPT CODES

The table below is a complete list of CPT codes that have been added since the 2018/2020 fee schedules.

These codes are identified in the fee schedule with “■.”

01937	01938	01939	01940	01941	01942
0505T	0506T	0507T	0509T	0510T	0511T
0512T	0513T	0515T	0516T	0517T	0518T
0519T	0520T	0521T	0522T	0523T	0524T
0525T	0526T	0527T	0528T	0529T	0530T
0531T	0532T	0537T	0538T	0539T	0540T
0541T	0542T	0543T	0544T	0545T	0546T
0547T	0552T	0553T	0554T	0555T	0556T
0557T	0558T	0559T	0560T	0561T	0562T
0563T	0564T	0565T	0566T	0567T	0568T
0569T	0570T	0571T	0572T	0573T	0574T
0575T	0576T	0577T	0578T	0579T	0580T
0581T	0582T	0583T	0584T	0585T	0586T
0587T	0588T	0589T	0590T	0591T	0592T
0593T	0594T	0596T	0597T	0598T	0599T
0600T	0601T	0602T	0603T	0604T	0605T
0606T	0607T	0608T	0609T	0610T	0611T
0612T	0613T	0614T	0615T	0616T	0617T
0618T	0619T	0620T	0621T	0622T	0623T
0624T	0625T	0626T	0627T	0628T	0629T
0630T	0631T	0632T	0633T	0634T	0635T
0636T	0637T	0638T	0639T	0640T	0643T
0644T	0645T	0646T	0647T	0648T	0649T
0650T	0651T	0652T	0653T	0654T	0655T
0656T	0657T	0658T	0659T	0660T	0661T
0662T	0663T	0664T	0665T	0666T	0667T
0668T	0669T	0670T	0671T	0672T	0673T
0674T	0675T	0676T	0677T	0678T	0679T
0680T	0681T	0682T	0683T	0684T	0685T
0686T	0687T	0688T	0689T	0690T	0691T
0692T	0693T	0694T	0695T	0696T	0697T
0698T	0699T	0700T	0701T	0704T	0705T
0706T	0707T	0708T	0709T	0710T	0711T
0712T	0713T	0714T	0716T	0717T	0718T
0719T	0720T	0721T	0722T	0723T	0724T
0725T	0726T	0727T	0728T	0729T	0730T
0731T	0732T	0733T	0734T	0735T	0736T
0737T	0738T	0739T	0740T	0741T	0742T
0743T	0744T	0745T	0746T	0747T	0748T

0749T	0750T	0751T	0752T	0753T	0754T
0755T	0756T	0757T	0758T	0759T	0760T
0761T	0762T	0763T	0764T	0765T	0766T
0767T	0770T	0771T	0772T	0773T	0774T
0776T	0777T	0778T	0779T	0780T	0781T
0782T	0783T	0784T	0785T	0786T	0787T
0788T	0789T	0790T	0791T	0792T	0793T
0794T	0795T	0796T	0797T	0798T	0799T
0800T	0801T	0802T	0803T	0804T	0805T
0806T	0807T	0808T	0810T	0811T	0812T
0813T	0814T	0815T	0816T	0817T	0818T
0819T	0820T	0821T	0822T	0823T	0824T
0825T	0826T	0827T	0828T	0829T	0830T
0831T	0832T	0833T	0834T	0835T	0836T
0837T	0838T	0839T	0840T	0841T	0842T
0843T	0844T	0845T	0846T	0847T	0848T
0849T	0850T	0851T	0852T	0853T	0854T
0855T	0856T	0857T	0858T	0859T	0860T
0861T	0862T	0863T	0864T	0865T	0866T
10004	10005	10006	10007	10008	10009
10010	10011	10012	11102	11103	11104
11105	11106	11107	15769	15771	15772
15773	15774	15778	15853	15854	20560
20561	20700	20701	20702	20703	20704
20705	20932	20933	20934	21601	21602
21603	22836	22837	22838	22860	27278
27369	30468	30469	31242	31243	32408
33016	33017	33018	33019	33267	33268
33269	33274	33275	33276	33277	33278
33279	33280	33281	33285	33286	33287
33288	33289	33370	33440	33509	33741
33745	33746	33858	33859	33866	33871
33894	33895	33897	33900	33901	33902
33903	33904	33995	33997	34717	34718
35702	35703	36573	36836	36837	38531
42975	43290	43291	43497	43762	43763
46948	49013	49014	49591	49592	49593
49594	49595	49596	49613	49614	49615
49616	49617	49618	49621	49622	49623
50436	50437	52284	53451	53452	53453
53454	53854	55867	55880	57465	58580
61736	61737	61889	61891	61892	62328
62329	63052	63053	64451	64454	64582
64583	64584	64596	64597	64598	64624
64625	64628	64629	66987	66988	66989

