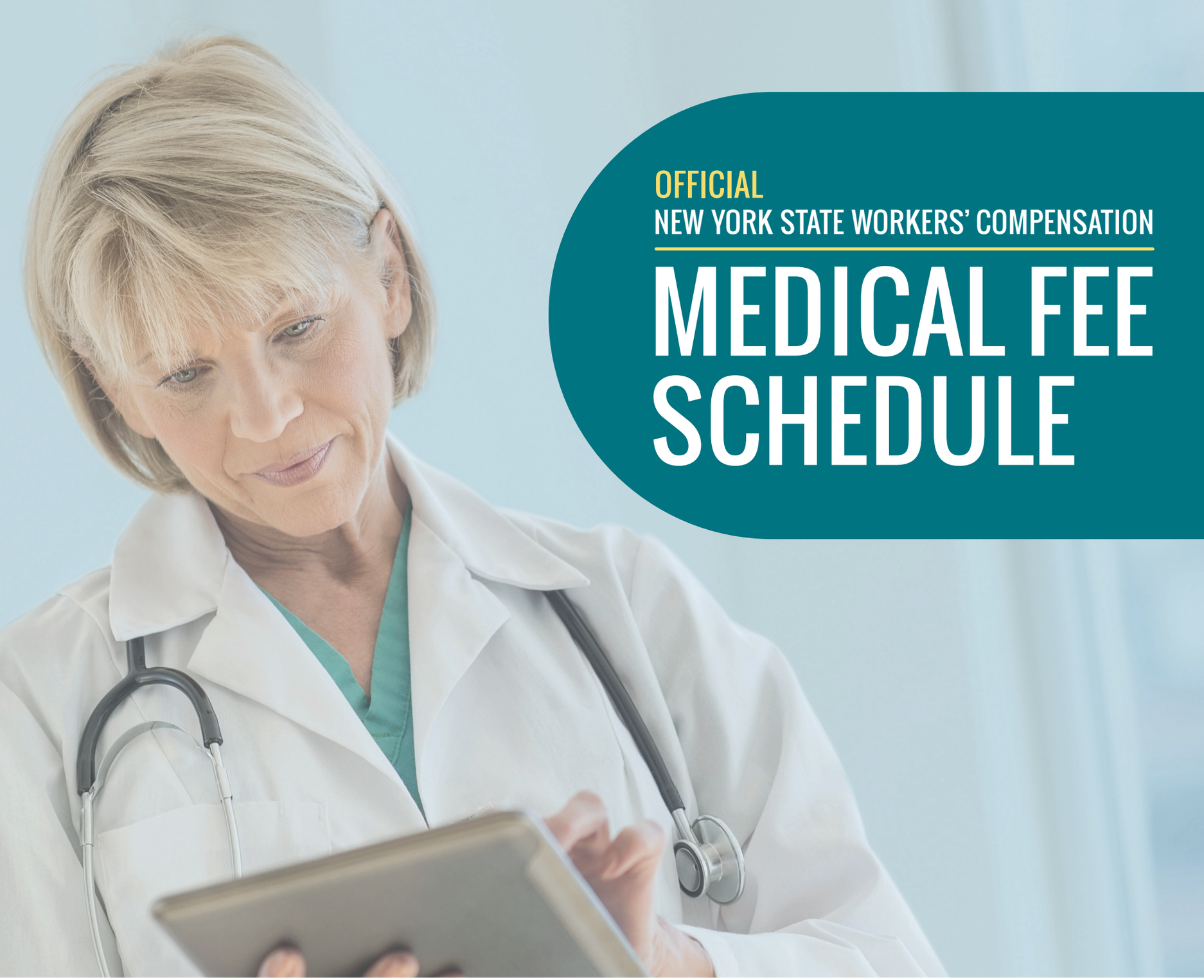

OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

MEDICAL FEE SCHEDULE

WCNY18

2018

NEW YORK STATE OF OPPORTUNITY.

Workers' Compensation Board

1.800.464.3649

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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.

Optum360 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.

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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 and 329.3, and Appendix C-3 of Title 12 of the Official Compilation of Codes, Rules, and Regulations of the State of New York.

Our Commitment to Accuracy

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Revised Printing

This revised printing includes changes to pages 60 and 371–372 that were shipped as corrected pages with the original printing.

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.

This fee schedule is effective for medical services rendered on or after April 1, 2019, 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

1 Introduction and General Guidelines

The *Official New York State Workers' Compensation Medical Fee Schedule* shows physician 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 by any or all physicians; 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 in the care of workers' compensation covered patients and to ensure the proper payment for such services by assuring that they are specifically identifiable.

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 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 and Management	99201–99499
Anesthesia	00100–01999, 99100–99140
Surgery	10021–69990
Radiology (including Nuclear Medicine and Diagnostic Ultrasound)	70010–79999
Pathology and Laboratory	80047–89398
Medicine	90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607
Physical Medicine	95831–95852, 97010–97124, 97139–97530, 97535–97546, 97750–97799, ∞97800
Category III Codes	0042T–0504T

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 except for Category III codes, which are subject to the conversion factor applicable to similar services. See the Category III Codes section for more information.

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 Behavioral Health schedule, Chiropractic schedule, and Podiatry schedule, included with this publication, have also been published as separate schedules. To purchase these schedules separately from the Medical Fee Schedule, contact Optum360 at 1.800.464.3649, option 1.

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 from June 1, 2012.

+ 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.

Ⓢ Optum360 identified modifier 51 exempt service—Additional modifier 51 exempt codes identified by Optum360 based upon CPT language are exempt from modifier 51 when performed in conjunction with other services.

® Altered CPT codes—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 2018* is used by arrangement with the AMA. Any altered CPT codes are identified with the registered trademark symbol (®). State-specific codes are identified with the infinity symbol (∞).

Description
This manual lists full 2018 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.

Specialty Classifications

The "C" rating (Consultant in Specialty, e.g., CS—Consultant-Surgery) may be granted to physicians certified as specialists by a board recognized by the American Board of Medical Specialties and the American Osteopathic Association. Applicants, who are qualified but have not attained board-certified status as defined above, will be granted a specialty rating without the "C" prefix (e.g., IM, OS, and S).

The rating "OP-GP" is given to osteopathic physicians in general practice. The "OP" designation, when combined with one of the specialty ratings, indicates that the specialist is an osteopathic physician (e.g., OPOS, is the proper rating for an osteopathic physician who is a qualified specialist in orthopedic surgery. Upon obtaining Consultant status, as defined above, a physician may apply for an "OP-COS" rating). The rating is listed below with the designation, dash, consultant if applicable, specialty classification.

Rating	Description
AL	Allergy/Immunology
AL-CLI	Clinical Laboratory Immunology
AL-DLI	Diagnostic Laboratory Immunology
AN	Anesthesiology
AN-CCM	Critical Care Medicine
AN-PM	Pain Management
CRS	Colon/Rectal Surgery
D	Dermatology
D-CLDI	Clinical and Laboratory Dermatological Immunology
D-DI	Dermatological Immunity/Diagnostic
D-DP	Dermatological Pathology
D-PD	Pediatric Dermatology
EM	Emergency Medicine
EM-MT	Medical Toxicology
EM-PEM	Pediatric Emergency Medicine
EM-SM	Sports Medicine
EM-UHM	Undersea and Hyperbaric Medicine
FP	Family Practice
FP-ADM	Adolescent Medicine
FP-GM	Geriatric Medicine
FP-SM	Sports Medicine
GP	General Practice
IM	Internal Medicine
IM-ADM	Adolescent Medicine
IM-CCEP	Clinical Cardiac Electrophysiology
IM-CCM	Critical Care
IM-CD	Cardiology
IM-CE	Cardiac Electrophysiology
IM-CLI	Clinical and Laboratory Immunology
IM-CVD	Cardiovascular
IM-DI	Diagnostic Immunology
IM-EDM	Endocrinology, Diabetes and Metabolism
IM-END	Endocrinology
IM-GE	Gastroenterology
IM-GM	Geriatric Medicine
IM-HEM	Hematology
IM-IC	Interventional Cardiology
IM-ID	Infectious Diseases

Rating	Description
IM-NEPH	Nephrology
IM-ONCL	Medical Oncology
IM-PD	Pulmonary Diseases
IM-RHE	Rheumatology
IM-SM	Sports Medicine
NS	Neurological Surgery
NS-CCM	Critical Care Medicine
NUM	Nuclear Medicine
NUM-NR	Nuclear Radiology
NUM-RP	Radioisotopic Pathology
O	Ophthalmology
OG	Obstetrics/Gynecology
OG-CCM	Critical Care Medicine
OG-MFM	Maternal/Fetal Medicine
OG-ONC	Gynecologic Oncology
OG-RE	Reproductive Endocrinology
OL	Otolaryngology
OL-ON	Otology/Neurotology
OL-PO	Pediatric Otolaryngology
OL-PSHN	Plastic Surgery Within the Head and Neck
OS	Orthopedic Surgery
OS-HS	Hand Surgery
P	Pediatrics
P-ADM	Adolescent Medicine
P-CCM	Critical Care Medicine
P-CD	Cardiology
P-CLI	Clinical and Laboratory Immunology
P-DBP	Developmental-Behavioral Pediatrics
P-DL	Diagnostic Laboratory Immunology
P-END	Endocrinology
P-GE	Gastroenterology
P-ID	Infectious Diseases
P-MT	Medical Toxicology
P-ND	Neurodevelopmental Disabilities
P-NEPH	Nephrology
P-NPER	Neonatal-Perinatal Medicine
P-PEM	Emergency Medicine
P-PHO	Hematology/Oncology
P-PUL	Pulmonology
P-RHE	Rheumatology
P-SM	Sports Medicine
PA	Pathology
PA-AP	Anatomic Pathology
PA-BB	Blood Banking
PA-CB	Clinical Bacteriology
PA-CC	Clinical Chemistry
PA-CLP	Clinical Pathology
PA-CM	Clinical Microbiology
PA-CP	Chemical Pathology
PA-CY	Cytopathology
PA-DP	Dermatopathology
PA-FOP	Forensic Pathology
PA-HEM	Hematology
PA-IP	Immunology
PA-MC	Medical Chemistry
PA-MGP	Molecular Genetic Pathology
PA-MMB	Medical Microbiology
PA-NP	Neuropathology
PA-PA	Pathologic Anatomy
PA-PDP	Pediatric Pathology
PA-RP	Radioisotopic
PM	Preventive Medicine
PM-AM	Aerospace Medicine
PM-GPM	General Preventive Medicine
PM-MT	Medical Toxicology
PM-OM	Occupational Medicine
PM-PH	Public Health
PM-UHM	Undersea and Hyperbaric Medicine
PMR	Physical Medicine/Rehabilitation
PMR-PM	Pain Management
PMR-SCINI	Spinal Cord Injury Medicine
PN	Psychiatry/Neurology
PN-ADP	Addiction Psychiatry
PN-CHAP	Child and Adolescent Psychiatry
PN-CHN	Child Neurology
PN-CHP	Child Psychiatry
PN-CNPH	Clinical Neurophysiology
PN-FPSY	Forensic Psychiatry
PN-GER	Geriatric Psychiatry

Rating	Description
PN-N	Neurology
PN-ND	Neurodevelopmental Disabilities
PN-P	Psychiatry
PN-PM	Pain Management
PS	Plastic Surgery
PS-HS	Hand Surgery
R	Radiology
R-DRA	Diagnostic Radiology
R-DRNR	Diagnostic Radiology/Nuclear Medicine
R-DRO	Diagnostic Roentgenology
R-DRP	Diagnostic Radiological Physics
R-MNP	Medical Nuclear Physics
R-NR	Nuclear Radiology
R-NRAD	Neuroradiology
R-PR	Pediatric Radiology
R-R	Radiology
R-RAO	Radiation Oncology
R-RO	Roentgenology
R-RP	Radiological Physics
R-RT	Radium Therapy
R-TRA	Therapeutic Radiology
R-TRP	Therapeutic Radiological Physics
R-VIR	Vascular and Interventional Radiology
S	Surgery
S-GVS	General Vascular Surgery
S-HS	Hand Surgery
S-PDS	Pediatric Surgery
S-SCC	Surgical Critical Care
TS	Thoracic Surgery
U	Urology

Postal ZIP Codes by Region

Postal ZIP codes included in each region:

Region I

From	*Thru*	*From*	*Thru*
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

From	*Thru*	*From*	*Thru*
12179	12183	13440	13449
12201	12288	13501	13599
12301	12345	13901	13905
12501	12594	14201	14280
12601	12614	14601	14694
13201	13290		

Region III

From	*Thru*	*From*	*Thru*
06390	06390	10801	10805
10501	10598	10901	10998
10601	10650	11901	11980
10701	10710		

Region IV

From	*Thru*	*From*	*Thru*
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

Numerical List of Postal ZIP Codes

From	*Thru*	*Region*	*From*	*Thru*	*Region*
00501	00501	IV	12401	12498	I
00544	00544	IV	12501	12594	II
06390	06390	III	12601	12614	II
10001	10099	IV	12701	12792	I
10100	10199	IV	12801	12887	I
10200	10299	IV	12901	12998	I
10301	10314	IV	13020	13094	I
10401	10499	IV	13101	13176	I
10501	10598	III	13201	13290	II
10601	10650	III	13301	13368	I
10701	10710	III	13401	13439	I
10801	10805	III	13440	13449	II
10901	10998	III	13450	13495	I
11001	11096	IV	13501	13599	II
11101	11120	IV	13601	13699	I
11201	11256	IV	13730	13797	I

From	*Thru*	*Region*	*From*	*Thru*	*Region*
11301	11390	IV	13801	13865	I
11401	11499	IV	13901	13905	II
11501	11599	IV	14001	14098	I
11601	11697	IV	14101	14174	I
11701	11798	IV	14201	14280	II
11801	11854	IV	14301	14305	I
11901	11980	III	14410	14489	I
12007	12099	I	14501	14592	I
12106	12177	I	14601	14694	II
12179	12183	II	14701	14788	I
12184	12199	I	14801	14898	I
12201	12288	II	14901	14925	I
12301	12345	II			

Conversion Factors

Regional conversion factors for services rendered on or after April 1, 2019.

Section	Region I	Region II	Region III	Region IV
E/M	$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
Physical Therapists/ Occupational Therapists (self-employed)	$7.69	$7.69	$8.79	$9.55
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

Category III codes are subject to the conversion factor applicable to similar services. See the Category III Codes section for more information.

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:

5.83	(Relative Value)
x $12.11	(E/M Section Conversion Factor for Region I or Region II)
= $70.60	

New CPT Codes

The table below is a complete list of CPT codes that have been added since the June 1, 2012 fee schedule.

These codes are identified in the fee schedule with "■".

0308T	0312T	0313T	0314T	0315T	0316T
0317T	0329T	0330T	0331T	0332T	0333T
0335T	0337T	0338T	0339T	0341T	0342T
0345T	0346T	0347T	0348T	0349T	0350T
0351T	0352T	0353T	0354T	0355T	0356T
0357T	0358T	0359T	0360T	0361T	0362T
0363T	0364T	0365T	0366T	0367T	0368T
0369T	0370T	0371T	0372T	0373T	0374T
0375T	0376T	0377T	0378T	0379T	0380T
0381T	0382T	0383T	0384T	0385T	0386T
0387T	0388T	0389T	0390T	0391T	0394T
0395T	0396T	0397T	0398T	0399T	0400T
0401T	0402T	0403T	0404T	0405T	0406T
0407T	0408T	0409T	0410T	0411T	0412T
0413T	0414T	0415T	0416T	0417T	0418T
0419T	0420T	0421T	0422T	0423T	0424T
0425T	0426T	0427T	0428T	0429T	0430T
0431T	0432T	0433T	0434T	0435T	0436T
0437T	0439T	0440T	0441T	0442T	0443T
0444T	0445T	0446T	0447T	0448T	0449T
0450T	0451T	0452T	0453T	0454T	0455T
0456T	0457T	0458T	0459T	0460T	0461T
0462T	0463T	0464T	0465T	0466T	0467T
0468T	0469T	0470T	0471T	0472T	0473T
0474T	0475T	0476T	0477T	0478T	0479T
0480T	0481T	0482T	0483T	0484T	0485T
0486T	0487T	0488T	0489T	0490T	0491T
0492T	0493T	0494T	0495T	0496T	0497T
0498T	0499T	0500T	0501T	0502T	0503T
0504T	10030	10035	10036	15730	15733
19081	19082	19083	19084	19085	19086
19281	19282	19283	19284	19285	19286
19287	19288	19294	20604	20606	20611
20939	20983	21811	21812	21813	22510
22511	22512	22513	22514	22515	22586
22853	22854	22858	22859	22867	22868
22869	22870	23333	23334	23335	23473
23474	24370	24371	27197	27198	27279
28291	28295	31241	31253	31257	31259
31298	31551	31552	31553	31554	31572
31573	31574	31591	31592	31647	31648
31649	31651	31652	31653	31654	31660
31661	32554	32555	32556	32557	32701
32994	33270	33271	33272	33273	33340
33361	33362	33363	33364	33365	33366
33367	33368	33369	33390	33391	33418
33419	33477	33927	33928	33929	33946
33947	33948	33949	33951	33952	33953
33954	33955	33956	33957	33958	33959
33962	33963	33964	33965	33966	33969
33984	33985	33986	33987	33988	33989
33990	33991	33992	33993	34701	34702
34703	34704	34705	34706	34707	34708

34709 34710 34711 34712 34713 34714
34715 34716 34839 34841 34842 34843
34844 34845 34846 34847 34848 36221
36222 36223 36224 36225 36226 36227
36228 36456 36465 36466 36473 36474
36482 36483 36901 36902 36903 36904
36905 36906 36907 36908 36909 37197
37211 37212 37213 37214 37217 37218
37236 37237 37238 37239 37241 37242
37243 37244 37246 37247 37248 37249
37252 37253 38222 38243 38573 39401
39402 43180 43191 43192 43193 43194
43195 43196 43197 43198 43206 43210
43211 43212 43213 43214 43229 43233
43252 43253 43254 43266 43270 43274
43275 43276 43277 43278 43284 43285
43286 43287 43288 44381 44384 44401
44402 44403 44404 44405 44406 44407
44408 44705 45346 45347 45349 45350
45388 45389 45390 45393 45398 45399
46601 46607 47383 47531 47532 47533
47534 47535 47536 47537 47538 47539
47540 47541 47542 47543 47544 49185
49405 49406 49407 50430 50431 50432
50433 50434 50435 50606 50693 50694
50695 50705 50706 52287 52356 52441
52442 54437 54438 55874 58575 58674
61645 61650 61651 62302 62303 62304
62305 62320 62321 62322 62323 62324
62325 62326 62327 62380 64461 64462
64463 64486 64487 64488 64489 64615
64616 64617 64642 64643 64644 64645
64646 64647 64912 64913 65785 66179
66183 66184 69209 71045 71046 71047
71048 72081 72082 72083 72084 73501
73502 73503 73521 73522 73523 73551
73552 74018 74019 74021 74712 74713
76641 76642 76706 77061 77062 77063
77065 77066 77067 77085 77086 77293
77306 77307 77316 77317 77318 77385
77386 77387 77767 77768 77770 77771
77772 78012 78013 78014 78071 78072
78265 78266 80081 80155 80159 80163
80165 80169 80171 80175 80177 80180
80183 80199 80203 80305 80306 80307
80320 80321 80322 80323 80324 80325
80326 80327 80328 80329 80330 80331
80332 80333 80334 80335 80336 80337
80338 80339 80340 80341 80342 80343
80344 80345 80346 80347 80348 80349
80350 80351 80352 80353 80354 80355
80356 80357 80358 80359 80360 80361
80362 80363 80364 80365 80366 80367
80368 80369 80370 80371 80372 80373
80374 80375 80376 80377 81105 81106
81107 81108 81109 81110 81111 81112
81120 81121 81161 81162 81170 81175
81176 81201 81202 81203 81218 81219
81230 81231 81232 81235 81238 81246
81247 81248 81249 81252 81253 81254
81258 81259 81269 81272 81273 81276
81283 81287 81288 81311 81313 81314
81321 81322 81323 81324 81325 81326
81327 81328 81334 81335 81346 81361
81362 81363 81364 81410 81411 81412
81413 81414 81415 81416 81417 81420
81422 81425 81426 81427 81430 81431
81432 81433 81434 81435 81436 81437
81438 81439 81440 81442 81445 81448
81450 81455 81460 81465 81470 81471
81479 81490 81493 81500 81503 81504
81506 81507 81508 81509 81510 81511
81512 81519 81520 81521 81525 81528
81535 81536 81538 81539 81540 81541
81545 81551 81595 81599 82777 83006
84410 86008 86152 86153 86711 86794
86828 86829 86830 86831 86832 86833
86834 86835 87483 87505 87506 87507
87623 87624 87625 87631 87632 87633
87634 87661 87662 87806 87910 87912
88341 88344 88350 88364 88366 88369
88373 88374 88375 88377 89337 90587
90620 90621 90625 90630 90651 90653
90672 90673 90674 90682 90685 90686
90687 90688 90697 90739 90750 90756
90785 90791 90792 90832 90833 90834
90836 90837 90838 90839 90840 90863
91112 91200 92145 92242 92521 92522
92523 92524 92537 92538 92920 92921
92924 92925 92928 92929 92933 92934
92937 92938 92941 92943 92944 93050
93260 93261 93355 93582 93583 93590
93591 93592 93644 93653 93654 93655
93656 93657 93702 93792 93793 93895
94617 94618 94669 95017 95018 95076
95079 95249 95782 95783 95907 95908
95909 95910 95911 95912 95913 95924
95940 95941 95943 96127 96160 96161
96377 96573 96574 96931 96932 96933
96934 96935 96936 97127 97161 97162
97163 97164 97165 97166 97167 97168
97169 97170 97171 97172 97607 97608
97610 97763 99151 99152 99153 99155
99156 99157 99177 99184 99188 99415
99416 99446 99447 99448 99449 99483
99484 99485 99486 99487 99489 99490
99492 99493 99494 99495 99496 99497
99498

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, or a PC/TC split change since the June 1, 2012 fee

schedule. 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 (June 1, 2012) fee schedule.

For each code listed, the following information is included:

NY 2018 RVU. This is the current RVU for services rendered on or after April 1, 2019.

NY 2012 RVU. This is the RVU effective June 1, 2012.

NY 2018 FUD. This is the FUD for services rendered on or after April 1, 2019**.**

NY 2012 FUD. This is the FUD listed in the June 1, 2012 fee schedule.

NY 2018 PC/TC Split. This is the PC/TC split for services rendered on or after April 1, 2019. 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 2012 PC/TC Split. This is the PC/TC split effective June 1, 2012.

These codes are identified in the fee schedule with "■."

CODE	NY 2018 RVU	NY 2012 RVU	NY 2018 FUD	NY 2012 FUD	NY 2018 PC/TC Split	NY 2012 PC/TC Split
0042T	15.44	BR	XXX	XXX		
0054T	2.47	BR	XXX	XXX		
0055T	3.23	BR	XXX	XXX		
0075T	18.68	BR	XXX	XXX		
0076T	17.50	BR	XXX	XXX		
0100T	16.22	BR	XXX	XXX		
0101T	2.78	BR	XXX	XXX		
0102T	2.78	BR	XXX	XXX		
0159T	0.83	BR	ZZZ	ZZZ		
0163T	17.56	BR	YYY	YYY		
0164T	3.25	BR	YYY	YYY		
0165T	3.61	BR	YYY	YYY		
0174T	0.60	BR	XXX	XXX		
0175T	0.60	BR	XXX	XXX		
0184T	6.22	BR	XXX	XXX		
0190T	1.87	BR	XXX	XXX		
0191T	6.40	BR	XXX	XXX		
0198T	9.99	BR	XXX	XXX		
0200T	8.70	BR	XXX	XXX		
0201T	11.98	BR	XXX	XXX		
0202T	15.40	BR	XXX	XXX		
0205T	0.53	BR	ZZZ	ZZZ		
0206T	37.42	BR	XXX	XXX		
0207T	3.76	BR	XXX	XXX		
0208T	5.20	BR	XXX	XXX		
0209T	9.65	BR	XXX	XXX		
0210T	6.43	BR	XXX	XXX		
0212T	8.14	BR	XXX	XXX		
0213T	1.19	BR	XXX	XXX		
0214T	0.60	BR	ZZZ	ZZZ		
0215T	0.61	BR	ZZZ	ZZZ		
0216T	1.07	BR	XXX	XXX		
0217T	0.54	BR	ZZZ	ZZZ		
0218T	0.55	BR	ZZZ	ZZZ		
0228T	1.75	BR	XXX	XXX		
0229T	0.83	BR	XXX	XXX		
0230T	1.60	BR	XXX	XXX		
0231T	0.70	BR	XXX	XXX		
0232T	0.37	BR	XXX	XXX		
0234T	11.12	BR	YYY	YYY		
0235T	10.84	BR	YYY	YYY		
0236T	9.27	BR	YYY	YYY		
0237T	4.62	BR	YYY	YYY		
0238T	6.28	BR	YYY	YYY		
0249T	3.08	BR	YYY	YYY		
0253T	7.12	BR	YYY	YYY		
0254T	7.74	BR	YYY	YYY		
0263T	2.67	BR	XXX	XXX		
0264T	1.19	BR	XXX	XXX		
0265T	0.19	BR	XXX	XXX		
0275T	BR	BR	XXX	YYY		
0295T	36.19	BR	XXX	XXX		
0296T	4.51	BR	XXX	XXX		
0297T	28.39	BR	XXX	XXX		
0298T	5.13	BR	XXX	XXX		
20240	1.71	1.71	000	010		
20245	2.90	2.90	000	010		
22505	0.00	0.94	010	010		
30140	3.47	3.47	000	090		
34812	2.02	2.46	ZZZ	000		
34820	3.45	4.16	ZZZ	000		
34833	3.95	3.84	ZZZ	000		

CODE	NY 2018 RVU	NY 2012 RVU	NY 2018 FUD	NY 2012 FUD	NY 2018 PC/TC Split	NY 2012 PC/TC Split
34834	1.27	1.92	ZZZ	000		
36215	2.25	2.25	000	XXX		
36216	2.90	2.90	000	XXX		
36217	3.40	3.40	000	XXX		
36470	0.37	0.37	000	010		
36471	0.84	0.84	000	010		
41530	24.64	24.64	000	010		
43775	11.68	11.68	090	XXX		
51784	0.66	0.66	XXX	000	85/15	85/15
51785	0.66	0.66	XXX	000	85/15	85/15
55970	BR	BR	YYY	XXX		
55980	BR	BR	YYY	XXX		
65778	11.24	11.24	000	010		
65779	8.90	8.90	000	010		
67101	7.96	7.96	010	090		
67105	7.96	7.96	010	090		
67227	5.53	5.53	010	090		
67228	5.71	5.71	010	090		
76932	4.41	4.41	YYY	XXX	45/55	45/55
76940	4.49	4.49	YYY	XXX	20/80	20/80
77002	2.81	2.81	ZZZ	XXX	34/66	34/66
77003	2.73	2.73	ZZZ	XXX	38/62	38/62
77778	31.88	31.88	000	090	80/20	80/20
88334	25.26	25.26	ZZZ	XXX	75/25	75/25
95831	0.00	5.16	XXX	XXX		
95832	0.00	5.83	XXX	XXX		
95833	0.00	13.53	XXX	XXX		
95834	0.00	14.88	XXX	XXX		
95851	0.00	5.41	XXX	XXX		
95852	0.00	5.41	XXX	XXX		
97010	0.55	2.37	XXX	XXX		
97750	0.00	5.41	XXX	XXX		
99075	$450.00	$400.00				

Changed Descriptions

The table below is a complete list of CPT codes that have had a description change since the June 1, 2012 fee schedule.

0075T	0076T	0191T	0195T	0196T	01991
01992	0200T	0201T	0253T	0254T	0274T
0275T	11603	11623	15740	15777	17250
19298	20240	20245	20600	20605	20610
20665	20982	21015	21016	21557	21558
21935	21936	22856	22904	22905	23077
23078	24077	24079	24160	24164	25077
25078	26117	26118	27049	27059	27280
27329	27364	27370	27615	27616	28046
28047	28289	28292	28296	28297	28298
28299	28890	31254	31255	31276	31575
31576	31577	31578	31579	31580	31584
31587	31645	31646	32551	32998	33215
33216	33217	33218	33220	33222	33223
33224	33225	33230	33231	33240	33241
33243	33244	33249	33262	33263	33264
33405	33406	33410	34812	34820	34833
34834	36140	36400	36405	36406	36410
36468	36470	36471	36476	36479	36516
37184	37185	37186	37192	37215	37216
37650	37660	38220	38221	38240	38241
38242	38760	43112	43200	43201	43202
43204	43205	43215	43216	43217	43220
43226	43227	43231	43232	43235	43236
43237	43238	43239	43240	43241	43242
43243	43244	43245	43246	43247	43248
43249	43250	43251	43255	43257	43259
43260	43263	43264	43265	43273	44360
44363	44380	44385	44386	44388	44390
44391	44392	44799	45330	45332	45333
45334	45337	45340	45378	45379	45380
45381	45382	45384	45385	45386	45391
45392	46600	47552	50387	52500	57240
57260	57265	59300	61055	62287	62290
62291	62370	64550	64561	64612	65778
65779	65800	65855	66180	66185	66740
67101	67105	67107	67108	67113	67227
67228	67399	67810	69210	72040	72050
72052	72080	74240	74241	74245	74246
74247	74250	74251	74340	75898	76000
76001	76376	76377	76881	76882	76885
76886	77002	77003	77071	77295	77401
77402	77407	77412	77417	77778	77789
78070	78264	80047	80048	80162	80164
80299	81210	81244	81245	81257	81275
81355	81371	81376	81400	81401	81402
81403	81404	81405	81406	81407	81408
82009	82010	82042	82043	82044	82542
83015	83018	83704	83789	84112	84600
86003	86005	86708	86709	86900	86901
86902	86904	86905	86906	87147	87197
87253	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	87450	87451
87498	87501	87521	87522	87535	87536
87538	87539	88342	88346	88360	88361
88365	88367	88368	90644	90647	90648
90649	90650	90654	90655	90656	90657
90658	90660	90661	90698	90723	90734
90746	90748	90846	90847	90875	90876
90889	90935	90945	90947	90951	90952
90953	90954	90955	90956	90957	90958
90959	90960	90961	90962	91040	91065

91110	91111	92235	92240	92286	92287
92612	92613	92614	92615	92616	92617
92973	92978	92979	93015	93016	93224
93227	93228	93229	93268	93272	93279
93280	93281	93282	93283	93284	93285
93286	93287	93288	93289	93290	93291
93292	93293	93294	93295	93296	93297
93298	93351	93642	93745	93750	93790
93797	93798	94014	94016	94452	94453
94610	94621	94640	94774	94777	95004
95024	95027	95120	95125	95130	95131
95132	95133	95134	95250	95251	95808
95810	95811	95830	95930	95954	95961
95962	95972	95991	96004	96020	96110
96567	97530	97533	97535	97537	97602
97605	97606	97755	97760	97761	98969
99000	99001	99002	99070	99071	99078
99091	99170	99174	99183	99201	99202
99203	99204	99205	99211	99212	99213
99214	99215	99217	99218	99219	99220
99221	99222	99223	99224	99225	99226
99231	99232	99233	99234	99235	99236
99241	99242	99243	99244	99245	99251
99252	99253	99254	99255	99281	99282
99283	99284	99285	99288	99304	99305
99306	99307	99308	99309	99310	99318
99324	99325	99326	99327	99328	99334
99335	99336	99337	99341	99342	99343
99344	99345	99347	99348	99349	99350
99354	99355	99360	99374	99375	99377
99378	99379	99380	99441	99442	99443
99444	99464	99466	99467		

Deleted CPT Codes

The table below is a complete list of CPT codes that have been deleted since the June 1, 2012 fee schedule.

0019T	0030T	0048T	0050T	0051T	0052T
0053T	0059T	0073T	0078T	0079T	0080T
0081T	0092T	0099T	0103T	0123T	0124T
0169T	0171T	0172T	0173T	0178T	0179T
0180T	0181T	0182T	0183T	0185T	0186T
0192T	0197T	0199T	0223T	0224T	0225T
0226T	0227T	0233T	0239T	0240T	0241T
0242T	0243T	0244T	0245T	0246T	0247T
0248T	0250T	0251T	0252T	0255T	0256T
0257T	0258T	0259T	0260T	0261T	0262T
0276T	0277T	0279T	0280T	0281T	0282T
0283T	0284T	0285T	0286T	0287T	0288T
0289T	0291T	0292T	0293T	0294T	0299T
0300T	0301T	11752	13150	15732	19102
19103	19290	19291	19295	21495	21800
21805	21810	22305	22520	22521	22522
22523	22524	22525	22851	23331	23332
27193	27194	28290	28293	28294	29020
29025	29582	29583	29590	29715	31320
31582	31588	31620	31656	31715	32201
32420	32421	32422	33332	33400	33401
33403	33472	33960	33961	34800	34802
34803	34804	34805	34806	34825	34826
34900	35450	35452	35458	35460	35471
35472	35475	35476	36120	36147	36148
36469	36515	36822	36870	37201	37202
37203	37204	37205	37206	37207	37208
37209	37210	37250	37251	39400	42508
42802	43219	43228	43234	43256	43258
43267	43268	43269	43271	43272	43350
43456	43458	44383	44393	44397	44901
45339	45345	45355	45383	45387	47011
47136	47500	47505	47510	47511	47525
47530	47560	47561	47630	48511	49021
49041	49061	50021	50392	50393	50394
50398	55450	58823	61334	61440	61470
61490	61542	61609	61875	62116	62310
62311	62318	62319	64412	64565	64613
64614	64752	64761	64870	65805	66165
67112	69400	69401	69405	69820	69840
70373	71010	71015	71020	71021	71022
71023	71030	71034	71035	71040	71060
72010	72069	72090	72291	72292	73500
73510	73520	73530	73540	73550	74000
74010	74020	74291	74305	74320	74327
74475	74480	75650	75658	75660	75662
75665	75671	75676	75680	75685	75791
75896	75900	75945	75946	75952	75953
75954	75960	75961	75962	75964	75966
75968	75978	75980	75982	76645	76950
77031	77032	77051	77052	77055	77056
77057	77082	77305	77310	77315	77326
77327	77328	77403	77404	77406	77408
77409	77411	77413	77414	77416	77418
77421	77422	77776	77777	77785	77786
77787	78000	78001	78003	78006	78007
78010	78011	78190	80100	80101	80102
80103	80104	80152	80154	80160	80166
80172	80174	80182	80196	80440	81280
81281	81282	82000	82003	82055	82101
82145	82205	82486	82487	82488	82489
82491	82492	82520	82541	82543	82544
82646	82649	82651	82654	82666	82690
82742	82953	82975	82980	83008	83055
83071	83499	83634	83788	83805	83840
83858	83866	83887	83890	83891	83892
83893	83894	83896	83897	83898	83900
83901	83902	83903	83904	83905	83906
83907	83908	83909	83912	83913	83914
83925	84022	84061	84127	86185	86243
86378	86729	86822	87001	87277	87470
87477	87515	87620	87621	87622	88154
88347	88349	88384	88385	88386	90645
90646	90665	90669	90692	90693	90701
90703	90704	90705	90706	90708	90712
90718	90719	90720	90721	90725	90727
90735	90801	90802	90804	90805	90806
90807	90808	90809	90810	90811	90812
90813	90814	90815	90816	90817	90818
90819	90821	90822	90823	90824	90826

90827	90828	90829	90857	90862	92140
92506	92543	92980	92981	92982	92984
92995	92996	93651	93652	93965	93982
94620	95010	95015	95075	95900	95903
95904	95920	95934	95936	95973	97001
97002	97003	97004	97005	97006	97532
97762	99143	99144	99145	99148	99149
99150	99363	99364	99420		

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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Multiple Procedures

It is appropriate to designate multiple procedures that are rendered on the same date by separate entries. For example, if a level three established patient office visit (99213) and an ECG (93000) are performed during the visit, 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. Unlisted Service or Procedure

When an unlisted service or procedure is provided, the procedure should be identified and the value substantiated "by report" (see Rule 3 below). All sections will have an unlisted service or procedure code number, usually ending in "99."

3. Procedures Listed Without Specified Relative Value Units

By report (BR) items: "BR" in the Relative Value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records, hence the importance of documentation. The original official record, such as operative report and hospital chart, will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the schedule as "BR," the physician shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

4. Materials Supplied by Physician

Do not 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. Surgical services do not include the supply of medications, sterile trays, and other materials which may be reported separately with code 99070. The specific items provided must be identified. Payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping and handling costs associated with delivery from the supplier of the item to the physician's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070. **Note:** The *Official New York State Workers' Compensation Podiatry Fee Schedule* has a separate list of state-specific appliance and prosthesis codes that should be used instead of 99070.

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 six of section 6810 of the Public Health Law.

Durable Medical Equipment Fee Schedule

The Durable Medical Equipment Fee Schedule adopted is still the Medicaid fee schedule. However, the regulation includes clarification on the application of the Medicaid fee schedule to workers' compensation claims. Specifically, the regulation provides that payments for bone growth stimulators

are made in a single payment for the entire amount, that the reimbursement for orthopedic footwear is the lesser of the acquisition cost to the provider plus 50 percent or the usual and customary price charged to the public, and that hearing aids are not considered durable medical equipment for purposes of the fee schedule and the reimbursement amount is the provider's usual and customary price.

The Durable Medical Equipment Fee Schedule does not apply to medical providers supplying durable medical equipment to injured workers as part of medical treatment described in the *Official New York State Workers' Compensation Medical Fee Schedule*. Billing and reimbursement follows the ground rules as described in this fee schedule.

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.

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. If no agreement between or among the physicians has been reached, the matter shall be referred to the Medical Arbitration Committee per Section 13-g of the Workers' Compensation Law.

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. (For consultations, see 99241–99255.)

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.

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 carrier) 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. If no proration agreement is reached by them, the amounts payable to each party shall be settled by an arbitration committee appointed pursuant to Section 13-g of the Workers' Compensation Law, without cost to the contestants. 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

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant physician or podiatrist is required at a hearing or deposition, such physician or podiatrist shall be entitled to an attendance fee of $450. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant chiropractor or psychologist is required at a hearing or deposition, such chiropractor or psychologist shall be entitled to an attendance fee of $350. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

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

A. Medical professionals that may render care and treatment in accordance with their scope of practice under NYS Education Law when supervised by an authorized physician include Physician's Assistants, Nurse Practitioners, and Licensed Clinical Social Workers. Only authorized physicians licensed to practice medicine may supervise such persons. Authorized psychologists, chiropractors and podiatrists are not permitted to supervise under the Workers' Compensation Law. For purposes of the *Official New York State Workers' Compensation Medical Fee Schedule*, the term "qualified health care professional" shall only include Physician's Assistants, Nurse Practitioners, and Licensed Clinical Social Workers.

"Active and personal supervision" means working under the supervision of an authorized physician who is readily available for consultation (in-person or by phone) and is actually available to provide in-person assistance when needed or in an emergency. The supervising authorized physician is responsible for the actions of such person, in accordance with Education Law, may only supervise four Physician's Assistants. Only the supervising authorized physician may offer an opinion as to initial disability or permanent disability or the degree thereof.

When the medical services are routinely performed within the normal scope of the supervising authorized physician's practice and the supervising physician is readily available for consultation, such techniques may be delegated by the supervising physician to such persons when they are:

1) Appropriately trained,

2) Qualified to perform the technique, and

3) Acting within the scope of their practice as determined by the New York State Education Department.

Reporting and Billing. The supervising authorized physician remains responsible for the actions of all such persons and must be identified in any reports, bills or other documents submitted to the Board. All reports and bills shall be submitted in the name of the supervising authorized physician and shall be payable at 80 percent of the fee available for such treatment code.

Note: This Ground Rule is not applicable to Surgery Ground Rule 12 (F), whereby the surgeon must be directly and personally supervising the surgical assistants and such surgeon (or when the NP or PA is employed by the facility where the service is performed, the facility representative) must submit the bill for the surgical assistant's services in accordance with that Ground Rule.

B. Billing for PA or NP Service

The supervising physician must render the bill for care, with the ensuing payment for the PA or NP service made directly to the supervising physician. Such bill shall include the modifier NP or PA to identify nurse practitioner or physician assistant and include the names of both the supervising physician and NP or PA. When an NP or PA is employed by the facility where the service was performed, the bill may be signed by the facility representative at 80 percent of the supervising physician's fee.

C. Management of a New or Established Patient with a New Workers' Compensation Problem

1) If the physician supervises the physician assistant's or nurse practitioner's evaluation, payment should be made at the physician's normal Workers' Compensation level for PA or NP services rendered in an outpatient setting.

2) Similar to Medicare regulations, which provide that where on-site direct physician supervision is not available in rural areas that meet the definition of Health Professional Shortage Areas (HPSA) and the physician assistant or nurse practitioner providing patient care is only able to communicate with a physician supervisor by telephone or other effective means of communication, payment for this service should be made at three-fourths (75 percent) of the Medical Fee Schedule.

3) Physician assistants and nurse practitioners acting in the capacity of an assistant at surgery will receive 10.7 percent of the total allowance for the surgical procedures. Payment will be made to the physician assistant's or nurse practitioner's employer (the physician).

D. Physician Assistant or Nurse Practitioner Care for New Problems

A physician assistant or nurse practitioner is not permitted to care for a new problem under the workers' compensation program without discussing the findings in person or by telephone with a responsible physician prior to instituting treatment. No payment should be made for care provided by the PA or NP that does not meet this requirement.

E. Follow-up Care of an Existing Patient with a Compensable Problem

If the physician supervises the physician assistant's or nurse practitioner's evaluation, all reports and bills shall be submitted in the name of the supervising authorized physician and shall be payable at 80 percent of the fee available for such treatment code.

F. Modifiers for Physician Assistant, Nurse Practitioner, and Licensed Clinical Social Worker's Services

When a physician assistant (PA) or nurse practitioner (NP) or licensed clinical social worker (AJ) bills for services (other than assistant at surgery), state-specific modifiers PA, NP, or HCPCS modifier AJ are used. 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 nonfacility 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, neurorrhaphy, 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 2018*.

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 Appendix E of *CPT 2018*.

In addition to the codes noted in Appendix E, Optum360 has identified codes that are modifier 51 exempt according to CPT guidelines. The following additional modifier 51 exempt codes are identified in the data with the icon ⓢ:

90281	90283	90284	90287	90288	90291
90296	90371	90375	90376	90378	90384
90385	90386	90389	90393	90396	90399
90476	90477	90581	90585	90586	90587
90620	90621	90625	90630	90632	90633
90634	90636	90644	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	90690	90691
90696	90697	90698	90700	90702	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	97140
97150	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			

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.

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.

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.

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.

63 Procedure Performed on Infants less than 4 kg
Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. **Note:** Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20005–69990 code series. Modifier 63 should not be appended to any CPT codes listed in the **Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory,** or **Medicine** sections.

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∞ Physician Assistant or Nurse Practitioner as Assistant Surgeon
When a physician assistant or nurse practitioner performs services for assistants at surgery, identify the services by adding modifier 83 to the usual procedure code. Services of a physician assistant or nurse practitioner are reimbursed at 10.7 percent of the listed value of the surgical code and payable to the supervising physician or facility where service was performed. This modifier is valid for surgery only. **Note:** General Ground Rule 11 is not applicable to Surgery Ground Rule 12 (F), whereby the surgeon must be directly and personally supervising the surgical assistants and such surgeon or facility where the service was performed must submit the bill for the surgical assistant's services in accordance with that Ground Rule.

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.

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.

1B∞ Behavioral Health Provider Enhanced Reimbursement
Provides a 20 percent reimbursement increase for E&M and Medicine services when rendered by providers with the following WCB assigned provider rating codes:
PN-P (Psychiatry), PN-ADP (Addiction Psychiatry), PN-PM (Pain Management) and PSY (Psychology).

1D∞ Designated Provider Enhanced Reimbursement
Provides an additional 20 percent reimbursement increase for E/M services performed by providers with the following WCB assigned provider rating codes: FP (Family Practice), GP (General Practice), and IM (Internal Medicine).

AJ Services Performed by a Licensed Clinical Social Worker
When services of a licensed clinical social worker are performed, identify the services by adding modifier AJ to the usual procedure code. Refer to Ground Rule 11 in this section for further clarification.

NP∞ Services Performed by a Nurse Practitioner
When services of a nurse practitioner are performed, identify the services by adding modifier NP to the usual procedure code. Refer to Ground Rule 11 in this section for further clarification.

PA∞ Services Performed by a Physician Assistant
When services of a physician assistant are performed, identify the services by adding modifier PA to the usual procedure code. Refer to Ground Rule 11 in this section for further clarification.

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. 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. 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. Designated Provider Enhanced Reimbursement

In an effort to increase the number of Board authorized providers in the general medicine (Family Practice, General Practice and Internal Medicine) specialties available to render care and treatment to injured workers, the WCB has established WCB specific modifier 1D which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1D provides an additional 20 percent reimbursement increase for E/M services performed by providers with the following WCB assigned provider rating codes: FP (Family Practice), GP (General Practice) and IM (Internal Medicine).

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 which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1B provides a 20 percent reimbursement increase for E/M and Medicine services when rendered by providers with the following WCB assigned provider rating codes: PN-P (Psychiatry), PN-ADP (Addiction Psychiatry), PN-PM (Pain Management) and PSY (Psychology).

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), and Psychologists (Behavioral Medicine Fee Schedule). A Podiatrist, Chiropractor, or Psychologist may not use the CPT coding guidelines contained in this Medical Fee Schedule. Podiatrists, Chiropractors, and Psychologists 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

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.

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. Conversion factors are located in the Introduction and General Guidelines section.

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.

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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

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 99241–99255.

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

Examples for E/M services are provided to assist physicians in understanding the meaning of the descriptors and selecting the correct code for the services they have rendered. 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 2018* guidelines define a new patient as listed below. The established patient definition has been expanded from *CPT 2018* 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/qualified health care professional, or another physician/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 procedure codes that exclusively represent established patient visits are identified in the fee schedule with the tilde symbol (~).

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

The first three components of history, examination, and medical decision making are the keys to selecting the correct level of E/M codes, and all three components must be addressed in the documentation. However, in established, subsequent, and follow-up categories, only two of the three components must be met or exceeded for a given code. *CPT 2018* guidelines define the following:

A) The history component is categorized by four levels:

Problem Focused: chief complaint; brief history of present illness or problem.

Expanded Problem Focused: chief complaint; brief history of present illness; problem-pertinent system review.

Detailed: chief complaint; extended history of present illness; problem-pertinent system review extended to include a review of limited number of additional systems; pertinent past, family medical and/or social history directly related to the patient's problems.

Comprehensive: chief complaint; extended history of present illness; review of systems which is directly related to the problems identified in the history of the present illness plus a review of all additional body systems; complete past, family, and social history.

B) The physical exam component is similarly divided into four levels of complexity:

Problem Focused: an exam limited to the affected body area or organ system.

Expanded Problem Focused: a limited examination of the affected body area or organ system and other symptomatic or related organ systems.

Detailed: an extended examination of the affected body areas and other symptomatic or related organ systems.

Comprehensive: a general multi-system examination or a complete examination of a single organ system.

CPT 2018 guidelines identify the following body areas:

- head, including face
- neck
- chest, including breasts and axilla
- abdomen
- genitalia, groin, buttocks
- back
- each extremity

CPT 2018 guidelines identify the following organ systems:

- eyes
- ears, nose, mouth, and throat
- cardiovascular
- respiratory
- gastrointestinal
- genitourinary
- musculoskeletal
- skin
- neurologic
- psychiatric
- hematologic/lymphatic/immunologic

C) Medical decision making is the final portion of the E/M coding process. Medical decision making refers to the complexity of establishing a

diagnosis or selecting a management option which can be measured by the following:

1) The number of diagnoses and/or the number of management options to be considered.
2) The amount and/or complexity of medical records, diagnostic tests, and other information that must be obtained, reviewed, and analyzed.
3) The risk of significant complications morbidity, and/or mortality, as well as co-morbidities associated with the patient's presenting problems, the diagnostic procedures, and/or the possible management options.

6. Contributory Components

Counseling, coordination of care, and the nature of the presenting problem are not major considerations in most encounters, so they generally provide contributory information to the code selection process. The exception arises when counseling or coordination of care dominates the encounter (more than 50 percent of the time spent). In these cases, time determines the proper code. Document the exact amount of time spent to substantiate the selected code and clearly record what was discussed during the encounter.

Counseling is defined in *CPT 2018* guidelines as a discussion with a patient and/or family concerning one or more of the following areas:

A) Diagnostic results, impressions, and/or recommended diagnostic studies;
B) Prognosis;
C) Risks and benefits of management (treatment) options;
D) Instructions for management (treatment) and/or follow-up;
E) Importance of compliance with chosen management (treatment) options;
F) Risk factor reduction; and
G) Patient and family education

E/M codes are designed to report actual work performed, not time spent. But when counseling or coordination of care dominates the encounter, time overrides the other factors and determines the proper code. Per *CPT 2018* guidelines for office encounters, count only the time spent face-to-face with the patient and/or family; for hospital or other inpatient encounters, count the time spent in the patient's unit or on the patient's floor. The time assigned to each code is an average and varies by provider.

According to the CPT book, "a presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason" for the patient encounter. *CPT 2018* defines five types of presenting problems. You should review these definitions frequently, but remember, this information merely contributes to code selection. The presenting problem is not a key factor.

7. Narrative Reports

A detailed narrative report must be submitted with the bill for the following procedures:

92004 92014 99204 99205 99215 99223
99244 99245 99254 99255 99285

When submitting a medical report and bill using the CMS-1500, all E/M codes must be submitted with a detailed narrative report.

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 2018*; much information is presented regarding aspects of a family history, the body areas, and organ systems associated with examinations, and so forth.

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

- A patient is considered an outpatient at a health care facility until formal inpatient admission occurs.
- All providers use codes 99281–99285 for reporting emergency department services, regardless of hospital-based or non-hospital-based status.

Office or Other Outpatient Services (99201–99215)

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

Hospital Observation Services (99217–99220, 99224–99226)

CPT codes 99217–99220 and 99224–99226 report E/M services provided to patients designated or admitted as "observation status" in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital to use these codes; however, whenever a patient is placed in a separately designated observation area of the hospital or emergency department, these codes should be used.

The *CPT 2018* instructional notes for Initial Hospital Observation Care include the following:

- Use these codes to report the encounters by the supervising physician or other qualified health care professional when the patient is designated as outpatient hospital "observation status."
- These codes include initiation of "observation status," supervision of the health care plan for observation, and performance of periodic reassessments.
- To report observation encounters by other physicians, see Office and Other Outpatient Consultation codes or subsequent observation care.
- When a patient is admitted to observation status in the course of an encounter in another site of service (e.g., hospital emergency department, physician's office, nursing facility), all E/M services provided by that physician or other qualified health care professional in conjunction with initiating "observation status" are considered part of the initial observation care when performed on the same date." Only one physician can report initial observation services. Do not use these observation codes for postrecovery of a procedure that is considered a global surgical service.
- Observation services are included in the inpatient admission service when provided on the same date. Use Initial Hospital Care codes for services provided to a patient who, after receiving observation services, is admitted to the hospital on the same date. The observation service is not reported separately.
- Admission to a hospital or nursing facility includes evaluation and management services provided elsewhere (office or emergency department) by the admitting provider on the same day.

Subsequent days of observation other than discharge date are reported with codes 99224–99226.

- To report observation services when the patient is admitted and discharged on the same date, see 99234–99236.

Observation Care Discharge Services (99217)

This code reports observation care discharge services. Use this code only if discharge from observation status occurs on a date other than the initial date of observation status. The code "includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. For observation or inpatient hospital care including admission and discharge of the patient on the same date, see codes 99234–99236 as appropriate.

Hospital Inpatient Services (99221–99223, 99231–99233)

The codes for hospital inpatient services report admission to a hospital setting, follow-up care provided in a hospital setting, and hospital discharge day management. Per *CPT 2018* guidelines for inpatient care, the time component includes not only face-to-face time with the patient but also the provider's time spent in the patient's unit or on the patient's floor. This time may include family counseling or discussing the patient's condition with the family; establishing and reviewing the patient's record; documenting within the chart; and communicating with other health care professionals, such as other providers, nursing staff, respiratory therapists, etc.

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

Observation or Inpatient Care Services (Including Admission and Discharge Services) (99234–99236)

Codes 99234–99236 report observation or inpatient hospital services provided to patients that are admitted and discharged on the same date of service. "When a patient is admitted to the hospital from observation status on the same date, only the initial hospital care code should be reported. The initial hospital care code reported by the admitting physician or other qualified health care professional should include the services related to the observation status services he/she provided on the same date of inpatient admission."

CPT 2018 guidelines state that when a patient is admitted to observation status in the course of an encounter in another site of service (e.g., hospital emergency department, office, nursing facility), all E/M services provided by the physician or other qualified health care professional in conjunction with initiating "observation status" are considered part of the initial observation care when performed on the same date. The observation care level of service should include the services related to initiating "observation status" provided in other sites of service as well as in the observation setting when provided by the same individual. Only one provider may report the same day admission and discharge services using codes 99234–99236.

For patients admitted to observation or inpatient care and discharged on a different date, see codes 99217 and 99218–99220, 99224–99226, or 99221–99223 and 99238–99239.

Hospital Discharge Services (99238–99239)

Codes 99238 and 99239 report hospital discharge day management, but excludes discharge of a patient from observation status (see 99217). When concurrent care is provided on discharge day by a provider other than the attending provider, report these services using Subsequent Hospital Care codes.

To report inpatient hospital services when the patient is admitted and discharged on the same date, see codes 99234–99236.

Consultations (99241–99255)

Consultations in *CPT 2018* fall under two subcategories: Office or Other Outpatient Consultations and Initial Inpatient Consultations. For Follow-up Inpatient Consultations, see Subsequent Hospital Care codes 99231–99233 and Subsequent Nursing Facility Care codes 99307–99310.

Evaluation and management consultation services will continue to be reported with CPT codes 99241–99245 for outpatient consultation services and codes 99251–99255 for inpatient consultation services. The rules and guidelines regarding the definition, documentation, and reporting of consultation services as contained in the CPT book will apply unless superseded by these guidelines.

Most requests for a consultation come from the attending physician, the employer, an attorney, or other appropriate source. The necessity for this service must be documented in the patient's record. Include the name of the requesting physician or other source on the claim form or electronic billing. Confirmatory consultations may be requested by the patient and/or family or may result from a second (or third) opinion. A confirmatory consultation requested by the patient and/or family is not reported with consultation codes but should instead be reported using the appropriate office visit codes (99201–99215). A confirmatory consultation requested by the attending physician, the employer, an attorney, or other appropriate source should be reported using the consultation code for the appropriate site of service (Office/Other Outpatient Consultations 99241–99245 or Initial Inpatient Consultations 99251–99255). If counseling dominates the encounter, time determines the correct code in both consultation subcategories.

Per *CPT 2018* guidelines the consultant may initiate diagnostic and/or therapeutic services, such as writing orders or prescriptions and initiating treatment plans.

The consultant's opinion and any services that were ordered or performed must be documented in the patient's medical record and communicated in writing to the requesting physician or other appropriate source.

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

If subsequent to the completion of a consultation the consultant assumes responsibility for the management of a portion or all of the patient's conditions the appropriate evaluation and management services code for the site of service should be reported.

Emergency Department Services (99281–99288)

Emergency department (ED) service codes do not differentiate between new and established patients and are used by hospital-based and non-hospital-based providers. The *CPT 2018* guidelines clearly define an emergency department as "an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day." Care provided in the ED setting for convenience should not be coded as an ED service. Also note that more than one ED service can be reported per calendar day if medically necessary.

Critical Care Services (99291–99292)

CPT 2018 guidelines define critical care as "the direct delivery by a physician(s) or other qualified health care professional of medical care for a critically ill or injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition." Carefully read the CPT guidelines for detailed information about the reporting of critical care services. "Critical care is usually, but not always, given in a critical care area such as a coronary care unit (CCU), intensive care unit (ICU), or respiratory care unit (RCU), or the emergency care facility." However, routine visits to a stabilized patient in ICU are not considered critical care. The following are instructional guidelines for the critical care service codes:

- Critical care codes include evaluation and management of the critically ill or injured patient, requiring constant attendance of the provider.
- Care provided to a patient who is not critically ill but happens to be in a critical care unit should be identified using Subsequent Hospital Care codes or Inpatient Consultation codes as appropriate.
- Critical care of less than 30 minutes should be reported using an appropriate E/M code.
- Critical care codes identify the total duration of time spent by a provider on a given date, even if the time is not continuous. Code 99291 reports the first hour of critical care and is used only once

per date. Code 99292 reports each additional 30 minutes of critical care per date.

- Critical care of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes should not be reported.

Nursing Facility Services (99304–99318)

Nursing Facility E/M Services have been grouped into four subcategories: Initial Nursing Facility Care, Subsequent Nursing Facility Care, Nursing Facility Discharge Services, and Other Nursing Facility Services. Included in these codes are E/M services provided to patients in psychiatric residential treatment centers. These facilities must provide a "24 hour therapeutically planned and professionally staffed group living and learning environment." Report other services, such as medical psychotherapy, separately when provided in addition to E/M services.

Domiciliary, Rest Home, Boarding Home, or Custodial Care Services (99324–99337)

These codes are used to report "evaluation and management services in a facility which provides room, board, and other personal assistance services generally on a long-term basis. The facility's services do not include a medical component."

Home Services (99341–99350)

Services and care provided at the patient's home are coded from this subcategory. Guidelines are similar to office and other outpatient E/M services.

Prolonged Services (99354–99359, 99360)

This section of E/M codes includes three service categories:

Prolonged Provider Service with Direct (Face-to-Face) Patient Contact

These codes report "services involving direct patient contact that is provided beyond the usual services," with separate codes for office or outpatient encounters (99354 and 99355) and for inpatient or observation encounters (99356 and 99357). Prolonged provider services are reportable in addition to other provider services, including any level of E/M service. Per *CPT 2018* guidelines, the codes report the total duration of face-to-face time spent by the physician or other qualified health care professional on a given date, even if the time spent by the physician or other health care professional on that date is not continuous.

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

Prolonged provider services should be reported only once per date of service, even if the time spent is not continuous. Please refer to *CPT 2018* for a more complete explanation of prolonged provider care.

Prolonged Provider Service without Direct (Face-to-Face) Patient Contact

Use code 99358 to report the first hour and 99359 for each additional 30 minutes. All aspects of time reporting are the same as explained above for direct patient contact services.

These prolonged provider services without direct patient contact may include review of extensive records and tests, and communication (other than telephone calls, 99441–99443) with other professionals and/or the patient and family. These are beyond the usual services and include both inpatient and outpatient settings. Report these services in addition to other services provided, including any level of E/M service.

Use code 99358 to report the first hour and 99359 for each additional 30 minutes. All aspects of time reporting are the same as explained above for direct patient contact services.

Provider Standby Services

Code 99360 is "used to report physician or other qualified health care professional standby services that are requested by another individual and that involve prolonged attendance without direct (face-to-face) patient contact. Care or services may not be provided to other patients during this period." Code 99360 may "not be used if the period of standby ends with the performance of a procedure subject to a surgical package by the individual who was on standby."

Standby services are reported in 30 minute increments. A standby period of less than 30 minutes is not reportable. Second and subsequent standby periods of 30 minutes are reportable only if a full 30 minutes of standby was provided.

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

Per *CPT 2018* care plan oversight services are reported separately from codes for office/outpatient, hospital, home, nursing facility, or domiciliary services, or non-face-to-face services. Care plan oversight services for patients under the individual supervision of a provider in a domiciliary, rest home, or home care

setting are reported with 99339–99340. Care plan oversight services for patients under the care of a home health agency, hospice, or nursing facility are reported with 99374–99380. "The complexity and the approximate time of the care plan oversight services provided within a 30-day period determine the code selection."

"Only one individual may report services for a given period of time, to reflect the sole or predominant supervisory role with a particular patient. These codes should not be reported for supervision of patients in a nursing facility or under the care of home health agencies unless they require recurrent supervision of therapy."

Special Evaluation and Management Services (99450–99456)

This series of codes reports provider evaluations performed to establish baseline information for insurance certification and/or work-related or medical disability.

Special Instructions for Use of Codes 99455 and 99456

Please refer to the General Ground Rules for information regarding reimbursement for By Report (BR) designated CPT codes.

Other Evaluation and Management Services (99499)

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

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. Modifiers commonly used with E/M procedures are as follows:

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.

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.

1B∞ Behavioral Health Provider Enhanced Reimbursement
Provides a 20 percent reimbursement increase for E/M and Medicine services when rendered by providers with the following WCB assigned provider rating codes: PN-P (Psychiatry), PN-ADP (Addiction Psychiatry), PN-PM (Pain Management) and PSY (Psychology).

1D∞ Designated Provider Enhanced Reimbursement
Provides an additional 20 percent reimbursement increase for E/M services performed by providers with the following WCB assigned provider rating codes: FP (Family Practice), GP (General Practice), and IM (Internal Medicine).

NP∞ Services Performed by a Nurse Practitioner
When services of a nurse practitioner are performed, identify the services by adding modifier NP to the usual procedure code. Refer to Ground Rule 11 in the Introduction and General Guidelines section for further clarification.

PA∞ Services Performed by a Physician Assistant
When services of a physician assistant are performed, identify the services by adding modifier PA to the usual procedure code. Refer to Ground Rule 11 in the Introduction and General Guidelines section for further clarification.

10. Designated Provider Enhanced Reimbursement

In an effort to increase the number of Board authorized providers in the general medicine (Family Practice, General Practice, and Internal Medicine) specialties available to render care and treatment to injured workers, the WCB has established WCB specific modifiers 1D which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1D provides an additional 20 percent reimbursement increase for E/M services performed by providers with the following WCB assigned provider rating codes: FP (Family Practice), GP (General Practice) and IM (Internal Medicine).

11. 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 which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1B provides a 20 percent reimbursement increase for E/M and Medicine services when rendered by providers with the following WCB assigned provider rating codes: PN-P (Psychiatry), PN-ADP (Addiction Psychiatry), PN-PM (Pain Management) and PSY (Psychology).

12. 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.