66991	67516	68841	69705	69706	69716
69719	69726	69727	69728	69729	69730
71271	74221	74248	75580	76145	76391
76981	76982	76983	76984	76987	76988
76989	77046	77047	77048	77049	78429
78430	78431	78432	78433	78434	78830
78831	78832	78835	80143	80145	80151
80161	80167	80179	80181	80187	80189
80193	80204	80210	80220	80230	80235
80280	80285	80503	80504	80505	80506
81163	81164	81165	81166	81167	81168
81171	81172	81173	81174	81177	81178
81179	81180	81181	81182	81183	81184
81185	81186	81187	81188	81189	81190
81191	81192	81193	81194	81204	81233
81234	81236	81237	81239	81271	81274
81277	81278	81279	81284	81285	81286
81289	81305	81306	81307	81308	81309
81312	81320	81329	81333	81336	81337
81338	81339	81343	81344	81345	81347
81348	81349	81351	81352	81353	81357
81360	81418	81419	81441	81443	81449
81451	81456	81457	81458	81459	81462
81463	81464	81513	81514	81517	81518
81522	81523	81529	81542	81546	81552
81554	81560	81596	82077	82166	82642
82653	82681	83521	83529	83722	84433
86015	86036	86037	86041	86042	86043
86051	86052	86053	86231	86258	86328
86362	86363	86364	86366	86381	86408
86409	86413	86596	86769	87154	87426
87428	87467	87468	87469	87478	87484
87523	87563	87593	87636	87637	87811
87913	90377	90380	90381	90584	90589
90611	90619	90622	90623	90626	90627
90671	90677	90678	90679	90683	90689
90694	90758	90759	90912	90913	91113
91304	92201	92202	92229	92273	92274
92517	92518	92519	92549	92622	92623
92650	92651	92652	92653	92972	93150
93151	93152	93153	93241	93242	93243
93244	93245	93246	93247	93248	93264
93319	93356	93569	93573	93574	93575
93584	93585	93586	93587	93588	93593
93594	93595	93596	93597	93598	93985
93986	94619	95700	95705	95706	95707
95708	95709	95710	95711	95712	95713
95714	95715	95716	95717	95718	95719
95720	95721	95722	95723	95724	95725
95726	95836	95976	95977	95983	95984
96547	96548	97037	99417	99418	99459

CHANGED CODES

Changed Values

The following table is a complete list of CPT and state-specific codes that have a relative value change, an FUD change, a PC/TC split change, an Add-on change, or modifier 51 exempt change since the 2018/2020 Fee Schedules. Codes that have had a description change, are listed in a separate table below.

Columns that are blank for any code either do not apply to the code or the code was not assigned a value on the current or previous (2018/2020) fee schedules.

For each code listed, the following information is included:

NY 2024 RVU. This is the current RVU for services rendered on or after TBD.

NY 2018/2020 RVU. This is the RVU effective in the 2018/2020 fee schedules.

NY 2024 FUD. This is the FUD for services rendered on or after TBD.

NY 2018/2020 FUD. This is the FUD listed in the 2018/2020 fee schedules.

NY 2024 PC/TC Split. This is the PC/TC split for services rendered on or after TBD. Only codes with distinct professional and technical components are assigned a PC/TC split; therefore, many codes will not have a value in this column.

NY 2018/2020 PC/TC Split. This is the PC/TC split effective in the 2018/2020 fee schedules.

NY 2024 Add-On. This is the Add-on status for services rendered on or after TBD.

NY 2018/2020 Add-On. This is the Add-on status in the 2018/2020 fee schedules.

NY 2024 Mod51 Exempt. This is the modifier 51 exempt status for services rendered on or after TBD.

NY 2018/2020 Mod51 Exempt. This is the modifier 51 exempt status in the 2018/2020 fee schedules.

These codes are identified in the fee schedule with “■.”

CODE	NY 2018/ 2020 RVU	NY 2024 RVU	NY 2018/ 2020 FUD	NY 2024 FUD	NY 2018/ 2020 PC/ TC Split	NY 2024 PC/ TC Split	NY 2018/ 2020 Add- On	NY 2024 Add- On	NY 2018/ 2020 Mod51 Exempt	NY 2024 Mod51
0275T	BR	BR	XXX	YYY						
0446T	BR	BR	YYY	000						
0447T	BR	BR	YYY	000						
0448T	BR	BR	YYY	000						
11981	0.74	0.74	XXX	000						
11982	0.74	0.74	XXX	000						
11983	0.81	0.81	XXX	000						
17004	1.08	1.08	010	010					⊖	
21315	0.79	0.79	010	000						
21320	1.98	1.98	010	000						
28001	3.23	3.23	010	000						
28002	3.67	3.67	010	000						
28003	3.67	3.67	090	000						
28820	3.67	3.67	090	000						
28825	3.23	3.23	090	000						
31500	0.94	0.94	000	000					⊖	
33990	4.16	4.16	XXX	000						
33991	6.13	6.13	XXX	000						
33992	1.95	1.95	XXX	000						
33993	1.71	1.71	XXX	000						
35600	5.06	5.06	ZZZ	ZZZ			+			⊖
36620	0.80	0.80	000	000					⊖	
37765	4.21	4.21	090	010						
37766	5.15	5.15	090	010						
46020	0.58	0.58	010	000						
46030	0.58	0.58	010	000						
49422	3.50	3.50	010	000						
64421	1.14	0.25	000	ZZZ			+			
67141	4.96	4.96	090	010						
67145	5.15	5.15	090	010						
76882	1.28	1.28	XXX	XXX	69/31	51/49				
92548	16.91	16.91	XXX	XXX	24/76	70/30				
93451	93.01	93.01	000	000	18/82	18/82			⊖	
93456	133.59	133.59	000	000	29/71	29/71			⊖	
93503	57.83	57.83	000	000					⊖	
93631	152.45	152.45	000	000	55/45	55/45			⊖	
96040	9.67	NC	XXX	XXX						
97161	9.47	9.47	XXX	XXX						(51)
97162	9.47	9.47	XXX	XXX						(51)
97163	9.47	9.47	XXX	XXX						(51)
97164	4.00	4.00	XXX	XXX						(51)