99201–99499 EVALUATION AND MANAGEMENT

Effective April 1, 2019 Medical Fee Schedule

		Code	Description	Relative Value	FUD
■		**99201**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	5.83	XXX
■		**99202**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	7.27	XXX
■		**99203**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	9.47	XXX
■		**99204**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	13.53	XXX
■		**99205**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	18.26	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. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	3.21	XXX
■	~	**99212**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	4.57	XXX
■	~	**99213**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	5.83	XXX
■	~	**99214**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	8.46	XXX

EVALUATION AND MANAGEMENT 99201–99499

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD
■	~	**99215**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	13.53	XXX
■		**99217**	Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.])	10.15	XXX
■		**99218**	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.	12.68	XXX
■		**99219**	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	17.25	XXX
■		**99220**	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	21.64	XXX
■		**99221**	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.	14.12	XXX
■		**99222**	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	19.02	XXX
■		**99223**	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	23.34	XXX

	Code	Description	Relative Value	FUD
■	**99224**	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.	4.06	XXX
■	**99225**	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.	8.12	XXX
■	**99226**	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.	11.33	XXX
■	**99231**	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.	7.44	XXX
■	**99232**	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.	10.15	XXX
■	**99233**	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.	14.97	XXX
■	**99234**	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.	13.95	XXX
■	**99235**	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	18.94	XXX

EVALUATION AND MANAGEMENT 99201–99499

Medical Fee Schedule **Effective April 1, 2019**

	Code	Description	Relative Value	FUD
■	**99236**	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.	23.84	XXX
	99238	Hospital discharge day management; 30 minutes or less	8.79	XXX
	99239	Hospital discharge day management; more than 30 minutes	10.99	XXX
■	**99241**	Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.	10.15	XXX
■	**99242**	Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	12.94	XXX
■	**99243**	Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	16.49	XXX
■	**99244**	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	21.56	XXX
■	**99245**	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.	27.23	XXX
■	**99251**	Inpatient consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit.	12.01	XXX
■	**99252**	Inpatient consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.	15.39	XXX

99201–99499 EVALUATION AND MANAGEMENT

Effective April 1, 2019 **Medical Fee Schedule**

	Code	Description	Relative Value	FUD
■	**99253**	Inpatient consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.	18.94	XXX
■	**99254**	Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent at the bedside and on the patient's hospital floor or unit.	23.67	XXX
■	**99255**	Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 110 minutes are spent at the bedside and on the patient's hospital floor or unit.	29.76	XXX
■	**99281**	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.	6.59	XXX
■	**99282**	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	8.88	XXX
■	**99283**	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	13.36	XXX
■	**99284**	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.	19.95	XXX
■	**99285**	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	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

■ New code, changed description, or changed value from June 1, 2012

EVALUATION AND MANAGEMENT 99201–99499

Medical Fee Schedule **Effective April 1, 2019**

	Code	Description	Relative Value	FUD
■	**99304**	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.	8.46	XXX
■	**99305**	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.	11.84	XXX
■	**99306**	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.	14.37	XXX
■	**99307**	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.	4.73	XXX
■	**99308**	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.	6.43	XXX
■	**99309**	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.	9.30	XXX
■	**99310**	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.	12.68	XXX
	99315	Nursing facility discharge day management; 30 minutes or less	8.79	XXX
	99316	Nursing facility discharge day management; more than 30 minutes	10.99	XXX
■	**99318**	Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and Medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 30 minutes are spent at the bedside and on the patient's facility floor or unit.	9.30	XXX

99201–99499 EVALUATION AND MANAGEMENT

Effective April 1, 2019 Medical Fee Schedule

		Code	Description	Relative Value	FUD
■		**99324**	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent with the patient and/or family or caregiver.	8.29	XXX
■		**99325**	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient and/or family or caregiver.	10.99	XXX
■		**99326**	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient and/or family or caregiver.	13.87	XXX
■		**99327**	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent with the patient and/or family or caregiver.	19.45	XXX
■		**99328**	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent with the patient and/or family or caregiver.	25.37	XXX
■	~	**99334**	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver.	5.92	XXX
■	~	**99335**	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.	8.46	XXX
■	~	**99336**	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient and/or family or caregiver.	12.68	XXX

EVALUATION AND MANAGEMENT 99201–99499

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD
■	~	**99337**	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent with the patient and/or family or caregiver.	17.76	XXX
		99339	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	6.76	XXX
		99340	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	22.18	XXX
■		**99341**	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	7.69	XXX
■		**99342**	Home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	9.64	XXX
■		**99343**	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	12.51	XXX
■		**99344**	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	17.76	XXX
■		**99345**	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent face-to-face with the patient and/or family.	24.01	XXX

99201–99499 EVALUATION AND MANAGEMENT

Effective April 1, 2019 **Medical Fee Schedule**

		Code	Description	Relative Value	FUD
■	~	**99347**	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.	6.00	XXX
■	~	**99348**	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	7.69	XXX
■	~	**99349**	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	11.16	XXX
■	~	**99350**	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.	17.84	XXX
■	+	**99354**	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)	19.45	ZZZ
■	+	**99355**	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)	9.72	ZZZ
	+	**99356**	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)	25.37	ZZZ
	+	**99357**	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)	12.68	ZZZ
		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

■ New code, changed description, or changed value from June 1, 2012

EVALUATION AND MANAGEMENT 99201–99499

Medical Fee Schedule **Effective April 1, 2019**

	Code	Description	Relative Value	FUD
■	**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
■	**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
	99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)	NC	XXX
	99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)	NC	XXX
	99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)	NC	XXX

	Code	Description	Relative Value	FUD
	99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)	NC	XXX
	99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years	NC	XXX
	99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years	NC	XXX
	99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older	NC	XXX
~	**99391**	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)	NC	XXX
~	**99392**	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)	NC	XXX
~	**99393**	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)	NC	XXX
~	**99394**	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)	NC	XXX
~	**99395**	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years	NC	XXX
~	**99396**	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years	NC	XXX
~	**99397**	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older	NC	XXX
	99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	NC	XXX
	99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes	NC	XXX
	99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes	NC	XXX
	99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes	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

■ New code, changed description, or changed value from June 1, 2012

EVALUATION AND MANAGEMENT 99201–99499

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD
		99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes	NC	XXX
		99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes	NC	XXX
■	+	**99415**	Prolonged clinical staff service (the service beyond the typical service time) 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 typical service time) 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
		99429	Unlisted preventive medicine service	NC	XXX
■	~	**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
■	~	**99444**	Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network	4.57	XXX
■		**99446**	Interprofessional telephone/Internet assessment and management service provided by a consultative physician 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 assessment and management service provided by a consultative physician 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 assessment and management service provided by a consultative physician 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 assessment and management service provided by a consultative physician 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

		Code	Description	Relative Value	FUD
		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
		99460	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant	14.37	XXX
		99461	Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center	7.61	XXX
		99462	Subsequent hospital care, per day, for evaluation and management of normal newborn	6.76	XXX
		99463	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date	15.22	XXX
■		99464	Attendance at delivery (when requested by the delivering physician or other qualified health care professional) and initial stabilization of newborn	15.22	XXX
		99465	Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	27.06	XXX
■		99466	Critical care face-to-face services, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or younger; first 30-74 minutes of hands-on care during transport	31.28	XXX
■	+	99467	Critical care face-to-face services, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or younger; each additional 30 minutes (List separately in addition to code for primary service)	18.60	ZZZ
		99468	Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger	120.06	XXX
		99469	Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger	80.32	XXX
		99471	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	105.69	XXX
		99472	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	76.10	XXX
		99475	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	89.62	XXX
		99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	67.64	XXX
		99477	Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or younger, who requires intensive observation, frequent interventions, and other intensive care services	84.55	XXX
		99478	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)	33.82	XXX
		99479	Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)	31.79	XXX
		99480	Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)	29.93	XXX

EVALUATION AND MANAGEMENT 99201–99499

Medical Fee Schedule **Effective April 1, 2019**

		Code	Description	Relative Value	FUD
■		**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, 50 minutes are spent face-to-face with the patient and/or family or caregiver.	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
■		**99485**	Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; first 30 minutes	15.53	XXX
■	+	**99486**	Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)	13.53	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 place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 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 place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, 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, 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: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.	8.14	XXX

		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 Medical decision making of at least moderate complexity 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 Medical decision making of high complexity 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

■ New code, changed description, or changed value from June 1, 2012

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 are located in the Introduction and General Guidelines section.

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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. General

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.

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 postoperative 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 diagnostic or therapeutic nerve block see 62320–62327, 64400–64681.

B) For cardiopulmonary resuscitation (separate procedure unrelated to the administration of anesthesia) see 92950.

C) For obstetrical anesthesia refer to Ground Rule 6: Calculation of Total Anesthesia Values.

D) 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.

E) 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.

F) 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 4.0 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 = Time Units)
= Total Units

Step 3:
Basic Value Units
\+ Time Units
x 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

These physical status modifiers are consistent with the American Society of Anesthesiologists (ASA) ranking of patient physical status, except for the exclusion of modifier P6. 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. 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.

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
= Basic Value Units

Step 2:
Basic Value Units
\+ Time Units (Anesthesia Time = Time Units)
= Total Units

Step 3:
Basic Value Units
\+ Time Units
\+ Qualifying Circumstances Unit
x 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 nonfacility setting, the conscious sedation service may be billed separately. See General Ground Rule 12 for additional guidelines related to reporting of moderate (conscious) sedation.

00100–01999, 99100–99140 ANESTHESIA

Effective April 1, 2019 Medical Fee Schedule

Code	Description	Basic Unit
00100	Anesthesia for procedures on salivary glands, including biopsy	5.00
00102	Anesthesia for procedures involving plastic repair of cleft lip	6.00
00103	Anesthesia for reconstructive procedures of eyelid (eg, blepharoplasty, ptosis surgery)	5.00
00104	Anesthesia for electroconvulsive therapy	4.00
00120	Anesthesia for procedures on external, middle, and inner ear including biopsy; not otherwise specified	5.00
00124	Anesthesia for procedures on external, middle, and inner ear including biopsy; otoscopy	4.00
00126	Anesthesia for procedures on external, middle, and inner ear including biopsy; tympanotomy	4.00
00140	Anesthesia for procedures on eye; not otherwise specified	5.00
00142	Anesthesia for procedures on eye; lens surgery	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
00326	Anesthesia for all procedures on the larynx and trachea in children younger than 1 year of age	8.00
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10.00
00352	Anesthesia for procedures on major vessels of neck; simple ligation	5.00
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified	3.00
00402	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; reconstructive procedures on breast (eg, reduction or augmentation mammoplasty, muscle flaps)	5.00
00404	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; radical or modified radical procedures on breast	5.00

ANESTHESIA 00100–01999, 99100–99140

Medical Fee Schedule Effective April 1, 2019

Code	Description	Basic Unit
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
00561	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, younger than 1 year of age	25.00
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

00100–01999, 99100–99140 ANESTHESIA

Effective April 1, 2019 Medical Fee Schedule

Code	Description	Basic Unit
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
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
00834	Anesthesia for hernia repairs in the lower abdomen not otherwise specified, younger than 1 year of age	5.00
00836	Anesthesia for hernia repairs in the lower abdomen not otherwise specified, infants younger than 37 weeks gestational age at birth and younger than 50 weeks gestational age at time of surgery	6.00
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified	6.00
00842	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; amniocentesis	4.00
00844	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; abdominoperineal resection	7.00
00846	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; radical hysterectomy	8.00
00848	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; pelvic exenteration	8.00
00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection	6.00

ANESTHESIA 00100–01999, 99100–99140

Medical Fee Schedule Effective April 1, 2019

Code	Description	Basic Unit
00860	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified	6.00
00862	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal procedures, including upper one-third of ureter, or donor nephrectomy	7.00
00864	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; total cystectomy	8.00
00865	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; radical prostatectomy (suprapubic, retropubic)	7.00
00866	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; adrenalectomy	10.00
00868	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal transplant (recipient)	10.00
00870	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; cystolithotomy	5.00
00872	Anesthesia for lithotripsy, extracorporeal shock wave; with water bath	7.00
00873	Anesthesia for lithotripsy, extracorporeal shock wave; without water bath	5.00
00880	Anesthesia for procedures on major lower abdominal vessels; not otherwise specified	15.00
00882	Anesthesia for procedures on major lower abdominal vessels; inferior vena cava ligation	10.00
00902	Anesthesia for; anorectal procedure	5.00
00904	Anesthesia for; radical perineal procedure	7.00
00906	Anesthesia for; vulvectomy	4.00
00908	Anesthesia for; perineal prostatectomy	6.00
00910	Anesthesia for transurethral procedures (including urethrocystoscopy); not otherwise specified	3.00
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

00100–01999, 99100–99140 ANESTHESIA

Effective April 1, 2019 **Medical Fee Schedule**

Code	Description	Basic Unit
00948	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); cervical cerclage	4.00
00950	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); culdoscopy	5.00
00952	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography	4.00
01112	Anesthesia for bone marrow aspiration and/or biopsy, anterior or posterior iliac crest	5.00
01120	Anesthesia for procedures on bony pelvis	6.00
01130	Anesthesia for body cast application or revision	3.00
01140	Anesthesia for interpelviabdominal (hindquarter) amputation	15.00
01150	Anesthesia for radical procedures for tumor of pelvis, except hindquarter amputation	10.00
01160	Anesthesia for closed procedures involving symphysis pubis or sacroiliac joint	4.00
01170	Anesthesia for open procedures involving symphysis pubis or sacroiliac joint	8.00
01173	Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum	12.00
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
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

ANESTHESIA 00100–01999, 99100–99140

Medical Fee Schedule Effective April 1, 2019

Code	Description	Basic Unit
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; interthoracoscapular (forequarter) amputation	15.00
01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	10.00
01650	Anesthesia for procedures on arteries of shoulder and axilla; not otherwise specified	6.00
01652	Anesthesia for procedures on arteries of shoulder and axilla; axillary-brachial aneurysm	10.00
01654	Anesthesia for procedures on arteries of shoulder and axilla; bypass graft	8.00
01656	Anesthesia for procedures on arteries of shoulder and axilla; axillary-femoral bypass graft	10.00
01670	Anesthesia for all procedures on veins of shoulder and axilla	4.00
01680	Anesthesia for shoulder cast application, removal or repair, not otherwise specified	3.00
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

00100–01999, 99100–99140 ANESTHESIA

Effective April 1, 2019 **Medical Fee Schedule**

	Code	Description	Basic Unit
	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
	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
	01935	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic	5.00
	01936	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic	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

ANESTHESIA 00100–01999, 99100–99140

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Basic Unit
	01960	Anesthesia for vaginal delivery only	5.00
	01961	Anesthesia for cesarean delivery only	7.00
	01962	Anesthesia for urgent hysterectomy following delivery	8.00
	01963	Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care	10.00
	01965	Anesthesia for incomplete or missed abortion procedures	4.00
	01966	Anesthesia for induced abortion procedures	4.00
	01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)	5.00
+	01968	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)	3.00
+	01969	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)	5.00
	01990	Physiological support for harvesting of organ(s) from brain-dead patient	7.00
■	01991	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different 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. Conversion factors are located in the Introduction and General Guidelines section.

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.

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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

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.) (For preoperative visits, see Surgery Ground Rule 2.)

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

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 ⓫). 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 ⓫) codes are designated with the appropriate icons and are also addressed in Ground Rules 13 and 14 of the General Ground Rules.

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.

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. Operative Reports and Billing

Bills for operative procedures must include an operative report. A bill for an operative procedure shall not be deemed properly submitted unless and until an operative report is received by the payer. If the procedure is performed in a hospital, a copy of the hospital operative report is required. For other sites, the location should be identified and an informative description of the surgery submitted. An operative report shall include but not be limited to a brief but

adequate summary of the history, physical findings, operative findings, and an accurate and complete description of the surgical procedures performed.

10. By Report (BR) Items

"BR" in the relative value column indicates that the value of this service is to be determined "by report" because the service is too unusual or variable to be assigned a relative value. Information concerning the nature, extent and need for the procedure or service, time, skill and equipment necessary, etc., is to be furnished using all of the following:

A) Diagnosis (postoperative), pertinent history, and physical findings.

B) Size, location, and number of lesions or procedures where appropriate.

C) A complete description of the major surgical procedure and the supplementary procedures.

D) When possible, list the closest similar procedure by code and relative value unit. The "BR" relative value unit shall be consistent in relativity with other relative value units in the schedule.

E) Estimated follow-up period, if not listed.

F) Operative time.

11. Unlisted Services or Procedures

Some services performed are not described by any CPT code. These services should be reported using an unlisted code and substantiating it by report as discussed in Surgery Ground Rule 10. The unlisted procedures and accompanying codes for surgery will be found at the end of the relevant section or subsection.

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:** 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.

C) **Two surgeons:** 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, 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.

In the event of no agreement between co-surgeons, the proration shall be determined by a WCB Medical Arbitration Committee.

E) **Surgical Team:** 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) **Physician Assistants and Nurse Practitioners:** Services of physician assistants and nurse practitioners assisting during surgical procedures will be paid at two-thirds of the surgical assistant percentage (16.0 percent). Physician assistants will receive 10.7 percent of the total allowance for the surgical procedures. Payment will be made to the supervising physician performing the surgery. General Ground Rule 11 is not

applicable to surgical assistants. The bill must be submitted by the supervising physician who performed the surgery where such assistance was rendered.

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. If no agreement is reached by the providers involved, the apportionment shall be determined by the WCB Medical Arbitration Committee.

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. If no proration agreement is reached by them, the amounts payable to each party shall be settled by an arbitration committee appointed pursuant to Section 13-g of the Workers' Compensation Law, without cost to the contestants. 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

Do not report supplies that are customarily included in surgical packages, such as gauze, sponges, Steri-strips, and dressings. Surgical services do not include the supply of medications, sterile trays, and other materials which may be reported separately with code 99070. The specific items provided must be identified. Payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping and handling 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.

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 six of section 6810 of the Public Health Law.

Durable Medical Equipment Fee Schedule

The Durable Medical Equipment Fee Schedule adopted is still the Medicaid fee schedule. However, the regulation includes clarification on the application of the Medicaid fee schedule to workers' compensation claims. Specifically, the regulation provides that payments for bone growth stimulators are made in a single payment for the entire amount, that the reimbursement for orthopedic footwear is the lesser of the acquisition cost to the provider plus 50 percent or the usual and customary price charged to the public, and that hearing aids are not considered durable medical equipment for purposes of the fee schedule and the reimbursement amount is the provider's usual and customary price.

The Durable Medical Equipment Fee Schedule does not apply to medical providers supplying durable medical equipment to injured workers as part of medical treatment described in the *Official New York State Workers' Compensation Medical Fee Schedule.* Billing and reimbursement follow the ground rules as described in this fee schedule.

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.

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 12-D, 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. Modifiers commonly used with surgical 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.

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.

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.

63 Procedure Performed on Infants less than 4 kg
Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. **Note:** Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20005–69990 code series. Modifier 63 should not be appended to any CPT codes listed in the **Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory**, or **Medicine** sections.

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∞ Physician Assistant or Nurse Practitioner as Assistant Surgeon
When a physician assistant or nurse practitioner performs services for assistants at surgery, identify the services by adding modifier 83 to the usual procedure code. Services of a physician assistant or nurse practitioner are reimbursed at 10.7 percent of the listed value of the surgical code and payable to the employing physician. This modifier is valid for surgery only. Please refer to Ground Rule 12 (F) and Surgery Ground Rule 12 for additional reimbursement guidelines.

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.

NP∞ Services Performed by a Nurse Practitioner
When pre- or postsurgery services of a nurse practitioner are performed, identify the services by adding modifier NP to the usual procedure code. Refer to General Ground Rule 11 for further clarification.

PA∞ Services Performed by a Physician Assistant
When pre- or postsurgery services of a physician assistant are performed, identify the services by adding modifier PA to the usual procedure code. Refer to General Ground Rule 11 for further clarification.

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
		10021	Fine needle aspiration; without imaging guidance	0.38	XXX	
		10022	Fine needle aspiration; with imaging guidance	0.56	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	
		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	

	Code	Description	Relative Value	FUD	PC/TC Split
+	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	
	11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion	0.34	000	
+	11101	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)	0.25	ZZZ	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
	11606	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm	2.42	010	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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 prosthesis	7.90	090	
11971	Removal of tissue expander(s) without insertion of prosthesis	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, non-biodegradable drug delivery implant	0.74	XXX	
11982	Removal, non-biodegradable drug delivery implant	0.74	XXX	
11983	Removal with reinsertion, non-biodegradable drug delivery implant	0.81	XXX	
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	
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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	Filleted 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	
+	**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	

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+	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	
	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	
	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	

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SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
■	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	
	15770	Graft; derma-fat-fascia	5.14	090	
	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	
	15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	7.80	090	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
	15850	Removal of sutures under anesthesia (other than local), same surgeon	0.50	XXX	
	15851	Removal of sutures under anesthesia (other than local), other surgeon	0.31	000	
	15852	Dressing change (for other than burns) under anesthesia (other than local)	0.35	000	
	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	15922	Excision, coccygeal pressure ulcer, with coccygectomy; with flap closure	6.28	090	
	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	
	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	

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■	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
	+	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	
		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	

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
		19260	Excision of chest wall tumor including ribs	6.18	090	
		19271	Excision of chest wall tumor involving ribs, with plastic reconstruction; without mediastinal lymphadenectomy	9.95	090	
		19272	Excision of chest wall tumor involving ribs, with plastic reconstruction; with mediastinal lymphadenectomy	10.85	090	
■		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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
19303	Mastectomy, simple, complete	4.85	090	
19304	Mastectomy, subcutaneous	3.68	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	
19316	Mastopexy	7.63	090	
19318	Reduction mammaplasty	10.00	090	
19324	Mammaplasty, augmentation; without prosthetic implant	3.49	090	
19325	Mammaplasty, augmentation; with prosthetic implant	5.84	090	
19328	Removal of intact mammary implant	3.77	090	
19330	Removal of mammary implant material	3.00	090	
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	3.54	090	
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	6.90	090	
19350	Nipple/areola reconstruction	6.90	090	
19355	Correction of inverted nipples	0.89	090	
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	10.00	090	
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant	16.00	090	
19364	Breast reconstruction with free flap	10.37	090	
19366	Breast reconstruction with other technique	8.86	090	
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;	21.00	090	
19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)	24.00	090	
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site	20.67	090	
19370	Open periprosthetic capsulotomy, breast	4.50	090	
19371	Periprosthetic capsulectomy, breast	7.00	090	
19380	Revision of reconstructed breast	3.85	090	
19396	Preparation of moulage for custom breast implant	0.45	000	
19499	Unlisted procedure, breast	BR	YYY	
20005	Incision and drainage of soft tissue abscess, subfascial (ie, involves the soft tissue below the deep fascia)	0.60	010	
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	
20225	Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)	2.02	000	

	Code	Description	Relative Value	FUD	PC/TC Split
■	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	
■	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	
	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
		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	
		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	
		20926	Tissue grafts, other (eg, paratenon, fat, dermis)	2.07	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	
	+	**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	

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
		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	
		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	

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SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	
21310	Closed treatment of nasal bone fracture without manipulation	1.03	000	
21315	Closed treatment of nasal bone fracture; without stabilization	0.79	010	
21320	Closed treatment of nasal bone fracture; with stabilization	1.98	010	
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	

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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 ostectomy	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	
	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	Ostectomy of sternum, partial	8.28	090	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
		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	

		Code	Description	Relative Value	FUD	PC/TC Split
■		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	
		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, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	18.42	090	
	+	22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy 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 level; cervical below C2 segment	16.08	090	
		22610	Arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)	15.81	090	
		22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	15.81	090	
	+	22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
+	**22632**	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)	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 and segment; lumbar	19.80	090	
+	**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 and segment; each additional interspace and segment (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	
+	**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	
+	**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	

		Code	Description	Relative Value	FUD	PC/TC Split
■	+	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 osteophytectomy 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 osteophytectomy 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	
		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	
■	+	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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 methyl-methacrylate; clavicle	6.14	090	
	23491	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methyl-methacrylate; 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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	
24000	Arthrotomy, elbow, including exploration, drainage, or removal of foreign body	6.62	090	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	
25275	Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)	5.18	090	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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, mallet finger)	3.23	090	
26433	Repair of extensor tendon, distal insertion, primary or secondary; without graft (eg, mallet finger)	3.67	090	

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

Code	Description	Relative Value	FUD	PC/TC Split
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	
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, methyl-methacrylate 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 auto-graft 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	
27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixa-tion and/or cast	14.33	090	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
■	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, open, sacroiliac joint, including 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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
■	27370	Injection of contrast for knee arthrography	0.40	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	

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	
27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed	12.94	090	

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	010	
	28002	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space	3.67	010	
	28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	3.67	090	
	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	
	28060	Fasciectomy, plantar fascia; partial (separate procedure)	4.74	090	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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 (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method	5.18	090	
■	**28295**	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal metatarsal osteotomy, any method	9.41	090	
■	**28296**	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method	7.77	090	
■	**28297**	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method	6.21	090	
■	**28298**	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method	5.61	090	
■	**28299**	Correction, hallux valgus (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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	28805	Amputation, foot; transmetatarsal	7.77	090	
	28810	Amputation, metatarsal, with toe, single	5.18	090	
	28820	Amputation, toe; metatarsophalangeal joint	3.67	090	
	28825	Amputation, toe; interphalangeal joint	3.23	090	
■	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	29435	Application of patellar tendon bearing (PTB) cast	0.74	000	
	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	7.55	090	
	29823	Arthroscopy, shoulder, surgical; debridement, extensive	8.20	090	
	29824	Arthroscopy, shoulder, surgical; distal claviculectomy 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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	
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	

	Code	Description	Relative Value	FUD	PC/TC Split
	31030	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyps	6.09	090	
	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	
■	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	
■	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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 medial or inferior orbital wall decompression	7.49	010	
	31293	Nasal/sinus endoscopy, surgical; with medial orbital wall and inferior orbital wall decompression	8.43	010	
	31294	Nasal/sinus endoscopy, surgical; with optic nerve decompression	9.90	010	
	31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa	16.39	000	
	31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)	18.73	000	
	31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)	18.73	000	
■	**31298**	Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation)	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	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
■	31551	Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, younger than 12 years of age	13.75	090	
■	31552	Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, age 12 years or older	13.79	090	
■	31553	Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, younger than 12 years of age	15.17	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	
	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	
	31595	Section recurrent laryngeal nerve, therapeutic (separate procedure), unilateral	4.68	090	
	31599	Unlisted procedure, larynx	BR	YYY	
	31600	Tracheostomy, planned (separate procedure);	3.28	000	
	31601	Tracheostomy, planned (separate procedure); younger than 2 years	3.75	000	
	31603	Tracheostomy, emergency procedure; transtracheal	3.75	000	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
+	**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	

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
■		**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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	31825	Surgical closure tracheostomy or fistula; with plastic repair	3.75	090	
	31830	Revision of tracheostomy scar	2.81	090	
	31899	Unlisted procedure, trachea, bronchi	BR	YYY	
	32035	Thoracostomy; with rib resection for empyema	6.09	090	
	32036	Thoracostomy; 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-plication 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	
	32405	Biopsy, lung or mediastinum, percutaneous needle	1.59	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	
	32491	Removal of lung, other than pneumonectomy; with resection-plication 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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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, extraperiosteal, 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	

	Code	Description	Relative Value	FUD	PC/TC Split
	33010	Pericardiocentesis; initial	1.26	000	
	33011	Pericardiocentesis; subsequent	0.77	000	
	33015	Tube pericardiostomy	1.69	090	
	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	
+	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
■	+	**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	
		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	
	+	**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	

		Code	Description	Relative Value	FUD	PC/TC Split
■		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	
■		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	
		33282	Implantation of patient-activated cardiac event recorder	3.08	090	
		33284	Removal of an implantable, patient-activated cardiac event recorder	2.21	090	
		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	
■		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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
■	+	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	
■		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	
■	+	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	
		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	
		33470	Valvotomy, pulmonary valve, closed heart; transventricular	14.98	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	

	Code	Description	Relative Value	FUD	PC/TC Split
■	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	
+	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
+	**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	
	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	

	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	
	33722	Closure of aortico-left ventricular tunnel	21.54	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	
	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
	33860	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed	21.07	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	
	33870	Transverse arch graft, with cardiopulmonary bypass	34.65	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	

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
		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	
■		33951	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	4.15	000	
■		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	
■		33953	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	4.64	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	**33955**	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	8.14	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	
■	**33957**	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	1.81	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	
■	**33959**	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance, when performed)	2.30	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	
■	**33963**	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)	4.59	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	
■	**33965**	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age	1.81	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	
■	**33969**	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	2.68	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	
	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	

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
■		33985	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	5.04	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; arterial access only	4.16	XXX	
■		33991	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; both arterial and venous access, with transseptal puncture	6.13	XXX	
■		33992	Removal of percutaneous ventricular assist device at separate and distinct session from insertion	1.95	XXX	
■		33993	Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion	1.71	XXX	
		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	
		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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
■	**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	

		Code	Description	Relative Value	FUD	PC/TC Split
■	+	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	
■	+	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	
	+	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	
		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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	**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	
■	**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 endoprostheses (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 endoprostheses (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 endoprostheses (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	

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	35361	Thromboendarterectomy, including patch graft, if performed; combined aortoiliac	13.58	090	
	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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 (List separately in addition to code for primary procedure)	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	
+	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	

	Code	Description	Relative Value	FUD	PC/TC Split
+	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), with or without lysis of artery; carotid artery	5.34	090	
	35721	Exploration (not followed by surgical repair), with or without lysis of artery; femoral artery	4.21	090	
	35741	Exploration (not followed by surgical repair), with or without lysis of artery; popliteal artery	4.21	090	
	35761	Exploration (not followed by surgical repair), with or without lysis of artery; other vessels	4.68	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, Dacron, 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	
	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
■		**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	
■		**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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	36262	Removal of implanted intra-arterial infusion pump	2.34	090	
	36299	Unlisted procedure, vascular injection	BR	YYY	
■	36400	Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein	0.26	XXX	
■	36405	Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; scalp vein	0.23	XXX	
■	36406	Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; other vein	0.23	XXX	
■	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	
	36420	Venipuncture, cutdown; younger than age 1 year	0.49	XXX	
	36425	Venipuncture, cutdown; age 1 or over	0.42	XXX	
	36430	Transfusion, blood or blood components	0.37	XXX	
	36440	Push transfusion, blood, 2 years or younger	0.66	XXX	
	36450	Exchange transfusion, blood; newborn	2.34	XXX	
	36455	Exchange transfusion, blood; other than newborn	2.34	XXX	
■	36456	Partial exchange transfusion, blood, plasma or crystalloid necessitating the skill of a physician or other qualified health care professional, newborn	1.05	XXX	
	36460	Transfusion, intrauterine, fetal	4.68	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
■	+	**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	
■	+	**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; younger than 5 years of age	2.81	000	

	Code	Description	Relative Value	FUD	PC/TC Split
	36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; 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	
	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	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	36838	Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)	11.24	090	
	36860	External cannula declotting (separate procedure); without balloon catheter	1.40	000	
	36861	External cannula declotting (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	
■	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	

		Code	Description	Relative Value	FUD	PC/TC Split
■		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	
		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 recanulization/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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	**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	
■	**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	
	37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	6.27	000	

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
■	+	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
■		**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	
		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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	090	
	37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions	5.15	090	
	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	Lymphangiotomy 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	
	38530	Biopsy or excision of lymph node(s); open, internal mammary node(s)	3.28	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**	Inguinofemoral lymphadenectomy, superficial, including Cloquet's node (separate procedure)	4.68	090	
	38765	Inguinofemoral 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	

	Code	Description	Relative Value	FUD	PC/TC Split
	38792	Injection procedure; radioactive tracer for identification of sentinel node	1.40	000	
	38794	Cannulation, thoracic duct	1.40	090	
+	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	
	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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 (frenumectomy, 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	
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 radio-element 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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	41500	Fixation of tongue, mechanical, other than suture (eg, K-wire)	2.34	090	
	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	
	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
	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 esophagogastrostomy, 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 esophagogastrostomy, 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 esophagogastrostomy, 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 esophagogastrostomy, with or without pyloroplasty	18.69	090	
	43122	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, 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 esophagostomy	8.76	090	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
■	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	
■	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	**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	
■	**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	

		Code	Description	Relative Value	FUD	PC/TC Split
■		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	
■		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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	43300	Esophagoplasty (plastic repair or reconstruction), cervical approach; without repair of tracheoesophageal fistula	8.76	090	
	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	
	43401	Transection of esophagus with repair, for esophageal varices	6.42	090	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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 gastrostomy; truncal or selective	11.27	090	
	43641	Vagotomy including pyloroplasty, with or without gastrostomy; 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	
	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	43760	Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance	0.70	000	
	43761	Repositioning of a naso- or oro-gastric feeding tube, through the duodenum for enteric nutrition	1.17	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	
	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	
	43850	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy	11.68	090	
	43855	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; with vagotomy	13.43	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	44345	Revision of colostomy; complicated (reconstruction in-depth) (separate procedure)	6.77	090	
	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	
■	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
■		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	
		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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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 supralevator, 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	
	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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 pre-dilation)	0.76	000	
■	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	

	Code	Description	Relative Value	FUD	PC/TC Split
■	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	
■	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	010	
	46030	Removal of anal seton, other marker	0.58	010	
	46040	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)	2.22	090	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	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	
	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	

Code	Description	Relative Value	FUD	PC/TC Split
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	
46762	Sphincteroplasty, anal, for incontinence, adult; implantation artificial sphincter	14.60	090	
46900	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical	0.47	010	
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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	46945	Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group	0.93	090	
	46946	Hemorrhoidectomy, internal, by ligation other than rubber band; 2 or more hemorrhoid columns/groups	1.40	090	
	46947	Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling	1.64	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	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
■		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	
■		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 choledochoenterostomy	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	
		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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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 pancreatojejunostomy	23.36	090	
	48152	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); without pancreatojejunostomy	21.61	090	
	48153	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy	23.36	090	
	48154	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy 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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
■	**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	
	49220	Staging laparotomy for Hodgkins disease or lymphoma (includes splenectomy, needle or open biopsies of both liver lobes, possibly also removal of abdominal nodes, abdominal node and/or bone marrow biopsies, ovarian repositioning)	11.68	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
+	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	010	
	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
	49560	Repair initial incisional or ventral hernia; reducible	7.01	090	
	49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	8.06	090	
	49565	Repair recurrent incisional or ventral hernia; reducible	8.06	090	
	49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated	9.23	090	
+	**49568**	Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)	1.87	ZZZ	
	49570	Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)	4.09	090	
	49572	Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated	5.11	090	
	49580	Repair umbilical hernia, younger than age 5 years; reducible	4.55	090	