CODE	NY 2018/ 2020 RVU	NY 2024 RVU	NY 2018/ 2020 FUD	NY 2024 FUD	NY 2018/ 2020 PC/ TC Split	NY 2024 PC/ TC Split	NY 2018/ 2020 Add- On	NY 2024 Add- On	NY 2018/ 2020 Mod51 Exempt	NY 2024 Mod51
97165	9.47	9.47	XXX	XXX						(51)
97166	9.47	9.47	XXX	XXX						(51)
97167	9.47	9.47	XXX	XXX						(51)
97168	4.00	4.00	XXX	XXX						(51)
97169	10.6	10.6	XXX	XXX						(51)
97170	10.6	10.6	XXX	XXX						(51)
97171	10.6	10.6	XXX	XXX						(51)
97172	5.20	5.20	XXX	XXX						(51)
99080	NC	BR	XXX	XXX						
99202	7.27	7.75	XXX	XXX						
99203	9.47	11.97	XXX	XXX						
99204	13.53	17.92	XXX	XXX						
99205	18.26	23.63	XXX	XXX						
99211	3.21	2.50	XXX	XXX						
99212	4.57	6.07	XXX	XXX						
99213	5.83	9.74	XXX	XXX						
99214	8.46	13.72	XXX	XXX						
99215	13.53	19.32	XXX	XXX						

CHANGED DESCRIPTIONS

The table below is a complete list of CPT codes that have had a description change since the 2018/2020 fee schedules.

0101T	0102T	0335T	0362T	0373T	0402T
10021	11970	11971	11981	15851	19318
19325	19328	19330	19340	19342	19357
19361	19364	19367	19368	19369	19370
19371	19380	21315	21320	22600	22610
22612	22614	22630	22632	22633	22634
22857	27280	28292	28295	28296	28297
28298	28299	29822	29823	31233	31235
31292	31293	31294	31295	31296	31297
31298	33471	33990	33991	33992	33993
35600	35701	35883	36568	36569	36584
46945	46946	50080	50081	54340	54344
54348	54352	54640	61641	61642	62270
62272	63048	63197	63685	63688	64400
64405	64408	64415	64416	64417	64418
64420	64421	64425	64430	64435	64445
64446	64447	64448	64449	64450	64455
64479	64480	64483	64484	64568	64575
64580	64581	64590	64595	66174	66175
66711	66982	66984	67141	67145	69714
69717	70250	71250	71260	71270	74022

74210	74220	74230	74240	74246	74250
74251	74270	74280	74425	74485	75573
76513	76882	77021	77022	77061	77062
77387	77402	77407	78130	78459	78491
78492	78800	78801	78802	78803	78804
80415	81162	81212	81215	81216	81217
81228	81229	81243	81244	81287	81327
81350	81400	81401	81402	81403	81404
81405	81406	81407	81408	81445	81450
81455	82075	82656	82670	86318	87301
87305	87320	87324	87327	87328	87329
87332	87335	87336	87337	87338	87339
87340	87341	87350	87380	87385	87389
87390	87391	87400	87420	87425	87427
87430	87449	87451	87802	87803	87804
87806	87807	87808	87809	87810	87850
87880	87899	90734	90739	92065	92227
92228	92284	92548	92626	92627	93279
93285	93286	93288	93290	93291	93294
93296	93297	93298	93568	93653	93654
93656	93784	93786	93788	93790	94617
94728	95070	95813	95970	95971	95972
96446	96920	96921	96922	99091	99202
99203	99204	99205	99211	99212	99213
99214	99215	99221	99222	99223	99231
99232	99233	99234	99235	99236	99238
99239	99242	99243	99244	99245	99252
99253	99254	99255	99281	99282	99283
99284	99285	99304	99305	99306	99307
99308	99309	99310	99315	99316	99341
99342	99344	99345	99347	99348	99349
99350	99415	99416	99446	99447	99448
99449	99483	99484	99487	99489	99490
99492	99493	99495	99496		

DELETED CPT CODES

The table below is a complete list of CPT codes that have been deleted since the 2018/2020 fee schedule.

0058T	0085T	0111T	0126T	0159T	0163T
0188T	0189T	0190T	0191T	0195T	0196T
0205T	0206T	0228T	0229T	0230T	0231T
0249T	0254T	0290T	0295T	0296T	0297T
0298T	0312T	0313T	0314T	0315T	0316T
0317T	0337T	0341T	0346T	0355T	0356T
0357T	0359T	0360T	0361T	0363T	0364T
0365T	0366T	0367T	0368T	0369T	0370T
0371T	0372T	0374T	0375T	0376T	0377T
0380T	0381T	0382T	0383T	0384T	0385T
0386T	0387T	0388T	0389T	0390T	0391T
0396T	0399T	0400T	0401T	0404T	0405T
0406T	0407T	0423T	0424T	0425T	0426T
0427T	0428T	0429T	0430T	0431T	0432T
0433T	0434T	0435T	0436T	0451T	0452T

0453T	0454T	0455T	0456T	0457T	0458T
0459T	0460T	0461T	0462T	0463T	0465T
0466T	0467T	0468T	0470T	0471T	0475T
0476T	0477T	0478T	0482T	0487T	0491T
0492T	0493T	0497T	0498T	0499T	0501T
0502T	0503T	0504T	00326	00561	00834
00836	01935	01936	10022	11100	11101
15850	19260	19271	19272	19304	19324
19366	20005	20926	21310	27370	31551
31553	31595	31601	32405	33010	33011
33015	33282	33284	33470	33722	33860
33870	33951	33953	33955	33957	33959
33963	33965	33969	33985	35721	35741
35761	36400	36405	36406	36420	36440
36455	36456	36460	41500	43401	43760
43850	43855	46762	49220	49560	49561
49565	49566	49568	49570	49572	49580
49582	49585	49587	49590	49652	49653
49654	49655	49656	49657	50395	57112
58293	59135	61332	61480	61610	61612
61870	62163	63180	63182	63194	63195
63196	63198	63199	63615	64402	64410
64413	64508	64550	66220	67229	69605
69715	69718	72275	74241	74245	74247
74249	74260	74710	76001	76010	76101
76102	76885	76886	76930	76970	77058
77059	77076	78135	78205	78206	78270
78271	78272	78320	78607	78647	78710
78805	78806	78807	80500	80502	81211
81213	81214	81545	87450	90644	90696
90700	90702	90951	90952	90953	90954
90955	90956	90963	90964	90967	90968
92225	92226	92275	92559	92560	92561
92564	92585	92586	92601	92602	92992
92993	93299	93530	93531	93532	93533
93561	93562	94011	94012	94013	94250
94400	94750	94770	94772	94774	94775
94776	94777	94780	94781	95071	95782
95783	95827	95831	95832	95833	95834
95943	95950	95951	95953	95956	95974
95975	95978	95979	98969	99090	99170
99201	99217	99218	99219	99220	99224
99225	99226	99241	99251	99318	99324
99325	99326	99327	99328	99334	99335
99336	99337	99339	99340	99343	99354
99355	99356	99357	99381	99382	99383
99384	99385	99386	99387	99391	99392
99393	99394	99395	99396	99397	99401
99402	99403	99404	99411	99412	99444
99460	99461	99462	99463	99464	99465
99466	99467	99468	99469	99471	99472
99475	99476	99477	99478	99479	99480
99485	99486				

Optum Exempt From Modifier 51 Codes (51)

90281	90283	90284	90287	90288	90291
90296	90371	90375	90376	90377	90378
90384	90385	90386	90389	90393	90396
90399	90476	90477	90581	90585	90586
90587	90619	90620	90621	90625	90630
90632	90633	90634	90636	90647	90648
90649	90650	90651	90653	90654	90655
90656	90657	90658	90660	90661	90662
90664	90666	90667	90668	90670	90672
90673	90674	90675	90676	90680	90681
90682	90685	90686	90687	90688	90689
90690	90691	90694	90697	90698	90707
90710	90713	90714	90715	90716	90717
90723	90732	90733	90734	90736	90738
90739	90740	90743	90744	90746	90747
90748	90749	90750	90756	97010	97012
97014	97016	97018	97022	97024	97026
97028	97032	97033	97034	97035	97036
97110	97112	97113	97116	97124	97130
97140	97150	97161	97162	97163	97164
97165	97166	97167	97168	97169	97170
97171	97172	97530	97533	97535	97537
97542	97545	97546	97597	97598	97602
97605	97606	97607	97608	97610	97750
97755	97760	97761	97763	99050	99051
99053	99056	99058	99060		