	Code	Description	Relative Value	FUD	PC/TC Split
	49582	Repair umbilical hernia, younger than age 5 years; incarcerated or strangulated	5.26	090	
	49585	Repair umbilical hernia, age 5 years or older; reducible	5.26	090	
	49587	Repair umbilical hernia, age 5 years or older; incarcerated or strangulated	6.07	090	
	49590	Repair spigelian hernia	5.84	090	
	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	
	49650	Laparoscopy, surgical; repair initial inguinal hernia	5.61	090	
	49651	Laparoscopy, surgical; repair recurrent inguinal hernia	6.42	090	
	49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible	8.53	090	
	49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated	10.51	090	
	49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	9.58	090	
	49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	11.68	090	
	49656	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible	9.69	090	
	49657	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	14.01	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 anatrophic pyelolithotomy)	11.52	090	
	50080	Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm	9.08	090	
	50081	Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm	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, pelviolithotomy, including coagulum pyelolithotomy)	8.43	090	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
	50389	Removal of nephrostomy tube, requiring fluoroscopic guidance (eg, with concurrent indwelling ureteral stent)	4.87	000	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	50395	Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous	2.81	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, calycoplasty)	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	
	50500	Nephrorrhaphy, suture of kidney wound or injury	8.43	090	
	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
■	+	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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, cystotomy with drainage	4.68	090	
51045	Cystotomy, with insertion of ureteral catheter or stent (separate procedure)	5.15	090	
51050	Cystolithotomy, cystotomy 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	
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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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 vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); simple	7.30	090	
	51841	Anterior vesicourethropexy, or urethropexy (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	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

Code	Description	Relative Value	FUD	PC/TC Split
53230	Excision of urethral diverticulum (separate procedure); female	5.62	090	
53235	Excision of urethral diverticulum (separate procedure); male	5.62	090	
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, Johannsen 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	
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 urethrocutaneous 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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	
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 inguinofemoral 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	

Code	Description	Relative Value	FUD	PC/TC Split
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	
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, prepucial 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 complications (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple	5.62	090	
54344	Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring mobilization of skin flaps and urethroplasty with flap or patch graft	7.49	090	
54348	Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring extensive dissection and urethroplasty with flap, patch or tubed graft (includes urinary diversion)	8.52	090	
54352	Repair of hypospadias cripple requiring extensive dissection and excision of previously constructed structures including re-release of chordee and reconstruction of urethra and penis by use of local skin as grafts and island flaps and skin brought in as flaps or grafts	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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 approach, with or without hernia repair	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	

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	
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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
	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	
■	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	

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	
57112	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)	10.77	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	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	
	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 bulbocavernosus 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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	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	
	58293	Vaginal hysterectomy, for uterus greater than 250 g; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	13.49	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	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	58578	Unlisted laparoscopy procedure, uterus	BR	YYY	
	58579	Unlisted hysteroscopy procedure, uterus	BR	YYY	
	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
	59135	Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy	7.87	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
+	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	59898	Unlisted laparoscopy procedure, maternity care and delivery	BR	YYY	
	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	
	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
+	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	
	61332	Exploration of orbit (transcranial approach); with biopsy	12.91	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	61480	Craniectomy, suboccipital; for mesencephalic tractotomy or pedunculotomy	10.55	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
+	61610	Transection or ligation, carotid artery in cavernous sinus, with repair by anastomosis or graft (List separately in addition to code for primary procedure)	18.36	ZZZ	
+	61611	Transection or ligation, carotid artery in petrous canal; without repair (List separately in addition to code for primary procedure)	4.55	ZZZ	
+	61612	Transection or ligation, carotid artery in petrous canal; with repair by anastomosis or graft (List separately in addition to code for primary procedure)	17.18	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
		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 family (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 family (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	
		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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	61870	Craniectomy for implantation of neurostimulator electrodes, cerebellar, cortical	15.00	090	
	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	
	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	
	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	
	62163	Neuroendoscopy, intracranial; with retrieval of foreign body	20.37	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
■	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	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	
	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	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
+	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
+	**63048**	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)	5.45	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	
	63055	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic	18.64	090	
	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 osteophytectomy; cervical, single interspace	14.36	090	
+	**63076**	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)	4.82	ZZZ	
	63077	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace	13.64	090	
+	**63078**	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, each additional interspace (List separately in addition to code for primary procedure)	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	

	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	
	63180	Laminectomy and section of dentate ligaments, with or without dural graft, cervical; 1 or 2 segments	13.82	090	
	63182	Laminectomy and section of dentate ligaments, with or without dural graft, cervical; more than 2 segments	16.55	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	
	63194	Laminectomy with cordotomy, with section of 1 spinothalamic tract, 1 stage; cervical	11.59	090	
	63195	Laminectomy with cordotomy, with section of 1 spinothalamic tract, 1 stage; thoracic	11.59	090	
	63196	Laminectomy with cordotomy, with section of both spinothalamic tracts, 1 stage; cervical	13.36	090	
	63197	Laminectomy with cordotomy, with section of both spinothalamic tracts, 1 stage; thoracic	12.82	090	
	63198	Laminectomy with cordotomy with section of both spinothalamic tracts, 2 stages within 14 days; cervical	14.55	090	
	63199	Laminectomy with cordotomy with section of both spinothalamic tracts, 2 stages within 14 days; thoracic	14.55	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	

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SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
+	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	63615	Stereotactic biopsy, aspiration, or excision of lesion, spinal cord	11.82	090	
	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, direct or inductive coupling	5.50	010	
	63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	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, anesthetic agent; trigeminal nerve, any division or branch	0.41	000	
	64402	Injection, anesthetic agent; facial nerve	0.55	000	
	64405	Injection, anesthetic agent; greater occipital nerve	0.64	000	
	64408	Injection, anesthetic agent; vagus nerve	0.55	000	
	64410	Injection, anesthetic agent; phrenic nerve	0.55	000	
	64413	Injection, anesthetic agent; cervical plexus	0.73	000	
	64415	Injection, anesthetic agent; brachial plexus, single	0.68	000	
	64416	Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)	0.45	000	
	64417	Injection, anesthetic agent; axillary nerve	0.68	000	
	64418	Injection, anesthetic agent; suprascapular nerve	0.64	000	
	64420	Injection, anesthetic agent; intercostal nerve, single	0.73	000	
	64421	Injection, anesthetic agent; intercostal nerves, multiple, regional block	1.14	000	
	64425	Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves	0.77	000	
	64430	Injection, anesthetic agent; pudendal nerve	0.59	000	
	64435	Injection, anesthetic agent; paracervical (uterine) nerve	0.55	000	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
		64445	Injection, anesthetic agent; sciatic nerve, single	0.59	000	
		64446	Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)	0.45	000	
		64447	Injection, anesthetic agent; femoral nerve, single	0.59	000	
		64448	Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)	0.41	000	
		64449	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)	0.82	000	
		64450	Injection, anesthetic agent; other peripheral nerve or branch	0.35	000	
		64455	Injection(s), anesthetic agent 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 and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level	0.82	000	
	+	64480	Injection(s), anesthetic agent 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 and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level	0.68	000	
	+	64484	Injection(s), anesthetic agent 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	

	Code	Description	Relative Value	FUD	PC/TC Split
+	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	
	64508	Injection, anesthetic agent; carotid sinus (separate procedure)	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	
■	64550	Application of surface (transcutaneous) neurostimulator (eg, TENS unit)	0.32	000	
	64553	Percutaneous implantation of neurostimulator electrode array; cranial nerve	0.73	010	
	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	Incision for 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	Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	1.09	090	
	64580	Incision for implantation of neurostimulator electrode array; neuromuscular	1.09	090	
	64581	Incision for implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)	1.09	090	
	64585	Revision or removal of peripheral neurostimulator electrode array	1.09	010	
	64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling	1.09	010	
	64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver	0.91	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	
■	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	
	64630	Destruction by neurolytic agent; pudendal nerve	1.23	010	
	64632	Destruction by neurolytic agent; plantar common digital nerve	0.82	010	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
		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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
		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	
		65135	Insertion of ocular implant secondary; after enucleation, muscles not attached to implant	5.85	090	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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); goniosynechiae	5.62	090	
	65870	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); anterior synechiae, except goniosynechiae	4.03	090	
	65875	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); posterior synechiae	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	
	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; without retention of device or stent	7.96	090	
	66175	Transluminal dilation of aqueous outflow canal; with retention of device or stent	8.24	090	
■	66179	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft	10.13	090	

	Code	Description	Relative Value	FUD	PC/TC Split
■	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	
	66220	Repair of scleral staphyloma; without graft	10.30	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	
	66711	Ciliary body destruction; cyclophotocoagulation, endoscopic	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	

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	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)	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	
+	**66990**	Use of ophthalmic endoscope (List separately in addition to code for primary procedure)	0.78	ZZZ	
	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	Discission 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	
■	**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	

		Code	Description	Relative Value	FUD	PC/TC Split
■		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, endo-laser 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, 1 or more sessions; cryotherapy, diathermy	4.96	090	
		67145	Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, 1 or more sessions; photocoagulation (laser or xenon arc)	5.15	090	
		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	
		67229	Treatment of extensive or progressive retinopathy, 1 or more sessions, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy	5.90	090	
		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	
		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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
+	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	
	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	
	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	

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

	Code	Description	Relative Value	FUD	PC/TC Split
	68811	Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia	1.03	010	
	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	
	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
69605	Revision mastoidectomy; with apicectomy	12.17	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	
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	

10021–69990 SURGERY

Effective April 1, 2019 Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	69676	Tympanic neurectomy	6.56	090	
	69700	Closure postauricular fistula, mastoid (separate procedure)	2.81	090	
	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, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	9.27	090	
	69715	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	11.09	090	
	69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	9.55	090	
	69718	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	11.46	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	
	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. Conversion factors are located in the Introduction and General Guidelines section.

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.

Radiology Ground Rules

Definitions and rules pertaining to radiology (including nuclear medicine and diagnostic ultrasound) services are as follows:

Note: Rules used by all provider 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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

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):

A) For two contiguous parts, the charge shall be the greater fee plus 50 percent of the lesser fee.

B) For two remote parts, the charge shall be the greater fee plus 75 percent of the lesser fee. Bilateral procedures are considered remote parts.

C) 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.

D) 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.

E) No charge shall be made for comparative qualified x-rays except when such x-rays are specifically authorized by the carrier or the chairman. 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.)

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.

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

Do not 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. Surgical services do not include the supply of medications, sterile trays, and other materials which may be reported separately with code 99070. The specific items provided must be identified. Payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping and handling 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.

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.

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 six of section 6810 of the Public Health Law.

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. Modifiers commonly used with radiology procedures are as follows:

22 Increased Procedure 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.

70010–79999 RADIOLOGY

Effective April 1, 2019 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	Radiologic 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	Orthopantogram (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
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

RADIOLOGY 70010-79999

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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

	Code	Description	Relative Value	FUD	PC/TC Split
	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; without contrast material	11.00	XXX	25/75
	71260	Computed tomography, thorax; with contrast material(s)	12.64	XXX	25/75
	71270	Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections	15.20	XXX	25/75
	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
	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

■ New code, changed description, or changed value from June 1, 2012

RADIOLOGY 70010-79999

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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
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
72275	Epidurography, radiological supervision and interpretation	7.92	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

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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
	73564	Radiologic examination, knee; complete, 4 or more views	1.86	XXX	40/60

RADIOLOGY 70010-79999

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, 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
	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

70010–79999 RADIOLOGY

Effective April 1, 2019 Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	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	2.52	XXX	40/60
	74220	Radiologic examination; esophagus	2.63	XXX	40/60
	74230	Swallowing function, with cineradiography/videoradiography	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, gastrointestinal tract, upper; with or without delayed images, without KUB	3.52	XXX	40/60
■	**74241**	Radiologic examination, gastrointestinal tract, upper; with or without delayed images, with KUB	3.54	XXX	40/60
■	**74245**	Radiologic examination, gastrointestinal tract, upper; with small intestine, includes multiple serial images	5.74	XXX	40/60
■	**74246**	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed images, without KUB	3.77	XXX	40/60
■	**74247**	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed images, with KUB	3.95	XXX	40/60
	74249	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with small intestine follow-through	5.87	XXX	40/60
■	**74250**	Radiologic examination, small intestine, includes multiple serial images;	2.93	XXX	40/60
■	**74251**	Radiologic examination, small intestine, includes multiple serial images; via enteroclysis tube	3.39	XXX	40/60
	74260	Duodenography, hypotonic	3.42	XXX	40/60
	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; contrast (eg, barium) enema, with or without KUB	4.13	XXX	40/60
	74280	Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon	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

RADIOLOGY 70010-79999

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
		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 (pyelostogram, nephrostogram, loopogram), 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
		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 nephrostomy, ureters, or urethra, radiological supervision and interpretation	6.20	XXX	35/65
		74710	Pelvimetry, with or without placental localization	2.45	XXX	40/60
■		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 LV cardiac function, RV structure and function and evaluation of venous structures, if performed)	7.15	XXX	66/34

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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
	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 supraselective (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 supraselective, 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
	75827	Venography, caval, superior, with serialography, radiological supervision and interpretation	19.44	XXX	15/85

■ New code, changed description, or changed value from June 1, 2012

RADIOLOGY 70010-79999

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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

70010–79999 RADIOLOGY

Effective April 1, 2019 Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	**76001**	Fluoroscopy, physician or other qualified health care professional time more than 1 hour, assisting a nonradiologic physician or other qualified health care professional (eg, nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)	6.59	XXX	35/65
	76010	Radiologic examination from nose to rectum for foreign body, single view, child	1.45	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
	76101	Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral	4.08	XXX	40/60
	76102	Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; bilateral	5.36	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	
■	**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
	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
	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	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

RADIOLOGY 70010-79999

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	**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
	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

	Code	Description	Relative Value	FUD	PC/TC Split
	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
■	**76882**	Ultrasound, limited, joint or 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	69/31
■	**76885**	Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician or other qualified health care professional manipulation)	4.59	XXX	45/55
■	**76886**	Ultrasound, infant hips, real time with imaging documentation; limited, static (not requiring physician or other qualified health care professional manipulation)	4.02	XXX	45/55
	76930	Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation	3.83	XXX	45/55
■	**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
	76970	Ultrasound study follow-up (specify)	2.99	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
	76998	Ultrasonic guidance, intraoperative	2.79	XXX	
	76999	Unlisted ultrasound procedure (eg, diagnostic, interventional)	BR	XXX	

■ New code, changed description, or changed value from June 1, 2012

RADIOLOGY 70010-79999

Medical Fee Schedule Effective April 1, 2019

		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 paraspinous 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 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 guidance for, and monitoring of, parenchymal tissue ablation	27.41	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
		77058	Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral	24.51	XXX	11/89
		77059	Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral	32.42	XXX	8/92
■		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	
		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
		77076	Radiologic examination, osseous survey, infant	2.55	XXX	55/45
		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

70010–79999 RADIOLOGY

Effective April 1, 2019 Medical Fee Schedule

		Code	Description	Relative Value	FUD	PC/TC Split
■		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
■		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

RADIOLOGY 70010-79999

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	**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 delivery, 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	
	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

70010–79999 RADIOLOGY

Effective April 1, 2019 Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	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	
■	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
	78135	Red cell survival study; differential organ/tissue kinetics (eg, splenic and/or hepatic sequestration)	6.22	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

RADIOLOGY 70010-79999

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	78205	Liver imaging (SPECT);	10.46	XXX	20/80
	78206	Liver imaging (SPECT); with vascular flow	11.50	XXX	20/80
	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
	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
	78270	Vitamin B-12 absorption study (eg, Schilling test); without intrinsic factor	2.73	XXX	25/75
	78271	Vitamin B-12 absorption study (eg, Schilling test); with intrinsic factor	2.88	XXX	25/75
	78272	Vitamin B-12 absorption studies combined, with and without intrinsic factor	3.37	XXX	25/75
	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
	78320	Bone and/or joint imaging; tomographic (SPECT)	10.25	XXX	20/80
	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
	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

	Code	Description	Relative Value	FUD	PC/TC Split
	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	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
	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; single study at rest or stress	17.01	XXX	16/84
	78492	Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress	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

■ New code, changed description, or changed value from June 1, 2012

RADIOLOGY 70010-79999

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	78607	Brain imaging, tomographic (SPECT)	10.94	XXX	20/80
	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
	78647	Cerebrospinal fluid flow, imaging (not including introduction of material); tomographic (SPECT)	9.38	XXX	20/80
	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	
	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
	78710	Kidney imaging morphology; tomographic (SPECT)	10.00	XXX	20/80
	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 or distribution of radiopharmaceutical agent(s); limited area	5.61	XXX	25/75
	78801	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); multiple areas	7.09	XXX	25/75
	78802	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging	8.95	XXX	25/75
	78803	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT)	9.54	XXX	25/75
	78804	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring 2 or more days imaging	10.20	XXX	25/75
	78805	Radiopharmaceutical localization of inflammatory process; limited area	5.00	XXX	25/75
	78806	Radiopharmaceutical localization of inflammatory process; whole body	8.57	XXX	25/75
	78807	Radiopharmaceutical localization of inflammatory process; tomographic (SPECT)	9.54	XXX	20/80
	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

70010–79999 RADIOLOGY

Effective April 1, 2019 **Medical Fee Schedule**

Code	Description	Relative Value	FUD	PC/TC Split
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
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
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. Conversion factors are located in the Introduction and General Guidelines section.

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.

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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

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. Supplies and Materials

Do not 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. Surgical services do not include the supply of medications, sterile trays, and other materials which may be reported separately with code 99070. The specific items provided must be identified. Payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping and handling 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.

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 six of section 6810 of the Public Health Law.

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. Reports

No bill for services or procedures included in this section shall be considered properly rendered unless it is accompanied by a report that includes the findings and the interpretation of such findings. Where the service or procedure results in producing

an image or graph, such shall be submitted together with the bill.

5. By Report "BR"

"BR" in the Relative Value column indicates that the relative value unit of this service is to be determined "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary. See the Ground Rules in the Introduction and General Guidelines section for a complete explanation of "by report" 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. Unlisted Service or Procedure

Specify the service by the last code number in the appropriate subdivision. Identify by name or description, and submit report (see Pathology and Laboratory Ground Rule 5).

8. Organ or Disease-Oriented Panels

Organ or disease-oriented panels (80047–80076), are used to confirm specific diagnoses. These panels are problem-oriented in scope. Each panel contains a list of the tests that must be included in order to use that particular code number. This is not meant to limit the number of tests performed or ordered if medically appropriate. Other tests performed that are not part of the panel may be separately reported. It is also inappropriate to separately report the components of a panel test if the full set of identified tests was performed.

Clinical information derived from results of laboratory data that are mathematically calculated is considered part of the test procedure and not separately coded. Please refer to CPT guidelines for a complete explanation of codes included in each panel.

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 (80500 and 80502) 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 as part of the non-acute pain management treatment protocol.

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.

Risk Category (Score)	Random Drug Frequency
Low Risk	Periodic (once/year)
Moderate Risk	Regular (2/year)
High Risk	Frequent (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. Modifiers commonly used with pathology and laboratory procedures are as follows:

22 Increased Procedure 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 April 1, 2019 Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	**80047**	Basic metabolic panel (Calcium, ionized)	14.79	XXX	0/100
■	**80048**	Basic metabolic panel (Calcium, total)	12.94	XXX	0/100
	80050	General health panel	33.89	XXX	0/100
	80051	Electrolyte panel	10.47	XXX	0/100
	80053	Comprehensive metabolic panel	17.87	XXX	0/100
	80055	Obstetric panel	38.81	XXX	0/100
	80061	Lipid panel	23.72	XXX	0/100
	80069	Renal function panel	14.17	XXX	0/100
	80074	Acute hepatitis panel	57.91	XXX	0/100
	80076	Hepatic function panel	12.32	XXX	0/100
■	**80081**	Obstetric panel (includes HIV testing)	83.06	XXX	0/100
	80150	Amikacin	27.72	XXX	0/100
■	**80155**	Caffeine	34.58	XXX	0/100
	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
■	**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
	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
■	**80180**	Mycophenolate (mycophenolic acid)	20.04	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
	80188	Primidone	24.64	XXX	0/100
	80190	Procainamide;	24.64	XXX	0/100
	80192	Procainamide; with metabolites (eg, n-acetyl procainamide)	33.89	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

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	80202	Vancomycin	24.64	XXX	0/100
■	**80203**	Zonisamide	14.54	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 cyclicals; 1 or 2	0.00	XXX	
■	**80336**	Antidepressants, tricyclic and other cyclicals; 3-5	0.00	XXX	
■	**80337**	Antidepressants, tricyclic and other cyclicals; 6 or more	0.00	XXX	
■	**80338**	Antidepressants, not otherwise specified	0.00	XXX	
■	**80339**	Antiepileptics, not otherwise specified; 1-3	0.00	XXX	
■	**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	

80047–89398 PATHOLOGY AND LABORATORY

Effective April 1, 2019 Medical Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
■	**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
	80400	ACTH stimulation panel; for adrenal insufficiency	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)	133.08	XXX	0/100
	80410	Calcitonin stimulation panel (eg, calcium, pentagastrin)	118.91	XXX	0/100
	80412	Corticotropic releasing hormone (CRH) stimulation panel	295.73	XXX	0/100
	80414	Chorionic gonadotropin stimulation panel; testosterone response	43.74	XXX	0/100
	80415	Chorionic gonadotropin stimulation panel; estradiol response This panel must include the following: Estradiol (82670 x 2 on 3 pooled blood samples)	43.74	XXX	0/100
	80416	Renal vein renin stimulation panel (eg, captopril)	138.01	XXX	0/100
	80417	Peripheral vein renin stimulation panel (eg, captopril)	59.15	XXX	0/100
	80418	Combined rapid anterior pituitary evaluation panel	823.73	XXX	0/100
	80420	Dexamethasone suppression panel, 48 hour	104.74	XXX	0/100
	80422	Glucagon tolerance panel; for insulinoma	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	154.03	XXX	0/100

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	80428	Growth hormone stimulation panel (eg, arginine infusion, l-dopa administration)	77.01	XXX	0/100
	80430	Growth hormone suppression panel (glucose administration)	93.65	XXX	0/100
	80432	Insulin-induced C-peptide suppression panel	166.96	XXX	0/100
	80434	Insulin tolerance panel; for ACTH insufficiency	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
	80436	Metyrapone panel	108.43	XXX	0/100
	80438	Thyrotropin releasing hormone (TRH) stimulation panel; 1 hour	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
	80500	Clinical pathology consultation; limited, without review of patient's history and medical records	25.26	XXX	
	80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	49.29	XXX	
	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 [GPIba]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-2a/b (T145M)	135.42	XXX	0/100
■	**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

	Code	Description	Relative Value	FUD	PC/TC Split
■	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, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis	2022.59	XXX	0/100
■	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
■	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
	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
	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	
	81211	BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants in BRCA1 (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)	0.00	XXX	
	81212	BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants	0.00	XXX	
	81213	BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; uncommon duplication/deletion variants	0.00	XXX	
	81214	BRCA1 (breast cancer 1) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)	0.00	XXX	
	81215	BRCA1 (breast cancer 1) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	0.00	XXX	

■ New code, changed description, or changed value from June 1, 2012

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	81216	BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	0.00	XXX	
	81217	BRCA2 (breast cancer 2) (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
■	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 constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (eg, bacterial artificial chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)	0.00	XXX	
	81229	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities	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
■	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
■	81238	F9 (coagulation factor IX) (eg, hemophilia B), full gene sequence	0.00	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 mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	0.00	XXX	
■	81244	FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and 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

	Code	Description	Relative Value	FUD	PC/TC Split
■	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
	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	

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	**81269**	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	
■	**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	0.00	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
■	**81283**	IFNL3 (interferon, lambda 3) (eg, drug response), gene analysis, rs12979860 variant	0.00	XXX	0/100
■	**81287**	MGMT (O-6-methylguanine-DNA methyltransferase) (eg, glioblastoma multiforme), 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
	81290	MCOLN1 (mucolipin 1) (eg, Mucolipidosis, 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	
	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	
	81310	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, exon 12 variants	0.00	XXX	

	Code	Description	Relative Value	FUD	PC/TC Split
■	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
■	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	
	81319	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	0.00	XXX	
■	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) methylation analysis	0.00	XXX	
■	81328	SLCO1B1 (solute carrier organic anion transporter family, member 1B1) (eg, adverse drug reaction), gene analysis, common variant(s) (eg, *5)	0.00	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	
■	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
	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	

■ New code, changed description, or changed value from June 1, 2012

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	81342	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	0.00	XXX	
■	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
	81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)	0.00	XXX	
■	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	
■	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
■	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	

		Code	Description	Relative Value	FUD	PC/TC Split
■		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	
■		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, cytogenomic array analysis for neoplasia)	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, TGFBR1, TGFBR2, 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 TGFBR1, TGFBR2, 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
■		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	

■ New code, changed description, or changed value from June 1, 2012

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	**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
■	**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
■	**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
■	**81445**	Targeted genomic sequence analysis panel, solid organ neoplasm, DNA analysis, and RNA analysis when performed, 5-50 genes (eg, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, NRAS, MET, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed	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

	Code	Description	Relative Value	FUD	PC/TC Split
■	81450	Targeted genomic sequence analysis panel, hematolymphoid neoplasm or disorder, DNA analysis, and RNA analysis when performed, 5-50 genes (eg, BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KRAS, KIT, MLL, NRAS, NPM1, NOTCH1), interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed	0.00	XXX	0/100
■	81455	Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm, DNA analysis, and RNA analysis when performed, 51 or greater genes (eg, ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NPM1, NRAS, MET, NOTCH1, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed	0.00	XXX	0/100
■	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
■	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	
■	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

■ New code, changed description, or changed value from June 1, 2012

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
■		**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
■		**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
■		**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
■		**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
■		**81545**	Oncology (thyroid), gene expression analysis of 142 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (eg, benign or suspicious)	0.00	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	
■		**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
■		**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	Adrenocorticotropic 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

80047–89398 PATHOLOGY AND LABORATORY

Effective April 1, 2019 **Medical Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
■	**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
	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	Androstanediol 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
	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; cholylglycine	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
	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

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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

Code	Description	Relative Value	FUD	PC/TC Split
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
82652	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed	49.29	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	28.96	XXX	0/100
82671	Estrogens; fractionated	51.75	XXX	0/100
82672	Estrogens; total	36.97	XXX	0/100
82677	Estriol	26.49	XXX	0/100
82679	Estrone	40.05	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

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	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, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation);	31.42	XXX	0/100
	82805	Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation); with O2 saturation, by direct measurement, except pulse oximetry	33.89	XXX	0/100
	82810	Gases, blood, O2 saturation only, by direct measurement, except pulse oximetry	17.25	XXX	0/100
	82820	Hemoglobin-oxygen affinity (pO2 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
	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	Glutamyltransferase, 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

Code	Description	Relative Value	FUD	PC/TC Split
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
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
83525	Insulin; total	24.03	XXX	0/100
83527	Insulin; free	27.11	XXX	0/100
83528	Intrinsic factor	32.04	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

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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
	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
	83935	Osmolality; urine	13.55	XXX	0/100
	83937	Osteocalcin (bone g1a protein)	44.36	XXX	0/100

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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
	84436	Thyroxine; total	11.09	XXX	0/100

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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

■ New code, changed description, or changed value from June 1, 2012

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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
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

Code	Description	Relative Value	FUD	PC/TC Split
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
85362	Fibrin(ogen) degradation (split) products (FDP) (FSP); agglutination slide, semi-quantitative	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

■ New code, changed description, or changed value from June 1, 2012

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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
	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
	86038	Antinuclear antibodies (ANA);	21.56	XXX	0/100
	86039	Antinuclear antibodies (ANA); titer	21.56	XXX	0/100
	86060	Antistreptolysin 0; titer	14.79	XXX	0/100
	86063	Antistreptolysin 0; 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	
	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	

Code	Description	Relative Value	FUD	PC/TC Split
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
86235	Extractable nuclear antigen, antibody to, any method (eg, nRNP, SS-A, SS-B, Sm, RNP, Sc170, 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
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
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, 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
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

■ New code, changed description, or changed value from June 1, 2012

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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
86367	Stem cells (ie, CD34), total count	40.05	XXX	0/100
86376	Microsomal antibodies (eg, thyroid or liver-kidney), each	25.88	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
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
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
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

	Code	Description	Relative Value	FUD	PC/TC Split
	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
■	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

■ New code, changed description, or changed value from June 1, 2012

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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
	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

	Code	Description	Relative Value	FUD	PC/TC Split
■	**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
	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

■ New code, changed description, or changed value from June 1, 2012

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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
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

	Code	Description	Relative Value	FUD	PC/TC Split
	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
■	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
	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
	87209	Smear, primary source with interpretation; complex special stain (eg, trichrome, iron hemotoxylin) for ova and parasites	8.01	XXX	0/100

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PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; adenovirus enteric types 40/41	13.55	XXX	0/100

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■	87305	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Aspergillus	19.72	XXX	0/100
■	87320	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Chlamydia trachomatis	13.55	XXX	0/100
■	87324	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; 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], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Cryptococcus neoformans	13.55	XXX	0/100
■	87328	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; cryptosporidium	13.55	XXX	0/100
■	87329	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; giardia	13.55	XXX	0/100
■	87332	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; cytomegalovirus	13.55	XXX	0/100
■	87335	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; 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], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Entamoeba histolytica dispar group	13.55	XXX	0/100
■	87337	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; 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], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; 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], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Helicobacter pylori	13.55	XXX	0/100
■	87340	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; 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], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; 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], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; hepatitis Be antigen (HBeAg)	20.95	XXX	0/100

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PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	**87380**	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; 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], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Histoplasma capsulatum	13.55	XXX	0/100
■	**87389**	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; 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], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; HIV-1	28.96	XXX	0/100
■	**87391**	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; HIV-2	28.96	XXX	0/100
■	**87400**	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Influenza, A or B, each	13.55	XXX	0/100
■	**87420**	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; 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], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; rotavirus	13.55	XXX	0/100
■	**87427**	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Shiga-like toxin	13.55	XXX	0/100
■	**87430**	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; 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], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative; multiple-step method, not otherwise specified, each organism	13.55	XXX	0/100
■	**87450**	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative; single step method, 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], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative; multiple step method, polyvalent for multiple organisms, each polyvalent antiserum	19.72	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
	87476	Infectious agent detection by nucleic acid (DNA or RNA); Borrelia burgdorferi, amplified probe technique	49.29	XXX	0/100

	Code	Description	Relative Value	FUD	PC/TC Split
	87480	Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe technique	24.64	XXX	0/100
	87481	Infectious agent detection by nucleic acid (DNA or RNA); Candida species, amplified probe technique	49.29	XXX	0/100
	87482	Infectious agent detection by nucleic acid (DNA or RNA); Candida species, quantification	49.60	XXX	0/100
■	87483	Infectious agent detection by nucleic acid (DNA or RNA); central nervous system pathogen (eg, Neisseria meningitidis, Streptococcus pneumoniae, Listeria, Haemophilus influenzae, E. coli, Streptococcus agalactiae, enterovirus, human parechovirus, herpes simplex virus type 1 and 2, human herpesvirus 6, cytomegalovirus, varicella zoster virus, Cryptococcus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets	461.85	XXX	0/100
	87485	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, direct probe technique	24.64	XXX	0/100
	87486	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, amplified probe technique	49.29	XXX	0/100
	87487	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, quantification	49.60	XXX	0/100
	87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique	24.64	XXX	0/100
	87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique	49.29	XXX	0/100
	87492	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification	49.60	XXX	0/100
	87493	Infectious agent detection by nucleic acid (DNA or RNA); Clostridium difficile, 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
	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

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PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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
	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

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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
■	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
	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

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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 observation; Streptococcus, group B	21.56	XXX	0/100
	87803	Infectious agent antigen detection by immunoassay with direct optical observation; Clostridium difficile toxin A	21.56	XXX	0/100
	87804	Infectious agent antigen detection by immunoassay with direct optical observation; Influenza	21.56	XXX	0/100
■	87806	Infectious agent antigen detection by immunoassay with direct optical 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 observation; respiratory syncytial virus	21.56	XXX	0/100
	87808	Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis	24.64	XXX	0/100
	87809	Infectious agent antigen detection by immunoassay with direct optical observation; adenovirus	24.64	XXX	0/100
	87810	Infectious agent antigen detection by immunoassay with direct optical observation; Chlamydia trachomatis	21.56	XXX	0/100
	87850	Infectious agent antigen detection by immunoassay with direct optical observation; Neisseria gonorrhoeae	21.56	XXX	0/100
	87880	Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group A	21.56	XXX	0/100
	87899	Infectious agent antigen detection by immunoassay with direct optical 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

	Code	Description	Relative Value	FUD	PC/TC Split
■	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
	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	
	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

■ New code, changed description, or changed value from June 1, 2012

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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	33.89	XXX	60/40
	88304	Level III - Surgical pathology, gross and microscopic examination	44.36	XXX	60/40
	88305	Level IV - Surgical pathology, gross and microscopic examination	64.07	XXX	70/30
	88307	Level V - Surgical pathology, gross and microscopic examination	102.89	XXX	75/25
	88309	Level VI - Surgical pathology, gross and microscopic examination	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
	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

■ New code, changed description, or changed value from June 1, 2012

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
	+	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	
■	+	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 endomicroscopic 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

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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

■ New code, changed description, or changed value from June 1, 2012

PATHOLOGY AND LABORATORY 80047–89398

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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. Conversion factors are located in the Introduction and General Guidelines section.

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.

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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Biofeedback

Biofeedback is a form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient through visual, auditory or tactile means, with coaching by a biofeedback specialist. Treatment is individualized to the patient's work-related diagnosis and needs. Home practice of skills is required for mastery and may be facilitated by the use of home training tapes. The ultimate goal of biofeedback treatment is the transfer of learned skills to the workplace and daily life. Candidates for biofeedback therapy or training must be motivated to learn and practice biofeedback and self-regulation techniques. Biofeedback is not appropriate for individuals suffering from acute pain or acute injury. It may be appropriate for non-acute pain when combined with a program including functional restoration.

- Time to Produce Effect: 3 to 4 sessions.
- Frequency: 1 to 2 times per week.
- Optimum Duration: 5 to 6 sessions.

Maximum Duration: 10 to 12 sessions. When more than one treatment is performed on the same day, reimbursement is limited to the highest single relative value unit.

2. Ophthalmology

Intermediate and comprehensive ophthalmological services: 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.

Intermediate ophthalmological services: This term describes a level of service pertaining to the evaluation of a new diagnosis or a previous diagnosis with the addition of a new complicating diagnosis. Services include history, general medical observation, external ocular and adnexal examination, and other diagnostic procedures.

Example

A) Review of history, external examination, ophthalmoscopy, biomicroscopy for an acute complicated condition (e.g., iritis) not requiring comprehensive ophthalmological services.

B) Review of interval history, external examination, ophthalmoscopy, biomicroscopy, and tonometry in established patient with known cataract not requiring comprehensive ophthalmological services.

Comprehensive ophthalmological services: This term describes a level of service in which the complete examination of the visual system is made. Services include history, general medical observation, external and ophthalmoscopic examination, gross visual field, and basic sensorimotor examination.

Example

A) The comprehensive services required for diagnosis and treatment of a patient with symptoms indicating possible disease of the visual system, such as glaucoma, cataract or retinal disease, or to rule out disease of the visual system, new or established patient.

B) Ophthalmology services include the ordering and scheduling of treatment including medication, lenses, and other therapy or diagnostic procedures as may be indicated.

Prescription of lenses may be deferred to a subsequent visit which is reported separately and billed as a separate item. Separate billing is based on medical necessity and documentation which will pertain to the **final** submitted attending ophthalmologist's report, and billable only once per injury. ("Prescription of lenses" does not include anatomical facial measurements or writing of laboratory specifications for spectacles. For Spectacle Services, see 92340 and subsequent codes.)

Special ophthalmological services: This term describes services in which a special evaluation of a visual system, performed to a greater level than considered part of a general service, are given. Included in this service is the special report when indicated.

Example

A) Fluorescein angioscopy, quantitative visual field examination, or extended color vision examination (e.g., Nagel's anomaloscope) should be specifically reported as special ophthalmological services.

B) Medical diagnostic evaluation by the provider is an integral part of all ophthalmological services. Technical procedures (which may or may not be performed by the provider personally) are often part of the service, but should not be mistaken to constitute the service itself.

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 CMS-1500 form or 837p electronic format and supported by a narrative report. These services are only covered for compensable work related injuries.

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 provider with special training, is used to treat somatic dysfunction and related disorders. Usually provided by osteopathic providers, it may be performed by a provider with OMT training. Codes are selected according to the number of body regions treated and are reported per treatment day. Please refer to procedure codes 98925–98929.

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.

Body regions are referred to in *CPT 2018* as:

- Head region
- Cervical region
- Thoracic region
- Lumbar region
- Sacral region
- Pelvic region
- Lower extremities
- Upper extremities

- Rib cage region
- Abdomen and viscera region

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 postsedation 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 nonfacility setting, the conscious sedation service may be billed separately.

Procedures that include moderate (conscious) sedation are addressed in General Ground Rule 12. See General Ground Rule 12 for additional guidelines related to reporting of moderate (conscious) sedation.

8. Use of Code 97127 and 97533

Please see Ground Rule 7 of the Behavioral Health Fee Schedule for guidelines related to the use of code 97127 and 97533.

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. Modifiers commonly used with medicine procedures are as follows:

22 Increased Procedure 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 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.)

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.

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.

1B∞ ***Behavioral Health Provider Enhanced Reimbursement***
Provides a 20 percent reimbursement increase for E/M and Medicine services when rendered by providers with the following WCB assigned provider rating codes: PN-P (Psychiatry), PN-ADP (Addiction Psychiatry), PN-PM (Pain Management), and PSY (Psychology).

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 which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1B provides a 20 percent reimbursement increase for E/M and Medicine services when rendered by providers with the following WCB assigned provider rating codes: PN-P (Psychiatry), PN-ADP (Addiction Psychiatry), PN-PM (Pain Management), and PSY (Psychology).

11. EDX (Codes 95907-95913)

EDX is only recommended where there is failure of suspected radicular pain to resolve or plateau after waiting 4 to 6 weeks (to provide for sufficient time to develop EMG abnormalities as well as time for conservative treatment to resolve the problems), equivocal imaging findings, e.g., on CT or MRI studies, and suspicion by history and physical examination that a neurologic condition other than radiculopathy may be present instead of or in addition to radiculopathy. When such testing is recommended, the provider shall select from codes 95907–95913 using 1 unit of the 1 code that most closely represents the nerve(s) tested. Requests for repeat testing require approval from the carrier.

		Code	Description	Relative Value	FUD	PC/TC Split
	⓫	**90281**	Immune globulin (Ig), human, for intramuscular use	BR	XXX	
	⓫	**90283**	Immune globulin (IgIV), human, for intravenous use	BR	XXX	
	⓫	**90284**	Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each	BR	XXX	
	⓫	**90287**	Botulinum antitoxin, equine, any route	BR	XXX	
	⓫	**90288**	Botulism immune globulin, human, for intravenous use	BR	XXX	
	⓫	**90291**	Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use	BR	XXX	
	⓫	**90296**	Diphtheria antitoxin, equine, any route	BR	XXX	
	⓫	**90371**	Hepatitis B immune globulin (HBIg), human, for intramuscular use	57.03	XXX	
	⓫	**90375**	Rabies immune globulin (RIg), human, for intramuscular and/or subcutaneous use	74.66	XXX	
	⓫	**90376**	Rabies immune globulin, heat-treated (RIg-HT), human, for intramuscular and/or subcutaneous use	74.66	XXX	
	⓫	**90378**	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each	BR	XXX	
	⓫	**90384**	Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use	11.84	XXX	
	⓫	**90385**	Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use	5.41	XXX	
	⓫	**90386**	Rho(D) immune globulin (RhIgIV), human, for intravenous use	12.68	XXX	
	⓫	**90389**	Tetanus immune globulin (TIg), human, for intramuscular use	6.55	XXX	
	⓫	**90393**	Vaccinia immune globulin, human, for intramuscular use	BR	XXX	
	⓫	**90396**	Varicella-zoster immune globulin, human, for intramuscular use	12.18	XXX	
	⓫	**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	
+		**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	
	⓫	**90476**	Adenovirus vaccine, type 4, live, for oral use	BR	XXX	
	⓫	**90477**	Adenovirus vaccine, type 7, live, for oral use	BR	XXX	
	⓫	**90581**	Anthrax vaccine, for subcutaneous or intramuscular use	14.08	XXX	
	⓫	**90585**	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use	16.28	XXX	
	⓫	**90586**	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use	18.52	XXX	
■	⓫	**90587**	Dengue vaccine, quadrivalent, live, 3 dose schedule, for subcutaneous use	BR	XXX	
■	⓫	**90620**	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB-4C), 2 dose schedule, for intramuscular use	BR	XXX	
■	⓫	**90621**	Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp), 2 or 3 dose schedule, for intramuscular use	BR	XXX	
■	⓫	**90625**	Cholera vaccine, live, adult dosage, 1 dose schedule, for oral use	BR	XXX	

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
■	⑤1	**90630**	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	3.90	XXX	
	⑤1	**90632**	Hepatitis A vaccine (HepA), adult dosage, for intramuscular use	6.21	XXX	
	⑤1	**90633**	Hepatitis A vaccine (HepA), pediatric/adolescent dosage-2 dose schedule, for intramuscular use	3.00	XXX	
	⑤1	**90634**	Hepatitis A vaccine (HepA), pediatric/adolescent dosage-3 dose schedule, for intramuscular use	3.00	XXX	
	⑤1	**90636**	Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use	9.30	XXX	
■	⑤1	**90644**	Meningococcal conjugate vaccine, serogroups C & Y and Haemophilus influenzae type b vaccine (Hib-MenCY), 4 dose schedule, when administered to children 6 weeks-18 months of age, for intramuscular use	2.71	XXX	
■	⑤1	**90647**	Haemophilus influenzae type b vaccine (Hib), PRP-OMP conjugate, 3 dose schedule, for intramuscular use	2.45	XXX	
■	⑤1	**90648**	Haemophilus influenzae type b vaccine (Hib), PRP-T conjugate, 4 dose schedule, for intramuscular use	1.86	XXX	
■	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	
■	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	
	⑤1	**90680**	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use	5.07	XXX	

		Code	Description	Relative Value	FUD	PC/TC Split
	⓫	**90681**	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use	7.61	XXX	
■	⓫	**90682**	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	8.82	XXX	
■	⓫	**90685**	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL, for intramuscular use	4.04	XXX	
■	⓫	**90686**	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use	3.63	XXX	
■	⓫	**90687**	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use	1.78	XXX	
■	⓫	**90688**	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use	3.42	XXX	
	⓫	**90690**	Typhoid vaccine, live, oral	3.21	XXX	
	⓫	**90691**	Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use	3.89	XXX	
	⓫	**90696**	Diphtheria, tetanus toxoids, acellular pertussis vaccine and inactivated poliovirus vaccine (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use	BR	XXX	
■	⓫	**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	
■	⓫	**90698**	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenzae type b, and inactivated poliovirus vaccine, (DTaP-IPV/Hib), for intramuscular use	7.61	XXX	
	⓫	**90700**	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use	2.96	XXX	
	⓫	**90702**	Diphtheria and tetanus toxoids adsorbed (DT) when administered to individuals younger than 7 years, for intramuscular use	1.40	XXX	
	⓫	**90707**	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use	4.86	XXX	
	⓫	**90710**	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use	13.53	XXX	
	⓫	**90713**	Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use	3.38	XXX	
	⓫	**90714**	Tetanus and diphtheria toxoids adsorbed (Td), preservative free, when administered to individuals 7 years or older, for intramuscular use	2.54	XXX	
	⓫	**90715**	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use	2.28	XXX	
	⓫	**90716**	Varicella virus vaccine (VAR), live, for subcutaneous use	5.79	XXX	
	⓫	**90717**	Yellow fever vaccine, live, for subcutaneous use	6.64	XXX	
■	⓫	**90723**	Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine (DTaP-HepB-IPV), for intramuscular use	7.44	XXX	
	⓫	**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	
	⓫	**90733**	Meningococcal polysaccharide vaccine, serogroups A, C, Y, W-135, quadrivalent (MPSV4), for subcutaneous use	10.10	XXX	
■	⓫	**90734**	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135, quadrivalent (MCV4 or MenACWY), for intramuscular use	9.64	XXX	
	⓫	**90736**	Zoster (shingles) vaccine (HZV), live, for subcutaneous injection	16.23	XXX	
	⓫	**90738**	Japanese encephalitis virus vaccine, inactivated, for intramuscular use	6.71	XXX	
■	⓫	**90739**	Hepatitis B vaccine (HepB), adult dosage, 2 dose schedule, for intramuscular use	24.90	XXX	
	⓫	**90740**	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use	19.15	XXX	
	⓫	**90743**	Hepatitis B vaccine (HepB), adolescent, 2 dose schedule, for intramuscular use	2.71	XXX	
	⓫	**90744**	Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use	2.71	XXX	
■	⓫	**90746**	Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use	5.50	XXX	

■ New code, changed description, or changed value from June 1, 2012

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

			Code	Description	Relative Value	FUD	PC/TC Split
		ⓢ	**90747**	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use	19.15	XXX	
■		ⓢ	**90748**	Hepatitis B and Haemophilus influenzae type b vaccine (Hib-HepB), for intramuscular use	5.20	XXX	
		ⓢ	**90749**	Unlisted vaccine/toxoid	BR	XXX	
■		ⓢ	**90750**	Zoster (shingles) vaccine (HZV), recombinant, subunit, adjuvanted, for intramuscular use	BR	XXX	
■		ⓢ	**90756**	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use	4.31	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	
			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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	90911	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry	16.91	000	
■	**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	
■	**90951**	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	126.83	XXX	
■	**90952**	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 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	101.46	XXX	
■	**90953**	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month	67.64	XXX	
■	**90954**	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	107.38	XXX	
■	**90955**	End-stage renal disease (ESRD) related services monthly, for patients 2-11 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	60.03	XXX	
■	**90956**	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month	42.28	XXX	
■	**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	

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	**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	
	90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	72.71	XXX	
	90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	60.54	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	
	90967	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age	2.71	XXX	
	90968	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age	2.20	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	
	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

		Code	Description	Relative Value	FUD	PC/TC Split
		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
		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
■		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	
		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 and/or pleoptic training, with continuing medical direction and evaluation	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

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	92082	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semi-quantitative, 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
	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
	92225	Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial	7.27	XXX	
	92226	Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; subsequent	6.26	XXX	
	92227	Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral	2.54	XXX	
	92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral	5.41	XXX	60/40
	92230	Fluorescein angioscopy 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
	92275	Electroretinography with interpretation and report	16.91	XXX	40/60
	92283	Color vision examination, extended, eg, anomaloscope or equivalent	6.26	XXX	
	92284	Dark adaptation examination with interpretation and report	8.96	XXX	
	92285	External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, 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

	Code	Description	Relative Value	FUD	PC/TC Split
	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; corneoscleral 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; corneoscleral 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	
	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	
	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	

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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
+	**92547**	Use of vertical electrodes (List separately in addition to code for primary procedure)	5.07	ZZZ	80/20
	92548	Computerized dynamic posturography	16.91	XXX	24/76
	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
	92559	Audiometric testing of groups	7.10	XXX	
	92560	Bekesy audiometry; screening	4.23	XXX	
	92561	Bekesy audiometry; diagnostic	8.46	XXX	
	92562	Loudness balance test, alternate binaural or monaural	2.11	XXX	
	92563	Tone decay test	3.72	XXX	
	92564	Short increment sensitivity index (SISI)	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	29.09	XXX	50/50
	92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited	18.60	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	
	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	
	92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	27.06	XXX	
	92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming	19.78	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	

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
■		**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	
		92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	13.70	XXX	
		92626	Evaluation of auditory rehabilitation status; first hour	4.23	XXX	
	+	**92627**	Evaluation of auditory rehabilitation status; 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	
		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	
■		**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	

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
■	+	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	
		92992	Atrial septectomy or septostomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)	444.56	090	
		92993	Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)	311.48	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
		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

■ New code, changed description, or changed value from June 1, 2012

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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
■	**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	
■	**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	
■	**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
■	**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	16.06	XXX	65/35

	Code	Description	Relative Value	FUD	PC/TC Split
■	**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
■	**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; implantable loop recorder 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	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	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 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; implantable loop recorder 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

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	**93294**	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead 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 or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	12.01	XXX	
■	**93297**	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular 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; implantable loop recorder 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	
	93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	BR	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
+	**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
+	**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

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
	⊘	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
		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

■ New code, changed description, or changed value from June 1, 2012

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	93530	Right heart catheterization, for congenital cardiac anomalies	131.90	000	45/55
	93531	Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies	304.38	000	45/55
	93532	Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies	313.17	000	45/55
	93533	Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies	278.68	000	45/55
	93561	Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)	47.86	000	40/60
	93562	Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output	23.50	000	40/60
+	**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	
+	**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 supravalvular 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 pulmonary angiography (List separately in addition to code for primary procedure)	18.60	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

			Code	Description	Relative Value	FUD	PC/TC Split
	+		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
			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	
■			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	
		⊘	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
	+		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

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
		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
		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 including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; 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 including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3D mapping, when performed, and 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 induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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 a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report	41.43	XXX	40/60
	93786	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only	6.17	XXX	0/100
	93788	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report	18.60	XXX	0/100
■	**93790**	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, 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	
	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

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	93981	Duplex scan of arterial inflow and venous outflow of penile vessels; follow-up or limited study	20.97	XXX	40/60
	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
	94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	23.67	XXX	

		Code	Description	Relative Value	FUD	PC/TC Split
		94012	Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age	38.89	XXX	
		94013	Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age	8.46	XXX	
■		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
		94250	Expired gas collection, quantitative, single procedure (separate procedure)	2.54	XXX	20/80
		94375	Respiratory flow volume loop	10.15	XXX	20/80
		94400	Breathing response to CO2 (CO2 response curve)	20.29	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	
■		94617	Exercise test for bronchospasm, including pre- and post-spirometry, electrocardiographic recording(s), and pulse oximetry	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
■		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	

■ New code, changed description, or changed value from June 1, 2012

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	**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 impulse 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
	94750	Pulmonary compliance study (eg, plethysmography, volume and pressure measurements)	15.56	XXX	40/60
	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
	94770	Carbon dioxide, expired gas determination by infrared analyzer	10.15	XXX	40/60
	94772	Circadian respiratory pattern recording (pediatric pneumogram), 12-24 hour continuous recording, infant	BR	XXX	40/60
■	**94774**	Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; includes monitor attachment, download of data, review, interpretation, and preparation of a report by a physician or other qualified health care professional	BR	YYY	
	94775	Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; monitor attachment only (includes hook-up, initiation of recording and disconnection)	BR	YYY	
	94776	Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; monitoring, download of information, receipt of transmission(s) and analyses by computer only	BR	YYY	
■	**94777**	Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; review, interpretation and preparation of report only by a physician or other qualified health care professional	BR	YYY	
	94780	Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; 60 minutes	10.59	XXX	
+	**94781**	Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; each additional full 30 minutes (List separately in addition to code for primary procedure)	4.12	ZZZ	
	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	

		Code	Description	Relative Value	FUD	PC/TC Split
■		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	
		95071	Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with antigens or gases, specify	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	
■		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	

■ New code, changed description, or changed value from June 1, 2012

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
■	**95782**	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	177.79	XXX	14/86
■	**95783**	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist	189.62	XXX	14/86
	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; greater than 1 hour	45.41	XXX	40/60
	95816	Electroencephalogram (EEG); including recording awake and drowsy	26.38	XXX	40/60
	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
	95827	Electroencephalogram (EEG); all night recording	33.82	XXX	40/60
	95829	Electrocorticogram at surgery (separate procedure)	54.96	XXX	95/05

		Code	Description	Relative Value	FUD	PC/TC Split
■		95830	Insertion by physician or other qualified health care professional of sphenoidal electrodes for electroencephalographic (EEG) recording	19.62	XXX	
			For codes 95831-95852, 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
	⊘	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

■ New code, changed description, or changed value from June 1, 2012

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
■		**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	
■	+	**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	
■		**95943**	Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, Valsalva maneuvers, and head-up postural change	24.56	XXX	57/43
		95950	Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours	67.64	XXX	40/60
		95951	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours	86.92	XXX	40/60
		95953	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended	78.12	XXX	40/60
■		**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
		95956	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse	78.12	XXX	40/60
		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

		Code	Description	Relative Value	FUD	PC/TC Split
■	+	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 system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming	10.91	XXX	
		95971	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming	16.40	XXX	
■		95972	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming	32.72	XXX	
		95974	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour	65.44	XXX	
	+	95975	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)	32.72	ZZZ	
		95978	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour	71.87	XXX	
	+	95979	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; each additional 30 minutes after first hour (List separately in addition to code for primary procedure)	35.51	ZZZ	
		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	

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
		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	9.67	XXX	
		96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	24.52	XXX	
		96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	11.16	XXX	
		96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report	7.10	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	17.00	XXX	
		96111	Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report	19.87	XXX	

	Code	Description	Relative Value	FUD	PC/TC Split
	96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	27.39	XXX	
	96118	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	29.59	XXX	
	96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	16.57	XXX	
	96120	Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report	12.18	XXX	
	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	
	96150	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment	5.92	XXX	
	96151	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment	2.96	XXX	
	96152	Health and behavior intervention, each 15 minutes, face-to-face; individual	2.96	XXX	
	96153	Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)	4.23	XXX	
	96154	Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)	4.23	XXX	
	96155	Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)	4.23	XXX	
■	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	

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MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
+	**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	
+	**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 indwelling 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	

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
		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	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm	42.28	000	
		96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm	63.41	000	
		96922	Laser treatment for inflammatory skin disease (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	
■		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	

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

			Code	Description	Relative Value	FUD	PC/TC Split
■	+		**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.			
■			**97127**	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact	Refer to Rules	XXX	
				For codes 97139-97530, please see the Physical Medicine section.			
■		⓼	**97533**	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes	Refer to Rules	XXX	
				For codes 97535-97546, please see the Physical Medicine section.			
		⓼	**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	
	+	⓼	**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	
■		⓼	**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	
■		⓼	**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	
■		⓼	**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	
■		⓼	**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	
■		⓼	**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	
■		⓼	**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	

		Code	Description	Relative Value	FUD	PC/TC Split
+		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	
		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	
■	~	98969	Online assessment and management service provided by a qualified nonphysician health care professional to an established patient or guardian, not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network	4.23	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	

■ New code, changed description, or changed value from June 1, 2012

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
		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	
	ⓢ	**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	
	ⓢ	**99051**	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	BR	XXX	
	ⓢ	**99053**	Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service	BR	XXX	
	ⓢ	**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	
	ⓢ	**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	
	ⓢ	**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	NC	XXX	
		99082	Unusual travel (eg, transportation and escort of patient)	NC	XXX	
		99090	Analysis of clinical data stored in computers (eg, ECGs, blood pressures, hematologic data)	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	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	

		Code	Description	Relative Value	FUD	PC/TC Split
■		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	
■	+	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	
■		99170	Anogenital examination, magnified, in childhood for suspected trauma, including image recording when performed	25.70	000	
		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 99201-99499, 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	

■ New code, changed description, or changed value from June 1, 2012

MEDICINE 90281–95830, 95857–96999, 97127, 97533, 97597–97610, 97802–99091, 99151–99199, 99500–99607

Medical Fee Schedule Effective April 1, 2019

	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.

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. Conversion factors are located in the Introduction and General Guidelines section.

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.

Physical Medicine Ground Rules

The fees for physical medicine and physical or occupational therapy services are payable when services are rendered by a physician or a non-physician (duly licensed physical therapist [PT] or occupational therapist [OT]). 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 provider in reporting their services are presented in the General Ground Rules in the Introduction and General Guidelines section.

1A. NYS Medical Treatment Guidelines

The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. The maximum reimbursement limitations per patient per day per accident or illness for modalities is 12.0 RVUs, re-evaluation plus modalities is 15.0 RVUs, and initial evaluation plus modalities is 18 RVUs. 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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Supervision by Physician

When services are rendered by a registered physical therapist or occupational therapist under direct or indirect physician supervision, the supervision includes a periodic history and physical examination of the patient. The supervising physician 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 follow-up period, no preauthorization from the insurance carrier is required for the referral.

4. Home Treatment

When treatment is rendered in a patient's home by a provider or self-employed 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 self-employed 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 sessions/visits per patient.

6. Report Requirements

Self-employed physical and occupational therapists shall submit OT/PT-4 reports as required by regulation.

7. Self-Employed Physical Therapist or Occupational Therapist

Self-employed physical or occupational therapists that render therapy during the follow-up period for fractures, dislocations, or other postoperative procedures shall be reimbursed for therapy during and after the follow-up period.

8. Initial Evaluation and Re-evaluation by a Self-employed Physical or Occupational Therapist

Self-employed physical therapists (PT) and occupational therapists (OT) 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 accident or illness when billing for an initial evaluation shall be limited to 18. 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 shall 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 accident or illness when billing for a re-evaluation shall be limited to 15. 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. Employed Physical and Occupational Therapists

Physical and occupational therapists employed by physicians (not self-employed) may not bill separately from the physician-employer.

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.

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 accident or illness 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 accident or illness from all providers. 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:

A) Specific written critical job demands and/or job site analysis

B) Verified written employment opportunities

Evaluation Process

Initial screening evaluation is performed by the treatment team consisting of:

A) Physical Therapy and/or Occupational Therapy PLUS

B) 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:

A) Recommendation of release to return to work

B) Acceptance into the program with an Individual Written Rehabilitation Plan stating specific goals and recommended services

C) Rejection from program for specific reasons

D) Referral back to provider for medical evaluation

E) Recommendation of vocational rehabilitation, either by referral to and acceptance by VESID, or by other providers if approved by the carrier

Claimants being treated by an attending provider who is not a physician must be referred to a physician authorized by the New York State Workers' Compensation Board (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) A minimum of two (2) of the following: Physical Therapist, Occupational Therapist, Vocational Rehabilitation Counselor, Psychologist/Psychiatrist, 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 VESID. 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 Director of Rehabilitation and Social Services 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) Psychology/psychiatry 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 a licensed physician in New York state, or may be requested by the carrier when indicated.

B) The FCE does not require prior authorization by the carrier.

C) The attending physician 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.

F) All evaluation tools must be standardized, and normative data and interpretive guidelines must be attached to the report.

G) Charges for psychometric testing performed as part of the FCE by providers other than psychologists or psychiatrists are inclusive and may not be billed separately.

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. Modifiers commonly used with physical medicine procedures are as follows:

22 Increased Procedure 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. Hospital Affiliated Therapy Services

Billing for hospital affiliated physical and occupational therapy services, whether performed on site or at off site facilities, will be paid at the level of physician-supervised therapy services, when billed under the hospital tax ID number.

17. Supplies and Materials

Do not 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. Surgical services do not include the supply of medications, sterile trays, and other materials which may be reported separately with code 99070. The specific items provided must be identified. Payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping and handling 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.

95831–95852, 97010–97124, 97139–97530, 97535–97546, 97750–∞97800 PHYSICAL MEDICINE

Effective April 1, 2019 **Medical Fee Schedule**

		Code	Description	Relative Value	FUD
■		**95831**	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk	0.00	XXX
■		**95832**	Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side	0.00	XXX
■		**95833**	Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands	0.00	XXX
■		**95834**	Muscle testing, manual (separate procedure) with report; total evaluation of body, including hands	0.00	XXX
■		**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
■	Ⓜ	**97010**	Application of a modality to 1 or more areas; hot or cold packs	0.55	XXX
	Ⓜ	**97012**	Application of a modality to 1 or more areas; traction, mechanical	2.71	XXX
	Ⓜ	**97014**	Application of a modality to 1 or more areas; electrical stimulation (unattended)	2.66	XXX
	Ⓜ	**97016**	Application of a modality to 1 or more areas; vasopneumatic devices	3.30	XXX
	Ⓜ	**97018**	Application of a modality to 1 or more areas; paraffin bath	2.71	XXX
	Ⓜ	**97022**	Application of a modality to 1 or more areas; whirlpool	2.62	XXX
	Ⓜ	**97024**	Application of a modality to 1 or more areas; diathermy (eg, microwave)	2.71	XXX
	Ⓜ	**97026**	Application of a modality to 1 or more areas; infrared	2.54	XXX
	Ⓜ	**97028**	Application of a modality to 1 or more areas; ultraviolet	2.54	XXX
	Ⓜ	**97032**	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	2.45	XXX
	Ⓜ	**97033**	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	3.55	XXX
	Ⓜ	**97034**	Application of a modality to 1 or more areas; contrast baths, each 15 minutes	2.37	XXX
	Ⓜ	**97035**	Application of a modality to 1 or more areas; ultrasound, each 15 minutes	2.41	XXX
	Ⓜ	**97036**	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes	3.89	XXX
		97039	Unlisted modality (specify type and time if constant attendance)	BR	XXX
	Ⓜ	**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
	Ⓜ	**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
	Ⓜ	**97113**	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	4.40	XXX
	Ⓜ	**97116**	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	3.51	XXX
	Ⓜ	**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
	Ⓜ	**97140**	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	4.23	XXX
	Ⓜ	**97150**	Therapeutic procedure(s), group (2 or more individuals)	3.63	XXX
■		**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

PHYSICAL MEDICINE 95831–95852, 97010–97124, 97139–97530, 97535–97546, 97750–∞97800

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD
■	**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
■	**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
■	**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
■	**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
■	**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
■	**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
■	**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

95831–95852, 97010–97124, 97139–97530, 97535–97546, 97750–∞97800 PHYSICAL MEDICINE

Effective April 1, 2019 **Medical Fee Schedule**

			Code	Description	Relative Value	FUD
■			**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
■			**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
■			**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
■			**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
■	Ⓜ		**97530**	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	2.87	XXX
■	Ⓜ		**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
■	Ⓜ		**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
	Ⓜ		**97542**	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	2.37	XXX
	Ⓜ	®	**97545**	Work hardening/conditioning ; initial 4 hours	28.00	XXX
+	Ⓜ	®	**97546**	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)	3.30	ZZZ
■	Ⓜ		**97750**	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	0.00	XXX
■	Ⓜ		**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
■	Ⓜ		**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
■	Ⓜ		**97761**	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	4.23	XXX
■	Ⓜ		**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	Refer to Rules	

■ New code, changed description, or changed value from June 1, 2012

9 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. Category III codes are released semiannually by the AMA. Because these codes are temporary, some of them may only be covered on a case-by-case review. 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 2018*.

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.

Conversion Factors

The following codes are subject to the conversion factor from the section listed.