POSTAL ZIP CODES BY REGION

Postal ZIP codes included in each region:

Region I

<i>From</i>	<i>Thru</i>	<i>From</i>	<i>Thru</i>
12007	12099	13601	13699
12106	12177	13730	13797
12184	12199	13801	13865
12401	12498	14001	14098
12701	12792	14101	14174
12801	12887	14301	14305
12901	12998	14410	14489
13020	13094	14501	14592
13101	13176	14701	14788
13301	13368	14801	14898
13401	13439	14901	14925
13450	13495		

Region II

<i>From</i>	<i>Thru</i>	<i>From</i>	<i>Thru</i>
12179	12183	13440	13449
12201	12288	13501	13599
12301	12345	13901	13905
12501	12594	14201	14280
12601	12614	14601	14694
13201	13290		

Region III

<i>From</i>	<i>Thru</i>	<i>From</i>	<i>Thru</i>
06390	06390	10801	10805
10501	10598	10901	10998
10601	10650	11901	11980
10701	10710		

Region IV

<i>From</i>	<i>Thru</i>	<i>From</i>	<i>Thru</i>
00501	00501	11101	11120
00544	00544	11201	11256
10001	10099	11301	11390
10100	10199	11401	11499
10200	10299	11501	11599
10301	10314	11601	11697
10401	10499	11701	11798
11001	11096	11801	11854

Behavioral Health Provider Enhanced Rating Codes

Rating Code	Description
CPN-ADP	ADDICTION PSYCHIATRY
OPCPN-ADP	ADDICTION PSYCHIATRY
OPPN-ADP	ADDICTION PSYCHIATRY
PN-ADP	ADDICTION PSYCHIATRY
CPN-CLP	CONSULTATION-LIAISON PSYCHIATRY
OPCPN-CLP	CONSULTATION-LIAISON PSYCHIATRY
OPPN-CLP	CONSULTATION-LIAISON PSYCHIATRY
PN-CLP	CONSULTATION-LIAISON PSYCHIATRY
CPN-FPSY	FORENSIC PSYCHIATRY

Rating Code	Description
OPCPN-FPSY	FORENSIC PSYCHIATRY
OPPN-FPSY	FORENSIC PSYCHIATRY
PN-FPSY	FORENSIC PSYCHIATRY
CPN-GER	GERIATRIC PSYCHIATRY
OPCPN-GER	GERIATRIC PSYCHIATRY
OPPN-GER	GERIATRIC PSYCHIATRY
PN-GER	GERIATRIC PSYCHIATRY
CPN-P	PSYCHIATRY
OPCPN-P	PSYCHIATRY
OPPN-P	PSYCHIATRY
PN-P	PSYCHIATRY
OPPN	PSYCHIATRY/NEUROLOGY
PN	PSYCHIATRY/NEUROLOGY
CPN-BIM	PSYCHIATRY AND NEUROLOGY - BRAIN INJURY MEDICINE
OPCPN-BIM	PSYCHIATRY AND NEUROLOGY -BRAIN INJURY MEDICINE
OPPN-BIM	PSYCHIATRY AND NEUROLOGY -BRAIN INJURY MEDICINE
PN-BIM	PSYCHIATRY AND NEUROLOGY -BRAIN INJURY MEDICINE
LCSW	LICENSED CLINICAL SOCIAL WORKER
LCSW-R	LICENSED CLINICAL SOCIAL WORKER PSYCHOTHERAPY
NP-P	NURSE PRACTITIONER IN PSYCHIATRY
PHYAS	PHYSICIAN ASSISTANT **
PSY	PSYCHOLOGY

** A supervising physician needs to have a rating code eligible for the modifier 1B enhancement.