Surgery

0054T 0055T 0075T 0076T 0100T 0101T
0102T 0163T 0164T 0165T 0184T 0190T
0191T 0200T 0201T 0202T 0205T 0213T
0214T 0215T 0216T 0217T 0218T 0228T
0229T 0230T 0231T 0232T 0234T 0235T
0236T 0237T 0238T 0249T 0253T 0254T
0263T 0264T 0265T 0308T 0338T 0339T
0345T 0377T 0387T 0388T 0406T 0407T
0474T 0479T 0480T 0483T 0484T 0487T
0491T 0492T 0499T

Radiology

0042T 0159T 0174T 0175T 0346T 0355T
0394T 0395T 0470T 0471T 0475T 0476T
0477T 0478T 0482T

Medicine

0198T 0206T 0207T 0208T 0209T 0210T
0212T 0295T 0296T 0297T 0298T 0379T
0389T 0390T 0391T 0472T 0473T 0497T
0498T

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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

CATEGORY III CODES 0042T–0504T

Medical Fee Schedule Effective April 1, 2019

		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	
		0058T	Cryopreservation; reproductive tissue, ovarian	BR	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	
		0085T	Breath test for heart transplant rejection	BR	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, high energy	2.78	XXX	
■		0102T	Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, involving 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	
		0111T	Long-chain (C20-22) omega-3 fatty acids in red blood cell (RBC) membranes	BR	XXX	
		0126T	Common carotid intima-media thickness (IMT) study for evaluation of atherosclerotic burden or coronary heart disease risk factor assessment	BR	XXX	
■	+	0159T	Computer-aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation, breast MRI (List separately in addition to code for primary procedure)	0.83	ZZZ	
■	+	0163T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)	17.56	YYY	
■	+	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	

0042T–0504T CATEGORY III CODES

Effective April 1, 2019 **Medical Fee Schedule**

		Code	Description	Relative Value	FUD	PC/TC Split
■	+	**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	
■	+	**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	
		0188T	Remote real-time interactive video-conferenced critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	BR	XXX	
	+	**0189T**	Remote real-time interactive video-conferenced 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)	BR	XXX	
■	+	**0190T**	Placement of intraocular radiation source applicator (List separately in addition to primary procedure)	1.87	XXX	
■		**0191T**	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion	6.40	XXX	
■		**0195T**	Arthrodesis, pre-sacral interbody technique, disc space preparation, discectomy, without instrumentation, with image guidance, includes bone graft when performed; L5-S1 interspace	BR	XXX	
■	+	**0196T**	Arthrodesis, pre-sacral interbody technique, disc space preparation, discectomy, without instrumentation, with image guidance, includes bone graft when performed; L4-L5 interspace (List separately in addition to code for primary procedure)	BR	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	
■	+	**0205T**	Intravascular catheter-based coronary vessel or graft spectroscopy (eg, infrared) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation, and report, each vessel (List separately in addition to code for primary procedure)	0.53	ZZZ	
■		**0206T**	Computerized database analysis of multiple cycles of digitized cardiac electrical data from two or more ECG leads, including transmission to a remote center, application of multiple nonlinear mathematical transformations, with coronary artery obstruction severity assessment	37.42	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	

CATEGORY III CODES 0042T–0504T

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
■		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	
■	+	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	
■		0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level	1.75	XXX	
■	+	0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)	0.83	XXX	
■		0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level	1.60	XXX	
■	+	0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)	0.70	XXX	
■		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	
■		0249T	Ligation, hemorrhoidal vascular bundle(s), including ultrasound guidance	3.08	YYY	
■		0253T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space	7.12	YYY	

	Code	Description	Relative Value	FUD	PC/TC Split
■	0254T	Endovascular repair of iliac artery bifurcation (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma, dissection) using bifurcated endograft from the common iliac artery into both the external and internal iliac artery, including all selective and/or nonselective catheterization(s) required for device placement and all associated radiological supervision and interpretation, unilateral	7.74	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	
	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	XXX	
	0278T	Transcutaneous electrical modulation pain reprocessing (eg, scrambler therapy), each treatment session (includes placement of electrodes)	BR	XXX	
+	0290T	Corneal incisions in the recipient cornea created using a laser, in preparation for penetrating or lamellar keratoplasty (List separately in addition to code for primary procedure)	BR	ZZZ	

CATEGORY III CODES 0042T–0504T

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
■		0295T	External electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation	36.19	XXX	
■		0296T	External electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	4.51	XXX	
■		0297T	External electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording and storage; scanning analysis with report	28.39	XXX	
■		0298T	External electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording and storage; review and interpretation	5.13	XXX	
■		0308T	Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis	11.74	YYY	
■		0312T	Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming	BR	XXX	
■		0313T	Vagus nerve blocking therapy (morbid obesity); laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator	BR	XXX	
■		0314T	Vagus nerve blocking therapy (morbid obesity); laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator	BR	XXX	
■		0315T	Vagus nerve blocking therapy (morbid obesity); removal of pulse generator	BR	XXX	
■		0316T	Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator	BR	XXX	
■		0317T	Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed	BR	XXX	
■		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	Extra-osseous subtalar joint implant for talotarsal stabilization	BR	YYY	
■		0337T	Endothelial function assessment, using peripheral vascular response to reactive hyperemia, non-invasive (eg, brachial artery ultrasound, peripheral artery tonometry), unilateral or bilateral	BR	YYY	
■		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	
■		0341T	Quantitative pupillometry with interpretation and report, unilateral or bilateral	BR	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	
■	+	0346T	Ultrasound, elastography (List separately in addition to code for primary procedure)	2.80	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	

		Code	Description	Relative Value	FUD	PC/TC Split
■		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	
■		0355T	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	36.27	YYY	
■		0356T	Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal canaliculus, each	BR	YYY	
■		0357T	Cryopreservation; immature oocyte(s)	BR	XXX	
■		0358T	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report	BR	YYY	
■		0359T	Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report	BR	YYY	
■		0360T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient	BR	YYY	
■	+	0361T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)	BR	ZZZ	
■		0362T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient	BR	YYY	
■	+	0363T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)	BR	ZZZ	
■		0364T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time	BR	YYY	
■	+	0365T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	BR	ZZZ	
■		0366T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time	BR	YYY	
■	+	0367T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	BR	ZZZ	
■		0368T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time	BR	YYY	
■	+	0369T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)	BR	ZZZ	

■ New code, changed description, or changed value from June 1, 2012

CATEGORY III CODES 0042T–0504T

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
■		0370T	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)	BR	YYY	
■		0371T	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)	BR	YYY	
■		0372T	Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients	BR	YYY	
■		0373T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient	BR	YYY	
■	+	0374T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure)	BR	ZZZ	
■		0375T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), cervical, three or more levels	BR	XXX	
■	+	0376T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; each additional device insertion (List separately in addition to code for primary procedure)	BR	XXX	
■		0377T	Anoscopy with directed submucosal injection of bulking agent for fecal incontinence	1.04	XXX	
■		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	
■		0380T	Computer-aided animation and analysis of time series retinal images for the monitoring of disease progression, unilateral or bilateral, with interpretation and report	BR	XXX	
■		0381T	External heart rate and 3-axis accelerometer data recording up to 14 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; includes report, scanning analysis with report, review and interpretation by a physician or other qualified health care professional	BR	XXX	
■		0382T	External heart rate and 3-axis accelerometer data recording up to 14 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; review and interpretation only	BR	XXX	
■		0383T	External heart rate and 3-axis accelerometer data recording from 15 to 30 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; includes report, scanning analysis with report, review and interpretation by a physician or other qualified health care professional	BR	XXX	
■		0384T	External heart rate and 3-axis accelerometer data recording from 15 to 30 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; review and interpretation only	BR	XXX	
■		0385T	External heart rate and 3-axis accelerometer data recording more than 30 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; includes report, scanning analysis with report, review and interpretation by a physician or other qualified health care professional	BR	XXX	
■		0386T	External heart rate and 3-axis accelerometer data recording more than 30 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; review and interpretation only	BR	XXX	
■		0387T	Transcatheter insertion or replacement of permanent leadless pacemaker, ventricular	5.41	XXX	
■		0388T	Transcatheter removal of permanent leadless pacemaker, ventricular	1.85	XXX	

		Code	Description	Relative Value	FUD	PC/TC Split
■		0389T	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, leadless pacemaker system	10.19	XXX	
■		0390T	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, leadless pacemaker system	5.54	XXX	
■		0391T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, leadless pacemaker system	6.84	XXX	
■		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	
■	+	0396T	Intra-operative use of kinetic balance sensor for implant stability during knee replacement arthroplasty (List separately in addition to code for primary procedure)	BR	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	
■	+	0399T	Myocardial strain imaging (quantitative assessment of myocardial mechanics using image-based analysis of local myocardial dynamics) (List separately in addition to code for primary procedure)	BR	XXX	
■		0400T	Multi-spectral digital skin lesion analysis of clinically atypical cutaneous pigmented lesions for detection of melanomas and high risk melanocytic atypia; one to five lesions	BR	XXX	
■		0401T	Multi-spectral digital skin lesion analysis of clinically atypical cutaneous pigmented lesions for detection of melanomas and high risk melanocytic atypia; six or more lesions	BR	XXX	
■		0402T	Collagen cross-linking of cornea (including removal of the corneal epithelium 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	
■		0404T	Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency	BR	XXX	
■		0405T	Oversight of the care of an extracorporeal liver assist system patient requiring review of status, review of laboratories and other studies, and revision of orders and liver assist care plan (as appropriate), within a calendar month, 30 minutes or more of non-face-to-face time	BR	XXX	
■		0406T	Nasal endoscopy, surgical, ethmoid sinus, placement of drug eluting implant;	0.01	XXX	
■		0407T	Nasal endoscopy, surgical, ethmoid sinus, placement of drug eluting implant; with biopsy, polypectomy or debridement	0.01	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	

■ New code, changed description, or changed value from June 1, 2012

CATEGORY III CODES 0042T–0504T

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
■		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	
■		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	
■		0423T	Secretory type II phospholipase A2 (sPLA2-IIA)	BR	XXX	
■		0424T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; complete system (transvenous placement of right or left stimulation lead, sensing lead, implantable pulse generator)	BR	XXX	
■		0425T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; sensing lead only	BR	XXX	
■		0426T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; stimulation lead only	BR	XXX	
■		0427T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; pulse generator only	BR	XXX	
■		0428T	Removal of neurostimulator system for treatment of central sleep apnea; pulse generator only	BR	XXX	
■		0429T	Removal of neurostimulator system for treatment of central sleep apnea; sensing lead only	BR	XXX	
■		0430T	Removal of neurostimulator system for treatment of central sleep apnea; stimulation lead only	BR	XXX	
■		0431T	Removal and replacement of neurostimulator system for treatment of central sleep apnea, pulse generator only	BR	XXX	
■		0432T	Repositioning of neurostimulator system for treatment of central sleep apnea; stimulation lead only	BR	XXX	
■		0433T	Repositioning of neurostimulator system for treatment of central sleep apnea; sensing lead only	BR	XXX	
■		0434T	Interrogation device evaluation implanted neurostimulator pulse generator system for central sleep apnea	BR	XXX	
■		0435T	Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; single session	BR	XXX	
■		0436T	Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; during sleep study	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	

		Code	Description	Relative Value	FUD	PC/TC Split
■	+	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	YYY	
■		0447T	Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision	BR	YYY	
■		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	YYY	
■		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	
■		0451T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; complete system (counterpulsation device, vascular graft, implantable vascular hemostatic seal, mechano-electrical skin interface and subcutaneous electrodes)	BR	YYY	
■		0452T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; aortic counterpulsation device and vascular hemostatic seal	BR	YYY	
■		0453T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; mechano-electrical skin interface	BR	YYY	
■		0454T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; subcutaneous electrode	BR	YYY	
■		0455T	Removal of permanently implantable aortic counterpulsation ventricular assist system; complete system (aortic counterpulsation device, vascular hemostatic seal, mechano-electrical skin interface and electrodes)	BR	YYY	
■		0456T	Removal of permanently implantable aortic counterpulsation ventricular assist system; aortic counterpulsation device and vascular hemostatic seal	BR	YYY	
■		0457T	Removal of permanently implantable aortic counterpulsation ventricular assist system; mechano-electrical skin interface	BR	YYY	
■		0458T	Removal of permanently implantable aortic counterpulsation ventricular assist system; subcutaneous electrode	BR	YYY	
■		0459T	Relocation of skin pocket with replacement of implanted aortic counterpulsation ventricular assist device, mechano-electrical skin interface and electrodes	BR	YYY	
■		0460T	Repositioning of previously implanted aortic counterpulsation ventricular assist device; subcutaneous electrode	BR	YYY	
■		0461T	Repositioning of previously implanted aortic counterpulsation ventricular assist device; aortic counterpulsation device	BR	YYY	

■ New code, changed description, or changed value from June 1, 2012

CATEGORY III CODES 0042T–0504T

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
■		0462T	Programming device evaluation (in person) with iterative adjustment of the implantable mechano-electrical skin interface and/or external driver to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable aortic counterpulsation ventricular assist system, per day	BR	YYY	
■		0463T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable aortic counterpulsation ventricular assist system, per day	BR	YYY	
■		0464T	Visual evoked potential, testing for glaucoma, with interpretation and report	BR	YYY	
■		0465T	Suprachoroidal injection of a pharmacologic agent (does not include supply of medication)	BR	YYY	
■	+	0466T	Insertion of chest wall respiratory sensor electrode or electrode array, including connection to pulse generator (List separately in addition to code for primary procedure)	BR	YYY	
■		0467T	Revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing pulse generator	BR	YYY	
■		0468T	Removal of chest wall respiratory sensor electrode or electrode array	BR	YYY	
■		0469T	Retinal polarization scan, ocular screening with on-site automated results, bilateral	BR	XXX	
■		0470T	Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; first lesion	3.23	XXX	40/60
■	+	0471T	Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; each additional lesion (List separately in addition to code for primary procedure)	1.11	XXX	40/60
■		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	
■		0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space	3.34	XXX	
■		0475T	Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording and storage, data scanning with signal extraction, technical analysis and result, as well as supervision, review, and interpretation of report by a physician or other qualified health care professional	5.90	XXX	
■		0476T	Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording, data scanning, with raw electronic signal transfer of data and storage	2.29	XXX	
■		0477T	Recording of fetal magnetic cardiac signal using at least 3 channels; signal extraction, technical analysis, and result	10.60	XXX	
■		0478T	Recording of fetal magnetic cardiac signal using at least 3 channels; review, interpretation, report by physician or other qualified health care professional	8.82	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	
■	+	0482T	Absolute quantitation of myocardial blood flow, positron emission tomography (PET), rest and stress (List separately in addition to code for primary procedure)	7.45	ZZZ	9/91
■		0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed	11.75	000	

		Code	Description	Relative Value	FUD	PC/TC Split
■		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	
■		0487T	Biomechanical mapping, transvaginal, with report	0.76	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	
■		0491T	Ablative laser treatment, non-contact, full field and fractional ablation, open wound, per day, total treatment surface area; first 20 sq cm or less	0.05	000	
■	+	0492T	Ablative laser treatment, non-contact, full field and fractional ablation, open wound, per day, total treatment surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	0.05	ZZZ	
■		0493T	Near-infrared spectroscopy studies of lower extremity wounds (eg, for oxyhemoglobin measurement)	BR	XXX	
■		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	
■		0497T	External patient-activated, physician- or other qualified health care professional-prescribed, electrocardiographic rhythm derived event recorder without 24 hour attended monitoring; in-office connection	1.78	XXX	
■		0498T	External patient-activated, physician- or other qualified health care professional-prescribed, electrocardiographic rhythm derived event recording without 24 hour attended monitoring; review and interpretation by a physician or other qualified health care professional per 30 days with at least one patient-generated triggered event	5.13	XXX	
■		0499T	Cystourethroscopy, with mechanical dilation and urethral therapeutic drug delivery for urethral stricture or stenosis, including fluoroscopy, when performed	2.27	000	
■		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	
■		0501T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model, with anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report	BR	XXX	

CATEGORY III CODES 0042T–0504T

Medical Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	0502T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission	BR	XXX	
■	0503T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model	BR	XXX	
■	0504T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report	BR	XXX	

OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

BEHAVIORAL HEALTH FEE SCHEDULE

Effective 4/1/2019

NEW YORK STATE OF OPPORTUNITY.

Workers' Compensation Board

1.800.464.3649

Optum360 Notice

The *Official New York State Workers' Compensation Behavioral Health 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.

Optum360 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 Workers' Compensation Board.

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New York Workers' Compensation Board Filing Notice

The Behavioral Health Fee Schedule was duly filed in the Office of the Department of State, and constitutes Sections 333.1 and 333.2 of Title 12 of the Official Compilation of Codes, Rules ,and Regulations of the State of New York.

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FOREWORD

The Workers' Compensation Board is pleased to present the updated version of the *New York State Workers' Compensation Behavioral Health 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.

This fee schedule is effective for medical services rendered on or after April 1, 2019, 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

Introduction and General Guidelines

The *Official New York State Workers' Compensation Behavioral Health Fee Schedule* shows behavioral health services and their relative value units. The services are listed by *Current Procedural Terminology* (CPT®) codes. The relative value unit set for each CPT service is based on comparative magnitude among various services and procedures. The relative value units 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.

Because the Behavioral Health 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 psychologists 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 psychologists and physicians in the care of workers' compensation covered patients and ensure the proper payment for such services by assuring that they are specifically identifiable. The Behavioral Health Fee Schedule is for use by psychologists and physicians providing behavioral health services and treatment to injured workers covered under Workers' Compensation Law. Physicians can use the full version of the *Official New York State Workers' Compensation Medical Fee Schedule* and the codes and conversion factors therein. Psychologists are to bill for services listed in this section of the fee schedule as appropriate.

An attempt has been made to adhere as closely as possible to the terminology and coding of the American Medical Association's *CPT 2018*.

To ensure uniformity of billing, when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately, and then the products are to be added.

Format

The *Official New York State Workers' Compensation Behavioral Health Fee Schedule* consists of one section, which uses the psychology conversion factor.

Introductory Information

The introductory ground rules that precede the data 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 Workers' Compensation 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 behavioral health services shall be determined by the region in which the services were rendered.

How To Interpret the Fee Schedule Data

The columns used in the Behavioral Health Fee Schedule vary by section throughout the schedule.

Icons

The following icons are included in the Behavioral Health Fee Schedule:

■ New and changed codes—Codes that are new, changed description, or changed value from June 1, 2012.

+ 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.

Ⓜ Optum360 identified modifier 51 exempt service—Additional modifier 51 exempt codes identified by Optum360 based upon CPT language are exempt from modifier 51 when performed in conjunction with other services.

® Altered CPT codes—Services listed have been altered from the official CPT code description.

∞ State-specific codes—Where a CPT code does not currently exist to describe a service there may be a state-specific code number assigned to describe the service. RVU's are state assigned or gap filled.

Code

The Code column lists the American Medical Association's (AMA) CPT code. *CPT 2018* is used by arrangement with the AMA. Any altered CPT codes are identified with the registered trademark symbol (®). State-specific codes are identified with the infinity symbol (∞).

Description

This manual lists full 2018 CPT code descriptions.

Relative Value

The Relative Value column lists the relative value units 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 units 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 96110, performed by a psychologist in Region I or Region II, would be calculated as follows:

17.00 (Relative Value)
x $7.94 (Psychology Conversion Factor for Region I and Region II)
= $134.98

BR

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

Postal ZIP Codes by Region

Postal ZIP codes included in each region:

Region I

From	*Thru*	*From*	*Thru*
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

From	*Thru*	*From*	*Thru*
12179	12183	13440	13449
12201	12288	13501	13599
12301	12345	13901	13905
12501	12594	14201	14280
12601	12614	14601	14694
13201	13290		

Region III

From	*Thru*	*From*	*Thru*
06390	06390	10801	10805
10501	10598	10901	10998
10601	10650	11901	11980
10701	10710		

Region IV

From	*Thru*	*From*	*Thru*
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

Numerical List of Postal ZIP Codes

From	*Thru*	*Region*	*From*	*Thru*	*Region*
00501	00501	IV	12401	12498	I
00544	00544	IV	12501	12594	II
06390	06390	III	12601	12614	II
10001	10099	IV	12701	12792	I
10100	10199	IV	12801	12887	I
10200	10299	IV	12901	12998	I
10301	10314	IV	13020	13094	I

From	*Thru*	*Region*	*From*	*Thru*	*Region*
10401	10499	IV	13101	13176	I
10501	10598	III	13201	13290	II
10601	10650	III	13301	13368	I
10701	10710	III	13401	13439	I
10801	10805	III	13440	13449	II
10901	10998	III	13450	13495	I
11001	11096	IV	13501	13599	II
11101	11120	IV	13601	13699	I
11201	11256	IV	13730	13797	I
11301	11390	IV	13801	13865	I
11401	11499	IV	13901	13905	II
11501	11599	IV	14001	14098	I
11601	11697	IV	14101	14174	I
11701	11798	IV	14201	14280	II
11801	11854	IV	14301	14305	I
11901	11980	III	14410	14489	I
12007	12099	I	14501	14592	I
12106	12177	I	14601	14694	II
12179	12183	II	14701	14788	I
12184	12199	I	14801	14898	I
12201	12288	II	14901	14925	I
12301	12345	II			

Conversion Factors

Regional conversion factors for services rendered on or after April 1, 2019.

Section	Region I	Region II	Region III	Region IV
Psychology	$7.94	$7.94	$9.08	$9.86

Physicians can bill codes from other sections of the *Official New York State Workers' Compensation Medical Fee Schedule* as appropriate (such as E/M, Medicine, etc.) and should determine their fees using the corresponding conversion factors listed in that manual's Introduction and General Guidelines section.

New CPT Codes

The table below is a complete list of CPT codes that have been added to the Behavioral Health Fee Schedule since the June 1, 2012 fee schedule.

These codes are identified in the fee schedule with "■".

90785 90791 90792 90832 90833 90834
90836 90837 90838 90839 90840 97127

Changed Codes

Changed Values

The following table is a list of CPT and state-specific codes applicable to the Behavioral Health Fee Schedule that have a relative value change, an FUD change, or a PC/TC split change since the June 1, 2012 fee schedule. 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 (June 1, 2012) fee schedule.

For each code listed, the following information is included:

NY 2018 RVU. This is the current RVU for services rendered on or after April 1, 2019.

NY 2012 RVU. This is the RVU effective June 1, 2012.

NY 2018 FUD. This is the FUD for services rendered on or after April 1, 2019.

NY 2012 FUD. This is the FUD listed in the June 1, 2012 fee schedule.

NY 2018 PC/TC Split. This is the PC/TC split for services rendered on or after April 1, 2019. 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 2012 PC/TC Split. This is the PC/TC split effective June 1, 2012.

These codes are identified in the fee schedule with "■."

CODE	NY 2018 RVU	NY 2012 RVU	NY 2018 FUD	NY 2012 FUD	NY 2018 PC/TC Split	NY 2012 PC/TC Split
99075	$350.00	$400.00				

Changed Descriptions

The table below is a list of CPT codes applicable to the Behavioral Health Fee Schedule that have had a description change since the June 1, 2012 fee schedule.

90846 90847 90875 90876 90889 96110
97533

Deleted CPT Codes

The table below is a list of CPT codes that have been deleted from the Behavioral Health Fee Schedule since the June 1, 2012 fee schedule.

90801 90802 90804 90806 90808 90810
90812 90814 90816 90818 90821 90823
90826 90828 90857 97532

Behavioral Health Services Provided by Psychologists or Under the Supervision of an Authorized Psychiatrist or Physician

Behavioral Health services will be rendered by a New York State Workers' Compensation Board (NYSWCB) authorized psychologist or under the active and personal supervision of a NYSWCB authorized psychiatrist or a NYSWCB authorized physician with a rating code of PN-ADP (Addiction Medicine) or PN-PM (Pain Management). The Workers' Compensation Law does not permit supervision by a psychologist. A psychologist that is not Board authorized may not provide treatment. Treatment by nonauthorized medical providers is only permitted by licensed clinical social workers, nurse practitioners, and physician assistants and must be in accordance with the following paragraph. The scope of these psychological services will conform to the training, supervision, and experience requirements mandated and specified under the NYS Education Law. Specifically, the use of unlicensed persons or persons without a limited permit to perform any services or activities that fall within the statutory definition of Behavioral Health is prohibited. These services include but are not limited to, psychological testing and counseling; psychoanalysis; psychotherapy; the diagnosis and treatment of mental, nervous, emotional, cognitive, or behavioral disorders, disabilities, ailments or illnesses, alcoholism, substance abuse, disorders of habit or conduct, the psychological aspects of physical illness, accident, injury or disability, psychological aspects of learning; and the use of accepted classification systems.

As more fully set forth in T*he Official New York State Workers' Compensation Medical Fee Schedule*, "1 Introduction and General Guidelines," Ground Rule 11, a licensed clinical social worker, nurse practitioner, or physician assistant may treat injured workers within the scope of the person's specialized training and when the treatment is under the active and personal supervision of an authorized physician. "Active and personal supervision" means working under the supervision of an authorized physician who is readily available for consultation (in-person or by phone) and is actually available to provide in-person assistance when needed or in an emergency. The supervising authorized physician is responsible for the actions of such person and, in accordance with Education Law, may only supervise four such providers. Only the supervising authorized physician may offer an opinion as to initial disability or permanent disability or the degree thereof.

When the laboratory and diagnostic techniques are routinely performed within the normal scope of the supervising authorized physician's practice and the supervising physician is readily available for consultation, such techniques may be delegated by the supervising physician to such persons when they are:

1. Appropriately trained,
2. Qualified to perform the technique, and
3. Acting within the scope of their practice as determined by the New York State Education Department.

Reporting and Billing—The supervising authorized physician remains responsible for the actions of all such persons and must be identified in any reports, bills or other documents submitted to the Board. All reports and bills shall be submitted in the name of the supervising authorized physician and shall be payable at 80 percent of the fee available for such treatment code. Such bill shall include the modifier NP, PA, or AJ to identify nurse practitioner, physician assistant or licensed clinical social worker respectively, and include the names of both the supervising physician and NP, PA or LCSW.

Behavioral Health 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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Biofeedback

Biofeedback is a form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient through visual, auditory or tactile means, with coaching by a biofeedback specialist. Treatment is individualized to the patient's work-related diagnosis and needs. Home practice of skills is required for mastery and may be facilitated by the use of home training tapes. The ultimate goal of biofeedback treatment is the transfer of learned skills to the workplace and daily life. Candidates for biofeedback therapy or training must be motivated to learn and practice biofeedback and self-regulation techniques.

Biofeedback is not appropriate for individuals suffering from acute pain or acute injury. It may be appropriate for non-acute pain when combined with a program including functional restoration.

- Time to Produce Effect: 3 to 4 sessions.

- Frequency: 1 to 2 times per week.
- Optimum Duration: 5 to 6 sessions.
- Maximum Duration: 10 to 12 sessions.

When more than one treatment is performed on the same day, the maximum reimbursement will be limited to the highest single relative value.

2. Testing

Psychological tests 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 not necessary or indicated when the clinical documentation supports improved outcomes.

Reimbursement for testing is limited to 11 hours of testing in any 12-month period.

3. Procedures Listed Without Specified Relative Value Units

By report (BR) items: "BR" in the Relative Value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records; hence the importance of documentation. The original official record, such as the chart notes will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the schedule as "BR," the psychologist shall establish a relative value unit consistent in relativity with other unit values shown in the schedule. The insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

4. Medical Testimony

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant physician is required at a hearing or deposition, such physician shall be entitled to an attendance fee of $450. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant psychologist is required at a hearing or deposition, such psychologist shall be entitled to an attendance fee of $350. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

5. Evaluation and Management

Evaluation and management services may be reported by physicians with codes 90833, 90836, and 90838 when both services are performed and documented.

6. Central Nervous System Assessments/Tests (e.g., Neuro-cognitive, Mental Status, Speech Testing) (96101–96127)

CPT codes 96101—96127 are used to report the services provided during testing of the cognitive function of the central nervous system. The testing of cognitive processes, visual motor responses, and abstractive abilities is accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate material that will be formulated into a report. 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 Education Law.

7. Use of code 97127 and 97533

Reimbursement for code 97127 is limited to a maximum of 1 unit per day. Code 97533 may be reported a maximum of 2 units per day and is limited to 1 unit per day when reported on the same date with code 97127. Both services must be performed face-to-face.

When billing code 97127, an initial report must be submitted containing:

A) Outline of the claimant's current cognitive skill level

B) Proposed treatment plan

C) Expected goals

Thereafter, a progress report should be filed at least every four weeks that updates:

A) The claimant's current cognitive skill level

B) The treatment plan

C) Claimant's progress towards expected goals

All reporting requirements are inclusive in the fee for the service.

8. 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.

Codes 96150–96155 describe services associated with an acute or chronic illness (not meeting criteria for psychiatric diagnosis), prevention of a physical illness or disability, and maintenance of health, not meeting criteria for a psychiatric diagnosis, or representing a preventive medicine service.

For patients that require psychiatric services (90785–90899) as well as health and behavior assessment/intervention (96150–96155), report the predominant service performed. Do not report codes 96150–96155 in addition to codes 90785–90899 on the same date.

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. Modifiers commonly used in the Medicine section are:

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.

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).

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.

1B∞ Behavioral Health Provider Enhanced Reimbursement

Provides a 20 percent reimbursement increase for E/M and Medicine services when rendered by providers with the following WCB assigned provider rating codes:
PN-P (Psychiatry), PN-ADP (Addiction Psychiatry), PN-PM (Pain Management), and PSY (Psychology).

AJ Services Performed by a Licensed Clinical Social Worker

When services of a licensed clinical social worker are performed, identify the services by adding modifier AJ to the usual procedure code. Refer to Ground Rule 11 for further clarification.

NP Services Performed by a Nurse Practitioner

When pre- or postsurgery services of a nurse practitioner are performed, identify the services by adding modifier NP to the usual procedure code. Refer to General Ground Rule 11 for further clarification.

PA Services Performed by a Physician Assistant

When pre- or postsurgery services of a physician assistant are performed, identify the services by adding modifier PA to the usual

procedure code. Refer to General Ground Rule 11 for further clarification.

10. 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. Payment for medical treatment shall be at the Fee Schedule 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. 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 objectives" of Workers' Compensation Law may be denied by the Board.

A medical provider who has had a NYSWCB 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.

11. Non-Schedule Permanency Evaluations

Code 99243 is used to report a non-scheduled permanency evaluation. Codes 99455–99456 may not be used for this purpose.

12. Behavioral Health Provider Enhanced Reimbursement

In an effort to increase the number of Board-authorized providers in behavioral health to render care and treatment to injured workers, the WCB has established WCB-specific modifier 1B which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1B provides a 20 percent reimbursement increase for E/M and Medicine services when rendered by providers with the following WCB assigned provider rating codes: PN-P (Psychiatry), PN-ADP (Addiction Psychiatry), PN-PM (Pain Management), and PSY (Psychology).

13. Codes in the Behavioral Health Fee Schedule

A psychologist may only use CPT codes contained in the Behavioral Health Fee Schedule for billing of treatment. A psychologist may not use codes that do not appear in the Behavioral Health Fee Schedule.

BEHAVIORAL HEALTH 90785–99499

Behavioral Health Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD
■	+	**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
		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
■		**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
		90911	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry	16.91	000
		96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	24.52	XXX
		96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	11.16	XXX
		96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report	7.10	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

			Code	Description	Relative Value	FUD
■			96110	Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument	17.00	XXX
			96111	Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report	19.87	XXX
			96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	27.39	XXX
			96118	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	29.59	XXX
			96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	16.57	XXX
			96120	Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report	12.18	XXX
			96150	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment	5.92	XXX
			96151	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment	2.96	XXX
			96152	Health and behavior intervention, each 15 minutes, face-to-face; individual	2.96	XXX
			96153	Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)	4.23	XXX
			96154	Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)	4.23	XXX
			96155	Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)	4.23	XXX
■			97127	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact	9.03	XXX
■		Ⓜ	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
		Ⓜ ®	97545	Work hardening/conditioning ; initial 4 hours	28.00	XXX
	+	Ⓜ ®	97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)	3.30	ZZZ
■			99075	Medical testimony	Refer to Rules	XXX
■			99243	Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	16.49	XXX
			99499	Unlisted evaluation and management service	BR	XXX

■ New code, changed description, or changed value from June 1, 2012

OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

CHIROPRACTIC FEE SCHEDULE

Effective 04/1/2019

NEW YORK STATE OF OPPORTUNITY.

Workers' Compensation Board

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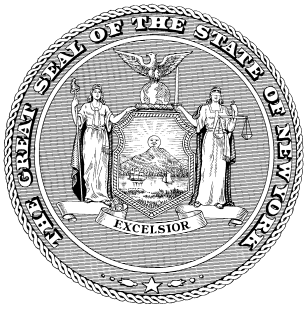

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Optum360 worked closely with the New York Workers' Compensation Board in the development, formatting, and production of this fee schedule. However, all decisions resulting in the final content of this schedule were made solely by the New York Workers' Compensation Board.

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The Chiropractic Fee Schedule was duly filed in the Office of the Department of State, and constitutes Sections 348.1 and 348.2, and Appendix C-3 of Title 12 of the Official Compilation of Codes, Rules, and Regulations of the State of New York.

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FOREWORD

The Workers' Compensation Board is pleased to present the updated version of the *New York State Workers' Compensation Chiropractic 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.

This fee schedule is effective for medical services rendered on or after April 1, 2019, 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

1 Introduction and General Guidelines

The *Official New York State Workers' Compensation Chiropractic Fee Schedule* shows chiropractic services and their relative value units. The services are listed by Current Procedural Terminology (CPT®) codes. The relative value unit 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.

The accompanying instructions and ground rules explain the application of these procedure descriptors and relative value units in chiropractic practice.

Because the Chiropractic 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 chiropractor 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 chiropractors in the care of workers' compensation covered patients and ensures the proper payment for such services by assuring that they are specifically identifiable.

This edition of the *Official New York State Workers' Compensation Chiropractic Fee Schedule* uses CPT procedure codes, modifiers, and descriptions. 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 Chiropractic Fee Schedule* consists of four sections. Each section has instructions which precede the codes, descriptions, and values. The sections in this schedule are: Evaluation and Management, Radiology, Medicine, and Physical Medicine.

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

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 Chiropractic services shall be determined by the region in which the services were rendered.

HOW TO INTERPRET THE FEE SCHEDULE DATA

There are six columns used throughout the Chiropractic Fee Schedule. The columns vary by section throughout the schedule.

Icons

The following icons are included in the Chiropractic Fee Schedule:

■ New and changed codes—Codes that are new, changed description, or changed value from June 1, 2012.

+ 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.

ⓠ Optum360 identified modifier 51 exempt service—Additional modifier 51 exempt codes identified by Optum360 based upon CPT language

are exempt from modifier 51 when performed in conjunction with other services.

® Altered CPT codes—Services listed have been altered from the official CPT code description.

∞ State-specific codes—Where a CPT code 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 (AMA) CPT code. *CPT 2018* is used by arrangement with the AMA. Any altered CPT codes are identified with the registered trademark symbol (®). State-specific codes are identified with the infinity symbol (∞).

Description

This manual lists full *CPT 2018* descriptions.

Relative Value

The Relative Value column lists the relative value units 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 units 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 99201, performed in Region I or Region II, would be calculated as follows:

5.83 (Relative Value)
x $6.37 (Chiropractic E/M Section Conversion Factor for Region I or Region II)
= $37.14

BR

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

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 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.

PC/TC Split

The Relative Value column lists the relative value units used to calculate the fee amount for a service. Except, as otherwise provided in this fee schedule, the maximum fee amount is calculated by multiplying the relative value unit by the applicable conversion factor. Conversion factors are listed in this fee schedule. The PC/TC column shows the percentage of the procedure that is professional or technical. A procedure with a relative value of 3.0 RVUs and a 40/60 in the PC/TC column would be calculated as follows: 40 percent of the value (3.0 x conversion factor x .40 = PC) is for the professional component and 60 percent of the value (3.0 x conversion factor x .60 = TC) represents the technical component. The total component reimbursed should never be more than the professional component plus the technical component combined.

Postal ZIP Codes By Region

Postal ZIP codes included in each region:

Region I

From	*Thru*	*From*	*Thru*
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

From	*Thru*	*From*	*Thru*
12179	12183	13440	13449
12201	12288	13501	13599
12301	12345	13901	13905
12501	12594	14201	14280
12601	12614	14601	14694
13201	13290		

Region III

From	*Thru*	*From*	*Thru*
06390	06390	10801	10805
10501	10598	10901	10998
10601	10650	11901	11980
10701	10710		

Region IV

From	*Thru*	*From*	*Thru*
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

Numerical List of Postal Zip Codes

From	*Thru*	*Region*	*From*	*Thru*	*Region*
00501	00501	IV	12401	12498	I
00544	00544	IV	12501	12594	II
06390	06390	III	12601	12614	II
10001	10099	IV	12701	12792	I
10100	10199	IV	12801	12887	I
10200	10299	IV	12901	12998	I
10301	10314	IV	13020	13094	I
10401	10499	IV	13101	13176	I
10501	10598	III	13201	13290	II
10601	10650	III	13301	13368	I
10701	10710	III	13401	13439	I
10801	10805	III	13440	13449	II
10901	10998	III	13450	13495	I
11001	11096	IV	13501	13599	II
11101	11120	IV	13601	13699	I
11201	11256	IV	13730	13797	I
11301	11390	IV	13801	13865	I
11401	11499	IV	13901	13905	II
11501	11599	IV	14001	14098	I
11601	11697	IV	14101	14174	I
11701	11798	IV	14201	14280	II
11801	11854	IV	14301	14305	I
11901	11980	III	14410	14489	I
12007	12099	I	14501	14592	I
12106	12177	I	14601	14694	II
12179	12183	II	14701	14788	I
12184	12199	I	14801	14898	I
12201	12288	II	14901	14925	I
12301	12345	II			

Conversion Factors

Regional conversion factors for services rendered on or after April 1, 2019.

Section	Region I	Region II	Region III	Region IV
E/M	$6.37	$6.37	$7.29	$7.92
Medicine	$6.09	$6.09	$6.97	$7.57
Physical Medicine	$5.77	$5.77	$6.60	$7.17
Radiology	$32.01	$32.01	$36.63	$39.82

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:

5.83 (Relative Value)
x $6.37 (Chiropractic E/M Section Conversion Factor for Region I or Region II)
= $37.14

New CPT Codes

The table below is a complete list of CPT codes that have been added to the Chiropractic Fee Schedule since the June 1, 2012 fee schedule.

These codes are identified in the fee schedule with "■".

72081	72082	72083	72084	73501	73502
73503	73521	73522	73523	73551	73552
95885	95886	95887	95907	95908	95909
95910	95911	95912	95913	97763	

Changed Codes

Changed Values

The following table is a list of CPT and state-specific codes applicable to the Chiropractic Fee Schedule that have a relative value change, an FUD change, or a PC/TC split

change since the June 1, 2012 fee schedule. 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 (June 1, 2012) fee schedule.

For each code listed, the following information is included:

NY 2018 RVU. This is the current RVU for services rendered on or after April 1, 2019.

NY 2012 RVU. This is the RVU effective June 1, 2012.

NY 2018 FUD. This is the FUD for services rendered on or after April 1, 2019.

NY 2012 FUD. This is the FUD listed in the June 1, 2012 fee schedule.

NY 2018 PC/TC Split. This is the PC/TC split for services rendered on or after April 1, 2019. 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 2012 PC/TC Split. This is the PC/TC split effective June 1, 2012.

These codes are identified in the fee schedule with "■."

CODE	NY 2018 RVU	NY 2012 RVU	NY 2018 FUD	NY 2012 FUD	NY 2018 PC/TC Split	NY 2012 PC/TC Split
97010	0.55	2.37	XXX	XXX		
97750	0.00	5.41	XXX	XXX		
99075	$350.00	$400.00				

Changed Descriptions

The table below is a complete list of CPT codes that have had a description change in the Chiropractic Fee Schedule since the June 1, 2012 fee schedule.

72040	72050	72052	72080	95930	97530
99070	99201	99202	99203	99204	99212

Deleted CPT Codes

The table below is a list of CPT codes that have been deleted from the Chiropractic Fee Schedule since the June 1, 2012 fee schedule.

72010	72069	72090	73500	73510	73520
73550	95900	95903	95904	95934	95936
97762					

General Ground Rules

1A. NYS Medical Treatment Guidelines

The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the 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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Unlisted Service or Procedure

When an unlisted service or procedure is provided the procedure should be identified and the value substantiated "by report" (see Ground Rule 2 below). All sections will have an unlisted service or procedure code number, usually ending in "99."

2. Procedures Listed Without Specified Relative Value Units

By report (BR) items: "BR" in the relative value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records; hence the importance of documentation. The original official record, such as operative report and hospital chart, will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the schedule as "BR," the chiropractor shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted "BR" unit values to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

3. Materials Supplied by a Chiropractor

Do not 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. Surgical services do not include the supply of medications, sterile trays, and other materials which may be reported separately with code 99070. The specific items provided must be identified. Payment shall not exceed the invoice cost of the item(s), applicable taxes, and any shipping and handling costs associated with delivery from the supplier of the item to the chiropractor's office. No additional "handling" costs will be added to the total cost of the item. To bill, use procedure code 99070.

The Durable Medical Equipment Fee Schedule does not apply to medical providers supplying durable medical equipment to injured workers as part of medical treatment described in the *Official New York State Workers' Compensation Medical Fee Schedule.* Billing and reimbursement follows the ground rules as described in this fee schedule.

4. Miscellaneous

When reporting services in which the relativity is predicated on the basis of time, information concerning the amount of time spent should be indicated.

5. Medical Testimony

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant chiropractor is required at a hearing or deposition, such chiropractor shall be entitled to an attendance fee of $350. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

6. Chiropractic Manipulative Treatment (CMT)

Chiropractic manipulative treatment (CMT) is a form of manual spinal treatment performed by a chiropractor. Please see procedure codes 98940–98943.

The CMT codes include charges for standard premanipulation assessment. Evaluation and management services can be reported separately by adding modifier 25, if the condition of a patient requires a significantly separate E/M service, beyond the usual pre- and postservice associated with the procedure.

Per *CPT 2018* the five spinal regions for CMT are:

- Cervical region includes atlanto-occipital joint
- Thoracic region—includes the costovertebral and costotransverse joints
- Lumbar region
- Sacral region
- Pelvic region—includes sacro-iliac joint

7. Periodic Re-evaluation

Code 99212 may be used to bill for a periodic re-evaluation consisting of documentation of: (1) an interim history describing the patient's response to the current treatment regimen (i.e., efficacy of the treatment/modality), (2) objective findings on physical examination, and (3) the future treatment plan and goals. If there is a positive patient response, functional gains must be objectively measured (including but not limited to improvement in positional tolerances, range of motion, strength, endurance) and documented. If the patient has not demonstrated a positive response, the treatment regimen should be modified or discontinued. The provider should re-evaluate the efficacy of the treatment or modality 2–3 weeks after the initial visit and every 3–4 weeks thereafter. The maximum number of RVUs (including treatment) per person per day per accident or illness when billing for a re-evaluation shall be limited to 15.

8. 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.

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

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.

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.

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.

9. 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. 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. 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.

10. Codes in the Chiropractic Fee Schedule

A chiropractor may only use CPT codes contained in the Chiropractic Fee Schedule for billing of treatment. A chiropractor may not use codes that do not appear in the Chiropractic Fee Schedule.

2 Evaluation and Management (E/M)

The relative value units listed in this section have been determined on an entirely different basis than those in other sections. A conversion factor applicable to this section is not applicable to any other section.

The relative value units listed in this section reflect the relativity of charges for procedures within this section only.

The fee for a particular procedure or service in this section is determined by multiplying the listed relative value unit by the current dollar conversion factor applicable to this section, 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, and then products are to be added.

Evaluation and Management Ground Rules

Visits, examinations, consultations, and similar services as listed in this section reflect the wide variations in time and skills required in the diagnosis and treatment of illness or injury. The listed relativities apply only when these services are performed by an authorized chiropractor unless otherwise stated. Please refer to the CPT guidelines for a full explanation of the proper use of the Evaluation and Management codes.

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."

Rules used by all chiropractors in reporting their services are presented in the Introduction and General Guidelines section. Definitions and rules pertaining to Evaluation and Management services are as follows:

1A. NYS Medical Treatment Guidelines

The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the 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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. New and Established Patient Service

Several code subcategories in the Evaluation and Management section are based on the patient's status; new or established. Evaluation and Management codes for initial visits are 99201–99204. E/M established visit code 99212 may be used to bill for a periodic re-evaluation consisting of a thorough examination and report documenting diagnosis, thorough interim history, clinical findings, and future course of treatment. Chiropractors may also report CPT code 99243 for office consultations for a new or established patient. The maximum number of RVUs (including treatment) per patient per day per accident or illness when billing for an initial evaluation shall be limited to 18. The following codes represent the treatments subject to this rule:

99201 99202 99203 99204 99212 99243

CPT 2018 guidelines define new and established patients. The patient definitions have been expanded from *CPT 2018* 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 chiropractor, or another chiropractor who* belongs to the same group practice, within the past three years.

Established Patient

An established patient *shall also be considered one who has been treated for the same injury by any chiropractor* 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 maximum number of RVUs (including treatment) per person per day per accident or illness when billing for a re-evaluation shall be limited to 15.

The procedure codes that exclusively represent established patient visits are identified in the fee schedule with the tilde (~) symbol.

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

2. Referral

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

3. Clinical Examples

The codes for E/M services are provided to assist chiropractors in understanding the meaning of the descriptors and selecting the correct code for the services they have rendered. It is important to note that the same problem, when seen by different specialists, may involve different 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 examples. For more examples please refer to CPT guidelines.

4. Periodic Re-evaluation

Code 99212 may be used to bill for a periodic re-evaluation consisting of documentation of: (1) an interim history describing the patient's response to the current treatment regimen (i.e., efficacy of the treatment/modality), (2) objective findings on physical examination, and (3) the future treatment plan and goals. If there is a positive patient response, functional gains must be objectively measured (including but not limited to improvement in positional tolerances, range of motion, strength, endurance) and documented. If the patient has not demonstrated a positive response, the treatment regimen should be modified or discontinued. The provider should re-evaluate the efficacy of the treatment or modality 2–3 weeks after the initial visit and every 3–4 weeks thereafter.

5. Narrative Reports

A detailed narrative report must be submitted with the bill for the following procedure: 99204.

6. 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.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of a 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 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 the decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

7. Non-Schedule Permanency Evaluations

Code 99243 is used for examination and reports of a non-schedule permanency evaluation.

99201–99456 EVALUATION AND MANAGMENT

Effective April 1, 2019 Chiropractic Fee Schedule

		Code	Description	Relative Value	FUD
■		**99201**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	5.83	XXX
■		**99202**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	7.27	XXX
■		**99203**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	9.47	XXX
■		**99204**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	13.53	XXX
■	~	**99212**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	4.57	XXX
■		**99243**	Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	16.49	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

3 Radiology

The relative values listed in this section have been determined on an entirely different basis than those in other sections. A conversion factor applicable to this section is not applicable to any other section.

The relative value units listed in this section reflect the relativity of charges for procedures within this section only. The fee for a particular procedure or service in this section is determined by multiplying the listed "relative value unit" by the current dollar "conversion factor" applicable to this section, 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, and then products are to be added.

Radiology Ground Rules

Rules used by all chiropractors in reporting their services are presented in the Introduction and General Guidelines section. Definitions and rules pertaining to radiology are as follows:

X-rays of any portion of the skeletal system are permitted if the x-rays are necessary to diagnose problems arising in the vertebral column.

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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. 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. 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.

When a diagnostic procedure in conjunction with clinical information provides sufficient information to establish an accurate diagnosis, the second procedure will be redundant if performed only for diagnostic purposes. At the same time, a subsequent diagnostic procedure can be a complementary diagnostic procedure if the first or preceding procedures in conjunction with clinical information cannot provide an accurate diagnosis.

2. Multiple Diagnostic Procedures

The following adjustments apply to all diagnostic radiology procedures (Chiropractic Fee Schedule codes 70100–76999) including MRI:

A) For two contiguous parts, the charge shall be the greater fee plus 50 percent of the lesser fee.

B) For two remote parts, the charge shall be the greater fee plus 75 percent of the lesser fee. Bilateral procedures are considered remote parts.

C) 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.

D) 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 rules 2A–2C above, whichever pertains.

E) No charge shall be made for comparative x-rays except when such x-rays are specifically authorized by the carrier or the Chairman. Comparative x-rays specifically authorized shall be subject to fees for contiguous and remote parts as provided in this formula as provided in rules 2A–2D above.

F) X-rays/imaging studies of different areas taken within 7 days of the first x-rays/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 rules 2A–2E above.

3. Specific Billing Instructions

The total relative value includes professional services plus expenses for personnel, materials (including usual contrast media), space, equipment, and other facilities. Supplies and materials provided by the chiropractor over and above those usually included with or necessitated by the services rendered may be charged for separately; in these instances, list items individually on the bill. Payment shall not exceed the cost of the item(s) to the chiropractor.

The listed values are for technical and professional components. Total reimbursement for the professional and technical components shall not exceed the listed value 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 value is apportioned as indicated in the PC/TC column of the fee schedule.

4. 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 chiropractor, insurance carrier, or self-insured employer. When requested, carriers and self-insured employers shall return original films to the chiropractor 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. 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.

These reproductions are not returnable to the chiropractor. Copies of images produced by copiers (e.g., Xerox) shall not merit any additional payment and shall not be returnable to the chiropractor; 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.) In cases where the patient transfers from one chiropractor to another, the original chiropractor will promptly forward all images or copies of images to the new attending chiropractor.

5. 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.

B) Relative value units for office visits are listed in the Evaluation and Management and Medicine sections.

C) For diagnostic ultrasound procedures, use code 76999 and submit the required report.

6. 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.

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 professional 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.

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.

70100–76999 RADIOLOGY

Effective April 1, 2019 Chiropractic Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	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	Radiologic 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
	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
	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
	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
	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
	72170	Radiologic examination, pelvis; 1 or 2 views	1.45	XXX	40/60

RADIOLOGY 70100–76999

Chiropractic Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	72190	Radiologic examination, pelvis; complete, minimum of 3 views	1.84	XXX	40/60
	72200	Radiologic examination, sacroiliac joints; less than 3 views	1.53	XXX	40/60
	72220	Radiologic examination, sacrum and coccyx, minimum of 2 views	1.56	XXX	40/60
	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
	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
	73090	Radiologic examination; forearm, 2 views	1.28	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
	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
■	**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
■	**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
	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
	73590	Radiologic examination; tibia and fibula, 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
	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
	76080	Radiologic examination, abscess, fistula or sinus tract study, radiological supervision and interpretation	2.35	XXX	35/65
	76999	Unlisted ultrasound procedure (eg, diagnostic, interventional)	BR	XXX	

4 Medicine

The relative values listed in this section have been determined on an entirely different basis than those in other sections. A conversion factor applicable to this section is not applicable to any other section. The relative value units listed in this section reflect the relativity of charges for procedures within this section only. The fee for a particular procedure or service in this section is determined by multiplying the listed relative value unit by the current dollar conversion factor applicable to this section, 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, and then the products are to be added.

Medicine Ground Rules

Rules used by all chiropractors in reporting their services are presented in the Introduction and General Guidelines section preceding the Medicine section. Definitions and rules pertaining to Medicine services are as follows:

1A. NYS Medical Treatment Guidelines

The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. The maximum reimbursement limitations per patient per day per accident or illness for modalities is 12.0 RVUs, re-evaluation plus modalities is 15.0 RVUs, and initial evaluation plus modalities is 18.0 RVUs. 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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Special Services and Reports

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.

2. 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 commonly used with medicine procedures are as follows:

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.

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).

TC ***Technical Component***
Certain procedures are a combination of a professional 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

3. EDX (Codes 95907–95913)

EDX is only recommended where there is failure of suspected radicular pain to resolve or plateau after waiting 4 to 6 weeks (to provide for sufficient time to develop EMG abnormalities as well as time for

conservative treatment to resolve the problems), equivocal imaging findings, e.g., on CT or MRI studies, and suspicion by history and physical examination that a neurologic condition other than radiculopathy may be present instead of or in addition to radiculopathy. When such testing is recommended, the provider shall select from codes 95907–95913 using 1 unit of the 1 code that most closely represents the nerve(s) tested. Requests for repeat testing require approval from the carrier.

95860-97814, 99050-99075 MEDICINE

Effective April 1, 2019 **Chiropractic Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	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
+	**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
■	**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
	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
■	**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
	95999	Unlisted neurological or neuromuscular diagnostic procedure	0.00	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	

MEDICINE 95860-97814, 99050-99075

Chiropractic Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
	ⓢ	**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	
	ⓢ	**99051**	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	BR	XXX	
	ⓢ	**99053**	Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service	BR	XXX	
	ⓢ	**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	
	ⓢ	**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	
	ⓢ	**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	
■		**99075**	Medical testimony	Refer to Rules	XXX	

5 Physical Medicine

The relative values 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. The fee for a procedure or service in this section is determined by multiplying the relative value by the physical medicine conversion factor, subject to the ground rules, instructions, and definitions of the schedule. Conversion factors are located in the Introduction and General Guidelines section. 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.

Physical Medicine Ground Rules

The fees for physical medicine services are payable when services are rendered by a chiropractor. 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 chiropractor 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 a chiropractor in reporting services are presented in the General Ground Rules in the Introduction and General Guidelines section.

1A. NYS Medical Treatment Guidelines

The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the medical treatment guidelines. The maximum reimbursement limitations per patient per day per accident or illness for modalities is 12.0 RVUs, re-evaluation plus modalities is 15.0 RVUs, and initial evaluation plus modalities is 18.0 RVUs. 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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

2. Initial Evaluation and Re-evaluation

Chiropractors may bill for an initial evaluation using CPT codes 99201–99204. Evaluations shall include the following elements: history, clinical testing, and interpretation of data and development of the plan of care with defined goals, appropriate interventions, and recommendations.

The maximum number of relative value units (including treatment) per patient per day when billing for an initial evaluation shall be limited to 18.0 RVUs. The maximum number of relative value units (including treatment) per patient per day when billing for a re-evaluation shall be limited to 15.0 RVUs.

The following codes represent the treatments subject to this rule:

97010	97012	97014	97024	97026	97028
97032	97033	97034	97035	97036	97039
97110	97112	97113	97116	97124	97139
97140	97530	98940	98941	98942	

Re-evaluations may be billed using CPT code 99212 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

3. 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 day per accident or illness 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 accident or illness from all providers. The following codes represent the physical medicine procedures and modalities subject to this rule:

97010	97012	97014	97024	97026	97028
97032	97033	97034	97035	97036	97039
97110	97112	97113	97116	97124	97139
97140	97530	98940	98941	98942	

4. Tests and Measurements

Code 97763 training and management for orthotic/prosthetic use, shall not be billed on the same day as an office visit.

5. 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 commonly used with physical medicine procedures are as follows:

22 Increased Procedure 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).

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.

97010–97763, 98940-98943 PHYSICAL MEDICINE

Effective April 1, 2019 Chiropractic Fee Schedule

			Code	Description	Relative Value	FUD
■	Ⓜ		**97010**	Application of a modality to 1 or more areas; hot or cold packs	0.55	XXX
	Ⓜ		**97012**	Application of a modality to 1 or more areas; traction, mechanical	2.71	XXX
	Ⓜ		**97014**	Application of a modality to 1 or more areas; electrical stimulation (unattended)	2.66	XXX
	Ⓜ		**97024**	Application of a modality to 1 or more areas; diathermy (eg, microwave)	2.71	XXX
	Ⓜ		**97026**	Application of a modality to 1 or more areas; infrared	2.54	XXX
	Ⓜ		**97028**	Application of a modality to 1 or more areas; ultraviolet	2.54	XXX
	Ⓜ		**97032**	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	2.45	XXX
	Ⓜ		**97033**	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	3.55	XXX
	Ⓜ		**97034**	Application of a modality to 1 or more areas; contrast baths, each 15 minutes	2.37	XXX
	Ⓜ		**97035**	Application of a modality to 1 or more areas; ultrasound, each 15 minutes	2.41	XXX
	Ⓜ		**97036**	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes	3.89	XXX
	Ⓜ		**97039**	Unlisted modality (specify type and time if constant attendance)	BR	XXX
	Ⓜ		**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
	Ⓜ		**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
	Ⓜ		**97113**	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	4.40	XXX
	Ⓜ		**97116**	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	3.51	XXX
	Ⓜ		**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
	Ⓜ		**97140**	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	4.23	XXX
■	Ⓜ		**97530**	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	2.87	XXX
	Ⓜ	®	**97545**	Work hardening/conditioning ; initial 4 hours	28.00	XXX
✚	Ⓜ	®	**97546**	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)	3.30	ZZZ
■	Ⓜ		**97750**	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	0.00	XXX
■	Ⓜ		**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
			98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions	4.57	000
			98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions	6.00	000
			98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions	7.10	000
			98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions	NC	XXX

OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

PODIATRY FEE SCHEDULE

Effective 4/1/2019

NEW YORK STATE OF OPPORTUNITY.

Workers' Compensation Board

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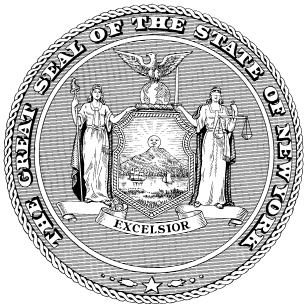

1.800.464.3649

Optum360 Notice

The *Official New York State Workers' Compensation Podiatry 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.

Optum360 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 Workers' Compensation Board.

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New York Workers' Compensation Board Filing Notice

The Podiatry Fee Schedule was duly filed in the Office of the Department of State, and constitutes Sections 343.1 and 343.2, and Appendix C-3 of Title 12 of the Official Compilation of Codes, Rules, and Regulations of the State of New York.

Our Commitment to Accuracy

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FOREWORD

The Workers' Compensation Board is pleased to present the updated version of the *New York State Workers' Compensation Podiatry 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.

This fee schedule is effective for medical services rendered on or after April 1, 2019, 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

1 Introduction and General Guidelines

The *Official New York State Workers' Compensation Podiatry Fee Schedule* shows podiatry services and their relative value units. The services are listed by *Current Procedural Terminology* (CPT®) codes. The relative value unit set for each CPT service is based on comparative magnitude among various services and procedures. The relative value units 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.

Because the Podiatry 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 podiatrist 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 podiatrists in the care of workers' compensation covered patients and ensure the proper payment for such services by assuring that they are specifically identifiable.

An attempt has been made to adhere as closely as possible to the terminology and coding of the American Medical Association's *CPT 2018*.

Format

The Podiatry Fee Schedule has six major sections—Evaluation and Management, Surgery, Radiology, Pathology and Laboratory, Medicine, and Appliances and Prostheses. Each section has specific instructions which precede it. Organization according to these sections stems from the types of services which each contains. Furthermore, the separation into these sections reflects the variations which exist in the overhead expense ratios for providing these services. Thus, separation provides the capability of merely changing the conversion factor (the dollar value to apply to a unit) in one section as economic factors affect the cost of providing services.

The introduction material, known as Ground Rules, precedes each of the six sections. These ground rules contain general information and instructions, and a list of general rules with which the user of each section must be acquainted before undertaking to use the section. Familiarity with these general rules, which include definitions, references, prohibitions, and directions for their proper employment, is necessary for all who use the 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.

How To Interpret Fee Schedule Data

There are six columns used throughout the Podiatry Fee Schedule. The columns vary by section throughout the schedule.

Icons

The following icons are included in the Podiatry Fee Schedule:

■ New and changed codes—Codes that are new, changed description, or changed value from June 1, 2012.

+ 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.

Ⓜ Optum360 identified modifier 51 exempt service—Additional modifier 51 exempt codes identified by Optum360 based upon CPT language are exempt from modifier 51 when performed in conjunction with other services.

® Altered CPT codes—Services listed have been altered from the official CPT code description.

∞ State-specific codes—Where a CPT code does not currently exist to describe a service there may be a state-specific code number assigned to describe the service. RVU's are state assigned or gap filled.

Code

The Code column lists the American Medical Association's CPT codes. *CPT 2018* is used by arrangement with the AMA. Any altered CPT codes are identified with the registered trademark symbol (®). State-specific codes or codes used only in New York State are identified with an infinity symbol (∞).

Description

This manual lists full 2018 CPT code descriptions.

Relative Value

The Relative Value column lists the relative value units 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 unit 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 99213, performed in Region I or Region II, would be calculated as follows:

5.83 (Relative Value)
x $12.11 (E/M Section Conversion Factor for Region I or Region II)
= $70.60

BR

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

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 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 portion of the service and 60 percent of the value (3.0 x conversion factor x .60 = TC) represents the technical portion of the service. The total component reimbursed should never be more than the professional and technical portions combined.

Postal ZIP Codes by Region

Postal ZIP codes included in each region:

Region I

From	*Thru*	*From*	*Thru*
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

From	*Thru*	*From*	*Thru*
12179	12183	13440	13449
12201	12288	13501	13599
12301	12345	13901	13905
12501	12594	14201	14280
12601	12614	14601	14694
13201	13290		

Region III

From	*Thru*	*From*	*Thru*
06390	06390	10801	10805
10501	10598	10901	10998
10601	10650	11901	11980
10701	10710		

Region IV

From	*Thru*	*From*	*Thru*
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

Numerical List of Postal ZIP Codes

From	*Thru*	*Region*	*From*	*Thru*	*Region*
00501	00501	IV	12401	12498	I
00544	00544	IV	12501	12594	II
06390	06390	III	12601	12614	II
10001	10099	IV	12701	12792	I
10100	10199	IV	12801	12887	I
10200	10299	IV	12901	12998	I
10301	10314	IV	13020	13094	I
10401	10499	IV	13101	13176	I
10501	10598	III	13201	13290	II
10601	10650	III	13301	13368	I
10701	10710	III	13401	13439	I
10801	10805	III	13440	13449	II
10901	10998	III	13450	13495	I
11001	11096	IV	13501	13599	II
11101	11120	IV	13601	13699	I
11201	11256	IV	13730	13797	I
11301	11390	IV	13801	13865	I
11401	11499	IV	13901	13905	II
11501	11599	IV	14001	14098	I
11601	11697	IV	14101	14174	I
11701	11798	IV	14201	14280	II
11801	11854	IV	14301	14305	I
11901	11980	III	14410	14489	I
12007	12099	I	14501	14592	I
12106	12177	I	14601	14694	II
12179	12183	II	14701	14788	I
12184	12199	I	14801	14898	I
12201	12288	II	14901	14925	I
12301	12345	II			

Conversion Factors

Regional conversion factors are for services rendered on or after April 1, 2019.

Section	Region I	Region II	Region III	Region IV
E/M	$12.11	$12.11	$13.85	$15.06
Medicine	$8.91	$8.91	$10.19	$11.07
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
Appliances and Prostheses	$17.18	$17.18	$17.18	$17.18

New CPT Codes

The table below is a list of CPT codes applicable to the Podiatry Fee Schedule that have been added since the June 1, 2012 fee schedule.

These codes are identified in the fee schedule with "■".

28291

Changed Codes

Changed Values

The following table is a list of CPT and state-specific codes applicable to the Podiatry Fee Schedule that have a relative value change, an FUD change, or a PC/TC split change since the June 1, 2012 fee schedule. 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 (June 1, 2012) fee schedule.

For each code listed, the following information is included:

NY 2018 RVU. This is the current RVU for services rendered on or after April 1, 2019.

NY 2012 RVU. This is the RVU effective June 1, 2012.

NY 2018 FUD. This is the FUD for services rendered on or after April 1, 2019.

NY 2012 FUD. This is the FUD listed in the June 1, 2012 fee schedule.

NY 2018 PC/TC Split. This is the PC/TC split for services rendered on or after April 1, 2019. 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 2012 PC/TC Split. This is the PC/TC split effective June 1, 2012.

These codes are identified in the fee schedule with "■."

CODE	NY 2018 RVU	NY 2012 RVU	NY 2018 FUD	NY2012 FUD	NY 2018 PC/TC Split	NY 2012 PC/TC Split
77002	2.81	2.81	ZZZ	XXX	34/66	34/66
99075	$450.00	$400.00				

Changed Descriptions

The table below is a list of CPT codes applicable to the Podiatry Fee Schedule that have had a description change since the June 1, 2012 fee schedule.

11623	15777	17250	20600	20605	20610
20665	27615	27616	28046	28047	28292
28296	28297	28298	28299	28890	76881
76882	77002	95004	95024	99205	99211
99213	99214	99215	99217	99218	99219
99220	99221	99222	99223	99224	99225
99226	99231	99232	99233	99234	99235
99236	99241	99242	99243	99244	99245
99251	99252	99253	99254	99255	99281
99282	99283	99284	99285	99304	99305
99306	99307	99308	99309	99310	99318
99324	99325	99326	99327	99328	99334
99335	99336	99337	99341	99342	99343
99344	99345	99347	99348	99349	99350
99354	99355	99375			

Deleted CPT Codes

The table below is a list of CPT codes applicable to the Podiatry Fee Schedule that have been deleted since the June 1, 2012 fee schedule.

11752	28290	28293	28294	29582	29590
95015					

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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Multiple Procedures

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

2. Unlisted Service or Procedure

Some services performed are not described by any CPT code. These services should be reported using an unlisted code and substantiating it by report as discussed in Rule 3 below. All sections will have an unlisted service or procedure code number, usually ending in "99."

3. Procedures Listed Without Specified Unit Values: By Report (BR) Items

"BR" in the unit value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records; hence the importance of documentation. The original official record, such as operative report and hospital chart, will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the Schedule as "BR," the podiatrist shall establish a relative value unit consistent in relativity with other relative value units shown in the Schedule. The insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

4. Materials Supplied by Podiatrist

Do not 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. Surgical services do not include the supply of medications, sterile trays, and other materials which may be reported separately with code 99070. The specific items provided must be identified. Payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping and handling costs associated with delivery from the supplier of the item to the podiatrist's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070. Appliances and prostheses as listed within this fee schedule can be billed separately and do not apply to the supply rules as listed here.

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 six of section 6810 of the Public Health Law.

Durable Medical Equipment Fee Schedule

The Durable Medical Equipment Fee Schedule adopted is still the Medicaid fee schedule. However, the regulation includes clarification on the application of the Medicaid fee schedule to workers' compensation claims. Specifically, the regulation provides that payments for bone growth stimulators are made in a single payment for the entire amount, that the reimbursement for orthopedic footwear is the lesser of the acquisition cost to the provider plus 50 percent or the usual and customary price charged to the public, and that hearing aids are not considered durable medical equipment for purposes of the fee schedule and the reimbursement amount is the provider's usual and customary price.

The Durable Medical Equipment Fee Schedule does not apply to medical providers supplying durable medical equipment to injured workers as part of medical treatment described in the *Official New York State Workers' Compensation Medical Fee Schedule.* Billing and reimbursement follow the ground rules as described in this fee schedule.

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.

6. Concurrent Care

When more than one provider treats a patient for the same condition during the same period of time, payment is made only to one provider. Where the concurrent care involves overlapping or common services, the fees payable shall not be increased but prorated. Each provider shall submit separate bills but indicate if agreement has been reached on the proration. If no agreement has been reached, the matter shall be referred to a Medical Arbitration Committee.

7. Alternating Providers

When providers of similar skills alternate in the care of a patient (e.g., partners, groups, or same facility covering for another provider on weekends or vacation periods), each provider shall bill individually for the services they personally rendered and in accordance with the fee schedule.

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 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 to the amounts to be prorated to each, they shall render separate bills accordingly. If no proration agreement is reached by them, the amounts payable to each party shall be settled by an arbitration committee, without cost to the contestants. When treatment is terminated by the departure of the patient from New York State before the expiration of the stated 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 the 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. Referrals/Direct Care

A fee is payable for the examination of a patient who seeks the care of a podiatrist either directly or by a referral from another provider or another podiatrist, in instances when it is incumbent upon the podiatrist to examine the patient in order to make a proper diagnosis, prognosis, and to decide on the necessity and type of treatment to be rendered. This fee is in addition to the unit fee prescribed for the operation or treatment subsequently rendered by the podiatrist except that where the therapeutic procedure or treatment is of a minor character and the fee for the procedure or treatment is in excess of the fee for the office visit, the greater fee (not both fees) is payable. Similarly, if the fee for the minor procedure or treatment is less than the fee for the office visit, the fee for the office visit alone is payable.

11. Multiple Services

Where a fee for an office therapeutic procedure or treatment is in excess of the fee for an ordinary office visit (e.g., a fee for a minor operation), the greater fee, not both, shall be payable.

12. Miscellaneous

A) Listings and relativities for other diagnostic, therapeutic, surgical, anesthetic, x-ray, and laboratory procedures may be found within the Surgery, Radiology and Nuclear Medicine, Pathology, and Appliances and Prostheses sections.

B) When reporting services in which the relativity is predicated on the basis of time, information concerning the amount of time spent should be indicated.

C) 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.

13. Medical Testimony

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant podiatrist is required at a hearing or deposition, such podiatrist shall be entitled to an attendance fee of $450.00. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

14. 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. If more than one modifier is needed, place modifier 99 after the procedure code to indicate that two or more modifiers will follow.

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.

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.

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.

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).

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).

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 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.

63 Procedure Performed on Infants less than 4 kg
Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. **Note:** Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20005–69990 code series. Modifier 63 should not be appended to any CPT codes listed in the **Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory,** or **Medicine** sections.

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 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.

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).

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.

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.

15. 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. 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. 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.

16. Codes in the Podiatry Fee Schedule

A podiatrist may only use CPT codes contained in the Podiatry Fee Schedule for billing of treatment. A podiatrist may not use codes that do not appear in the Podiatry Fee Schedule.

2 Evaluation and Management (E/M)

The relative value units in this section were determined uniquely for evaluation and management services. Use the E/M conversion factor when determining fee amounts.

The relative value units listed in this section reflect the relativity of charges for procedures within this section only.

The fee for a procedure or service in this section is determined by multiplying the relative value units 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.

Visits, examinations, consultations, and similar services as listed in this section reflect the wide variations in time and skills required in the diagnosis and treatment of illness or injury. The listed relativities apply only when these services are performed by or under the responsible and direct supervision of a podiatrist unless otherwise stated. Please refer to CPT guidelines for a full explanation of the proper use of the evaluation and management codes.

Evaluation and Management 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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Emergency Room

Podiatrists shall bill for services rendered in a hospital emergency room in accordance with the provisions of this schedule. If the treatment rendered is covered by a line item in sections other than office and hospital visits, the fees applicable to the appropriate code shall be payable. (See Surgery Ground Rule 3 for preoperative hospital visits and services.)

2. New and Established Patient Service

Several code subcategories in the E/M section are based on the patient's status as being either new or established. The new versus established patient guidelines also clarify the situation in which one podiatrist is on call or covering for another podiatrist. In this instance, classify the patient encounter the same as if it were for the podiatrist who is unavailable.

CPT 2018 guidelines define new and established patients. The patient definitions have been expanded from *CPT 2018* 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 podiatrist, or another podiatrist* who belongs to the same group practice, within the past three years.

Established Patient

An established patient is one who has received professional services from the *podiatrist, or another podiatrist* who belongs to the same group practice, within the past three years. *Because initial records such as history and physical are available within the group's facility, an initial new patient visit would not be warranted.*

The procedure codes that exclusively represent established patient visits are identified in the fee schedule with the tilde symbol (~).

3. 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 commonly used in the Evaluation and Management section of this fee schedule are:

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.

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.

4. Narrative Reports

A detailed narrative report must be submitted with the bill for the following procedures:

92004 92014 99204 99205 99215 99223
99244 99245 99254 99255 99285

When submitting a medical report and bill using the CMS-1500, all E/M codes must be submitted with a detailed narrative report.

EVALUATION AND MANAGEMENT 99201–99456

Podiatry Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD
■		**99201**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	5.83	XXX
■		**99202**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	7.27	XXX
■		**99203**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	9.47	XXX
■		**99204**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	13.53	XXX
■		**99205**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	18.26	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. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	3.21	XXX
■	~	**99212**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	4.57	XXX
■	~	**99213**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	5.83	XXX
■	~	**99214**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	8.46	XXX

99201–99456 EVALUATION AND MANAGEMENT

Effective April 1, 2019 **Podiatry Fee Schedule**

		Code	Description	Relative Value	FUD
■	~	**99215**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	13.53	XXX
■		**99217**	Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.])	10.15	XXX
■		**99218**	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.	12.68	XXX
■		**99219**	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	17.25	XXX
■		**99220**	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	21.64	XXX
■		**99221**	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.	14.12	XXX
■		**99222**	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	19.02	XXX
■		**99223**	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	23.34	XXX

EVALUATION AND MANAGEMENT 99201–99456

Podiatry Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD
■	**99224**	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.	4.06	XXX
■	**99225**	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.	8.12	XXX
■	**99226**	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.	11.33	XXX
■	**99231**	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.	7.44	XXX
■	**99232**	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.	10.15	XXX
■	**99233**	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.	14.97	XXX
■	**99234**	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.	13.95	XXX
■	**99235**	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	18.94	XXX

	Code	Description	Relative Value	FUD
■	**99236**	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.	23.84	XXX
	99238	Hospital discharge day management; 30 minutes or less	8.79	XXX
	99239	Hospital discharge day management; more than 30 minutes	10.99	XXX
■	**99241**	Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.	10.15	XXX
■	**99242**	Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	12.94	XXX
■	**99243**	Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	16.49	XXX
■	**99244**	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	21.56	XXX
■	**99245**	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.	27.23	XXX
■	**99251**	Inpatient consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit.	12.01	XXX
■	**99252**	Inpatient consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.	15.39	XXX

EVALUATION AND MANAGEMENT 99201–99456

Podiatry Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD
■	**99253**	Inpatient consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.	18.94	XXX
■	**99254**	Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent at the bedside and on the patient's hospital floor or unit.	23.67	XXX
■	**99255**	Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 110 minutes are spent at the bedside and on the patient's hospital floor or unit.	29.76	XXX
■	**99281**	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.	6.59	XXX
■	**99282**	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	8.88	XXX
■	**99283**	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	13.36	XXX
■	**99284**	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.	19.95	XXX
■	**99285**	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	29.76	XXX
■	**99304**	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.	8.46	XXX

	Code	Description	Relative Value	FUD
■	**99305**	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.	11.84	XXX
■	**99306**	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.	14.37	XXX
■	**99307**	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.	4.73	XXX
■	**99308**	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.	6.43	XXX
■	**99309**	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.	9.30	XXX
■	**99310**	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.	12.68	XXX
	99315	Nursing facility discharge day management; 30 minutes or less	8.79	XXX
	99316	Nursing facility discharge day management; more than 30 minutes	10.99	XXX
■	**99318**	Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and Medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 30 minutes are spent at the bedside and on the patient's facility floor or unit.	9.30	XXX
■	**99324**	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent with the patient and/or family or caregiver.	8.29	XXX

EVALUATION AND MANAGEMENT 99201–99456

Podiatry Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD
■		**99325**	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient and/or family or caregiver.	10.99	XXX
■		**99326**	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient and/or family or caregiver.	13.87	XXX
■		**99327**	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent with the patient and/or family or caregiver.	19.45	XXX
■		**99328**	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent with the patient and/or family or caregiver.	25.37	XXX
■	~	**99334**	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver.	5.92	XXX
■	~	**99335**	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.	8.46	XXX
■	~	**99336**	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient and/or family or caregiver.	12.68	XXX
■	~	**99337**	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent with the patient and/or family or caregiver.	17.76	XXX

99201–99456 EVALUATION AND MANAGEMENT

Effective April 1, 2019 **Podiatry Fee Schedule**

		Code	Description	Relative Value	FUD
		99339	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	6.76	XXX
		99340	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	22.18	XXX
■		**99341**	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	7.69	XXX
■		**99342**	Home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	9.64	XXX
■		**99343**	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	12.51	XXX
■		**99344**	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	17.76	XXX
■		**99345**	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent face-to-face with the patient and/or family.	24.01	XXX
■	~	**99347**	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.	6.00	XXX

EVALUATION AND MANAGEMENT 99201–99456

Podiatry Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD
■	~	**99348**	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	7.69	XXX
■	~	**99349**	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	11.16	XXX
■	~	**99350**	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.	17.84	XXX
■	+	**99354**	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)	19.45	ZZZ
■	+	**99355**	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)	9.72	ZZZ
	+	**99356**	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)	25.37	ZZZ
	+	**99357**	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)	12.68	ZZZ
		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
■		**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
		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

3 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 relative value units listed in this section reflect the relativity of charges for procedures within this section only.

The fee for a procedure or service in this section is determined by multiplying the relative value units 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.

Items used by all podiatrists in reporting their services are presented in the Introduction and General Guidelines section under General Ground Rules.

Surgery 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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

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." (For preoperative visits, see Ground Rule 2, below). Payment is for the procedure coded and described, irrespective of the method or appliance used to perform the procedure.

2. Immediate Preoperative Visits and Other Services by the Surgeon

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 procedures not usually part of the basic surgical procedure 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 case situation unless an emergency situation exists or arises. For example, it will not apply when the procedure is performed early or late for the convenience of the patient, podiatrist, or hospital. Circumstances justifying the additional payment should be set forth in a statement accompanying the bill.

4. Follow-up Care for Diagnostic Procedures

Follow-up care for diagnostic procedures (e.g., endoscopy, injection procedures for radiography) includes only that care related to recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and

may be charged for in accordance with the services rendered.

5. Multiple or Bilateral Procedures

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 principle procedure cannot be adequately performed. Codes denoted as "each additional" are valued as listed and are not subject to the 50 percent reduction of the multiple procedures calculation.

Example: Related Procedures

A) **Open Reduction of a Fracture:** The excision of previous scars, the incision of fascia and muscles, the identification and retraction of nerves, muscles and area structures, and the closure of the wound, irrespective of type of closure, are all related to the principle procedure of the bone repair and merit no additional fee. If more than one podiatrist is involved in performing such related procedures, they will be considered as co-surgeons and the applicable fee for the principle procedure will apply and be prorated.

B) **Repair of a Tendon:** The skin incision and closure, irrespective of type, as well as the identification, incision and retraction of adjacent or overlying structures are related to the principle procedure and merit no additional fees.

C) **Each Additional Codes:** Within the fee schedule are procedures that are inherently related to each other due to additional levels or areas that are performed after a primary procedure. These procedures are identified with the + symbol and are not subject to the multiple procedure reductions. For example: When procedure code 15100 (split graft 100 sq. cm) is billed in conjunction with procedure code 15101 (each additional 100 sq. cm), each procedure will be reimbursed its full value.

6. Follow-up or Aftercare

A) Follow-up care for therapeutic surgical procedures includes all normal postoperative care. Uncommon or unusual complications, recurrence or the presence of other diseases or injuries requiring significant additional services concurrent with the procedure(s) or during the listed period of follow-up care may warrant additional charges. If such charges are made, explain by report with adequate description.

B) When an additional surgical procedure is performed during the follow-up period and it 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 as one item.

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 "separate procedure" is applicable. Therefore, when a procedure is ordinarily a component of a larger procedure and is performed alone for a specific purpose, it may be considered a separate procedure.

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 subsequently. For example, where a tendon is lacerated and it is 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. Operative Reports and Billing

Bills for operative procedures must include an operative report. A bill for an operative procedure shall not be deemed properly submitted unless and until an operative report is received by the payer. If the procedure is performed in a hospital, a copy of the hospital operative report is required. For other sites, the location should be identified and an informative description of the surgery should be submitted. An operative report shall include but not be limited to a brief but adequate summary of the history, physical findings, and operative findings, and an accurate and complete description of the surgical procedure performed.

10. By Report (BR) Items

"BR" in the Relative Value column indicates that the value of this service is to be determined "by report" because the service is too unusual or variable to be assigned a relative value unit. Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished, using any of the following as indicated:

A) Diagnosis (postoperative), pertinent history and physical findings.

B) Size, location, and number of lesion(s) or procedure(s) where appropriate.

C) Major surgical procedure with supplementary procedure(s).

D) Whenever possible, list the closest similar procedure by number and relative value unit. The "BR" relative value units shall be consistent in relativity with other relative value units in the schedule.

E) Estimated follow-up period, if not listed.

F) Operative time.

11. Unlisted Services or Procedures

Some services performed are not described by any CPT code. These services should be reported using an unlisted code and substantiated by report as discussed in Surgery Ground Rule 10 above. The unlisted procedures and accompanying codes for surgery will be found at the end of the relevant section or subsection.

12. Concurrent Services by More Than One Podiatrist

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

A) **Identifiable medical services** provided prior to or during the surgical procedure or in the postoperative period are to be charged for by the podiatrist rendering the service identified by the appropriate code and relative value units. Such payable fees are unrelated to the surgeon's fee.

B) **Surgical assistants:** Identify surgery performed by code number, appropriate modifier, description of procedures, and bill at 16 percent of the code fee. The code 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.

C) **Two surgeons:** Under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical problem. By prior agreement, the total value for the procedures may be apportioned 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. Identify surgery performed by code number, appropriate modifier, and description of procedures.

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. By prior agreement, the total value may be apportioned in relation to the responsibility and work done. The total value for the procedure shall not, however, be increased but shall be prorated between the co-surgeons. Identify surgery performed by code number, appropriate modifier, and description of procedures.

In the event of no agreement between co-surgeons, the proration shall be determined by an Arbitration Committee.

E) **Surgical team:** Under some circumstances highly complex procedures 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. The value should be supported by a report to include itemization of the provider services, paramedical personnel, and equipment involved.

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. 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 prorated between the providers. If no agreement is reached by the providers involved, the apportionment shall be determined by arbitration.

14. Repeat Procedure by Another Provider

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

15. Proration of a 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 to the amounts to be prorated to each, they shall render separate bills accordingly. If no proration agreement is reached by them, the amounts payable to each party shall be settled by an arbitration committee, without cost to the contestants. When treatment is terminated by the departure of the patient from New York State before the expiration of the stated 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 the follow-up days, the full fee is payable, subject to proration where applicable.

16. Materials Supplied by Podiatrist

Do not 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. Surgical services do not include the supply of medications, sterile trays, and other materials which may be reported separately with code 99070. The specific items provided must be identified. Payment shall not exceed the cost of the items to the podiatrist. **Note:** The *Official New York State Workers' Compensation Podiatry Fee Schedule* has a separate list of state-specific appliance and prosthesis codes that should be used instead of 99070 for the listed supplies in the Podiatry Fee Schedule.

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 six of section 6810 of the Public Health Law.

Durable Medical Equipment Fee Schedule

The Durable Medical Equipment Fee Schedule adopted is still the Medicaid fee schedule. However, the regulation includes clarification on the application of the Medicaid fee schedule to workers' compensation claims. Specifically, the regulation provides that payments for bone growth stimulators are made in a single payment for the entire amount, that the reimbursement for orthopedic footwear is the lesser of the acquisition cost to the provider plus 50 percent or the usual and customary price charged to the public, and that hearing aids are not considered durable medical equipment for purposes of the fee schedule and the reimbursement amount is the provider's usual and customary price.

The Durable Medical Equipment Fee Schedule does not apply to medical providers supplying durable medical equipment to injured workers as part of medical treatment described in the *Official New York State Workers' Compensation Medical Fee Schedule.* Billing and reimbursement follows the ground rules as described in this fee schedule.

17. Reference (outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting podiatrist, 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 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 codes.

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 podiatrist may warrant an additional payment when performed during the inclusive follow-up period; see Surgery Ground Rule 6, Follow-up or Aftercare.

C) **Bone, Cartilage, and Fascial Grafts**
Listed values for most graft procedures include obtaining the graft. When a second surgeon obtains the graft, the value of the total procedure will not be increased but in accordance with Surgery Ground Rule 12-D, the value may be apportioned between the surgeons. Procedure 20900 is NOT to be used with procedures that include the graft as part of the descriptor. Procedure 20900 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 value 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 podiatrist.

D) **Dislocations Complicated by a Fracture**
Increase the unit value 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 foot, and not otherwise specified, see Surgery Ground Rule 5, Multiple or Bilateral Procedures. 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. Modifiers commonly used in surgery 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.

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.

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).

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).

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.

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 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 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.

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).

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.

SURGERY 10060–64911

Podiatry Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
	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	
	11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion	0.34	000	
+	**11101**	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)	0.25	ZZZ	
	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	
	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	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	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	
	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	
	11900	Injection, intralesional; up to and including 7 lesions	0.22	000	
	11901	Injection, intralesional; more than 7 lesions	0.34	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10060–64911

Podiatry Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	12047	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; over 30.0 cm	2.29	010	
	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	
	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	
	14350	Filleted finger or toe flap, including preparation of recipient site	3.99	090	
	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	

	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	
	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	
	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	
	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	
	15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet	5.75	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	
	15756	Free muscle or myocutaneous flap with microvascular anastomosis	18.09	090	
	15757	Free skin flap with microvascular anastomosis	21.28	090	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10060–64911

Podiatry Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
		15758	Free fascial flap with microvascular anastomosis	23.43	090	
■	+	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	
		15782	Dermabrasion; regional, other than face	2.50	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	
		15792	Chemical peel, nonfacial; epidermal	1.00	090	
		15793	Chemical peel, nonfacial; dermal	1.51	090	
		15850	Removal of sutures under anesthesia (other than local), same surgeon	0.50	XXX	
		15851	Removal of sutures under anesthesia (other than local), other surgeon	0.31	000	
		15852	Dressing change (for other than burns) under anesthesia (other than local)	0.35	000	
		15860	Intravenous injection of agent (eg, fluorescein) to test vascular flow in flap or graft	0.90	000	
		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	
		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	
		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	
		17340	Cryotherapy (CO2 slush, liquid N2) for acne	0.15	010	
		20005	Incision and drainage of soft tissue abscess, subfascial (ie, involves the soft tissue below the deep fascia)	0.60	010	
		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	
		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	
		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	

		Code	Description	Relative Value	FUD	PC/TC Split
■		20600	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance	0.28	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	
■		20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	0.25	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	
■		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	
		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	
		20900	Bone graft, any donor area; minor or small (eg, dowel or button)	1.60	000	
		20924	Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)	2.17	090	
		20926	Tissue grafts, other (eg, paratenon, fat, dermis)	2.07	090	
	⊘	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	
	+	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	
		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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10060–64911

Podiatry Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
■	**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	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
+	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	
	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	
	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	
	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	
	27745	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, tibia	8.69	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	
	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	

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SURGERY 10060–64911

Podiatry Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	5.18	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	
	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	010	
	28002	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space	3.67	010	
	28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	3.67	090	
	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	

	Code	Description	Relative Value	FUD	PC/TC Split
■	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	
	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	
	28150	Phalangectomy, toe, each toe	3.23	090	
	28153	Resection, condyle(s), distal end of phalanx, each toe	3.23	090	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10060–64911

Podiatry Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	28288	Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head	3.23	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 (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method	5.18	090	
■	**28296**	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method	7.77	090	
■	**28297**	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method	6.21	090	
■	**28298**	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method	5.61	090	

	Code	Description	Relative Value	FUD	PC/TC Split
■	28299	Correction, hallux valgus (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	
	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	

SURGERY 10060–64911

Podiatry Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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	
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	

	Code	Description	Relative Value	FUD	PC/TC Split
	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	
	28805	Amputation, foot; transmetatarsal	7.77	090	
	28810	Amputation, metatarsal, with toe, single	5.18	090	
	28820	Amputation, toe; metatarsophalangeal joint	3.67	090	
	28825	Amputation, toe; interphalangeal joint	3.23	090	
■	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	
	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	
	29440	Adding walker to previously applied cast	0.20	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	
	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	
	29700	Removal or bivalving; gauntlet, boot or body cast	0.25	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	
	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	

■ New code, changed description, or changed value from June 1, 2012

SURGERY 10060–64911

Podiatry Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	29897	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, limited	7.11	090	
	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	
	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	
	29999	Unlisted procedure, arthroscopy	BR	YYY	
	64450	Injection, anesthetic agent; other peripheral nerve or branch	0.35	000	
	64455	Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)	0.23	000	
	64632	Destruction by neurolytic agent; plantar common digital nerve	0.82	010	
	64640	Destruction by neurolytic agent; other peripheral nerve or branch	0.82	010	
	64702	Neuroplasty; digital, 1 or both, same digit	2.73	090	
	64704	Neuroplasty; nerve of hand or foot	3.27	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	
	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	
+	**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	
	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	
+	**64837**	Suture of each additional nerve, hand or foot (List separately in addition to code for primary procedure)	2.27	ZZZ	
	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	
	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	
+	**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	
	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	

4 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 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.

Fees for radiology items are for podiatrists who perform their own radiology work.

Items used by all podiatrists in reporting their services are presented in the Introduction and General Guidelines section under General Ground Rules.

Radiology 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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. 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 to re-x-ray.

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.

2. Multiple Diagnostic Procedures

The following adjustments apply to all diagnostic radiology procedures including MRI (Podiatry Fee Schedule codes 73600–76499, 76881–76882, 77002):

A) For two contiguous parts, the charge shall be the greater fee plus 50 percent of the lesser fee.

B) For two remote parts, the charge shall be the greater fee plus 75 percent of the lesser fee. Bilateral procedures are considered remote parts.

C) 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.

D) 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 2A–C above, whichever pertains.

E) No charge shall be made for comparative x-rays except when such x-rays are specifically authorized by the carrier or the Chairman. Comparative x-rays specifically authorized shall be subject to fees for contiguous and remote parts as provided in 2A–D above.

F) X-rays/imaging studies of different areas taken within 7 days of the initial x-rays/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 2A–E above.

3. Xeroradiography

Imaging performed by this process shall have the identical values listed for conventional x-ray procedures of the same area and views.

4. 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.

5. 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. Values 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. Supplies and materials provided by the podiatrist (e.g., sterile trays, radioisotopes) over and above those usually included with or necessitated by the services rendered 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 podiatrist.

The listed values are for technical and professional components. Total reimbursement for the professional and technical components shall not exceed the listed value for the total procedure, regardless of the sites 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 value is apportioned as indicated in the PC/TC Split column of the fee schedule.

A) **Professional Component**
The professional component represents the value of the professional radiological services of the podiatrist. This includes examination of the patient, when indicated, interpretation and written report of the examination, and consultation with the referring podiatrist. (Report using modifier 26.)

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. Podiatrists 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 the minimum number listed for respective procedures.

6. 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 podiatrist, insurance carrier, or self-insured employer. When requested, carriers and self-insured employers shall return original films to the podiatrist within 20 days of their receipt.

When a carrier or self-insured employer requests x-rays and satisfactory reproductions 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 podiatrist. Copies of images produced by copiers (e.g., Xerox) shall not merit any additional payment and shall not be returnable to the podiatrist; 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 podiatrist to another, the former treating podiatrist will promptly forward all images or copies of images to the new attending podiatrist.

7. Materials Supplied by Podiatrist

Do not 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. Surgical services do not include the supply of medications, sterile trays, and other materials which may be reported separately with code 99070. The specific items provided must be identified. Payment shall not exceed the cost of the items to the podiatrist. **Note:** The *Official New York State Workers' Compensation Podiatry Fee Schedule* has a separate list of state-specific appliance and prosthesis codes that should be used instead of 99070 for the listed supplies in the Podiatry Fee Schedule.

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.

Appliances and prostheses as listed within this fee schedule can be billed separately and do not apply to the supply rules as listed here.

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 six of section 6810 of the Public Health Law.

8. 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.

9. Miscellaneous

A) Emergency services rendered between 10 p.m. and 7 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. Submit report (see Medicine Ground Rule 1B).

B) Relative value units for office, home and hospital visits, consultation, and other medical services, surgical and laboratory procedures are listed in the Evaluation and Management, Medicine, Surgery, and Pathology and Laboratory sections.

10. 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. If more than one modifier is needed, place modifier 99 after the procedure code to indicate that two or more modifiers will follow. 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.

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).

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).

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 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.

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.

73600–77002 RADIOLOGY

Effective April 1, 2019 Podiatry Fee Schedule

		Code	Description	Relative Value	FUD	PC/TC Split
		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
		76080	Radiologic examination, abscess, fistula or sinus tract study, radiological supervision and interpretation	2.35	XXX	35/65
		76499	Unlisted diagnostic radiographic procedure	BR	XXX	
■		**76881**	Ultrasound, complete joint (ie, joint space and peri-articular soft tissue structures) real-time with image documentation	4.46	XXX	25/75
■		**76882**	Ultrasound, limited, joint or 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	69/31
■	+	**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

5 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.

Fees for pathology items are for podiatrists who perform their own laboratory work. All serological procedures are to be performed by registered pathologists or laboratories.

Items used by all podiatrists in reporting their services are presented in the Introduction and General Guidelines section under General Ground Rules.

Pathology and Laboratory 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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Attending Podiatrist

The attending podiatrist will not make a charge for obtaining and handling of specimens.

2. Supplies and Materials

Do not 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. Surgical services do not include the supply of medications, sterile trays, and other materials which may be reported separately with code 99070. The specific items provided must be identified. Payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping and handling costs associated with delivery from the supplier of the item to the podiatrist's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

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 six of section 6810 of the Public Health Law.

3. Referral Laboratory

When the service or procedure is performed by other than the attending podiatrist, 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. Reports

No bill for services or procedures included in this section shall be considered properly rendered unless it is accompanied by a report that includes the findings and the interpretation of such findings. Where the service or procedure results in producing an image or graph, such shall be submitted together with the bill.

5. By Report "(BR)"

"BR" in the Relative Value column indicates that the relative value unit of this service is to be determined "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary. See the General Ground Rules for an explanation of "BR" 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. Unlisted Service or Procedure

Specify the service by the last code number in the appropriate subdivision. Identify by name or description, and submit report (see Pathology and Laboratory Ground Rule 5 above).

8. Organ or Disease-Oriented Panels

Organ or disease-oriented panels (80047–80076), are used to confirm specific diagnoses. These panels are problem-oriented in scope. Each panel contains a list of the tests that must be included in order to use that particular code number. This is not meant to limit the number of tests performed or ordered if medically appropriate. Other tests performed that are not part of the panel may be separately reported. It is also inappropriate to separately report the components of a panel test if the full set of identified tests was performed. Please refer to CPT guidelines for a complete explanation of codes included in each panel.

9. Specific Billing Instructions

The relative value units listed in this section include recording the specimen, performance of the test, and reporting of 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 podiatrists, podiatrist-owned laboratories, commercial laboratories, and hospital laboratories.

The column designated PC/TC Split indicates the percent of the global fee (relative value) 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 podiatrist. This includes examination of the patient, when indicated, interpretation and written report of the laboratory procedure, and consultation with the referring podiatrist. (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.

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 (80500 and 80502) are reimbursable under this circumstance. The review of diagnostic tests is included in the evaluation and management codes.

12. 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 commonly used with surgical 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.

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.

13. Drug Screening

Drug screening may be required as part of the non-acute pain management treatment protocol.

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.

Risk Category (Score)	Random Drug Frequency
Low Risk	Periodic (once/year)
Moderate Risk	Regular (2/year)
High Risk	Frequent (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 GLC, 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.

80305–80307, 80375–80377, 81000–89051 PATHOLOGY AND LABORATORY

Effective April 1, 2019 **Podiatry Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
■	**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	0.00	XXX	0/100
■	**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
	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
	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
	81005	Urinalysis; qualitative or semiquantitative, except immunoassays	4.93	XXX	0/100
	82310	Calcium; total	8.01	XXX	0/100
	82435	Chloride; blood	8.01	XXX	0/100
	82465	Cholesterol, serum or whole blood, total	8.32	XXX	0/100
	82565	Creatinine; blood	8.01	XXX	0/100
	82945	Glucose, body fluid, other than blood	26.49	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
	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
	84100	Phosphorus inorganic (phosphate);	8.01	XXX	0/100
	84132	Potassium; serum, plasma or whole blood	8.01	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
	84550	Uric acid; blood	8.01	XXX	0/100
	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

PATHOLOGY AND LABORATORY 80305–80307, 80375–80377, 81000–89051

Podiatry Fee Schedule Effective April 1, 2019

Code	Description	Relative Value	FUD	PC/TC Split
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
85048	Blood count; leukocyte (WBC), automated	8.63	XXX	0/100
85049	Blood count; platelet, automated	8.63	XXX	0/100
85345	Coagulation time; Lee and White	6.16	XXX	0/100
85347	Coagulation time; activated	6.16	XXX	0/100
85651	Sedimentation rate, erythrocyte; non-automated	7.70	XXX	0/100
86430	Rheumatoid factor; qualitative	11.71	XXX	0/100
87181	Susceptibility studies, antimicrobial agent; agar dilution method, per agent (eg, antibiotic gradient strip)	10.47	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
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

6 Medicine

The relative value units listed in this section have been determined on an entirely different basis than those in other sections. A conversion factor applicable to this section is not applicable to any other section.

The relative value units listed in this section reflect the relativity of charges for procedures within this section only.

The fee for a particular procedure or service in this section is determined by multiplying the listed relative value unit by the current dollar conversion factor applicable to this section, 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, and then the products are to be added.

Medicine 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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Special Services and Reports

The procedures with code numbers 99000–99075 provide the reporting podiatrist with the means of identifying the completion of special reports and services that are adjunct to the basic services rendered. The specific number assigned indicates the special circumstances under which a basic procedure is performed.

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.

2. 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 commonly used in the Medicine section are:

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.

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).

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).

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.

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.

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.)

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.

			Code	Description	Relative Value	FUD
■			95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests	0.42	XXX
■			95024	Intracutaneous (intradermal) tests with allergenic extracts, 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
			95199	Unlisted allergy/clinical immunologic service or procedure	BR	XXX
	Ⓢ	®	97545	Work hardening/conditioning ; initial 4 hours	28.00	XXX
✚	Ⓢ	®	97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)	3.30	ZZZ
	Ⓢ		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
	Ⓢ		99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	BR	XXX
	Ⓢ		99053	Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service	BR	XXX
	Ⓢ		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
	Ⓢ		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
	Ⓢ		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
■			99075	Medical testimony	Refer to Rules	XXX

7 Appliances and Prostheses

The relative value units in this section have been determined on an entirely different basis than those in other sections. A conversion factor applicable to this section is not applicable to any other section.

The relative value units listed in this section reflect the relativity of charges for procedures within this section only.

The fee for a particular procedure or service in this section is determined by multiplying the listed relative value units by the current dollar conversion factor applicable to this section, 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, and then the products are to be added.

Appliances and Prostheses 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. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

Podiatric Appliances and Prostheses

Fees allowed include cost of materials.

APPLIANCES AND PROSTHESES ∞09006–∞09053

Podiatry Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value
∞	09006	Foot molds (pair)	4.25
∞	09007	Functional rigid appliance (pair)	4.00
∞	09008	Shoes (pair)	4.50
∞	09009	Heel cup, single	1.20
∞	09010	Heel cup, pair	1.50
∞	09011	Bunion or bunionette jacket, single	1.20
∞	09012	Bunion or bunionette jacket, multiple	1.50
∞	09013	Missing parts (toes, forefoot, etc.)	BR
∞	09021	Toe jacket, single	1.30
∞	09022	Toe jacket, multiple (adjacent toes)	1.50
∞	09023	Toe jacket, multiple (nonadjacent toes)	1.80
∞	09024	Silicone toe crest (one (foot)	1.60
∞	09025	Silicone toe crest (both feet)	2.35
∞	09026	Silicone toe crest (one foot) with dorsal retainer (one toe)	1.80
∞	09027	Silicone toe crest (both feet) with dorsal retainer (multiple toes)	2.55
∞	09028	Silicone toe crest (one foot) with dorsal retainer (multiple toes)	2.00
∞	09029	Silicone toe crest (both feet) with dorsal retainer (multiple toes)	2.75
∞	09030	Silicone toe crest with hallux wedge (one foot)	2.00
∞	09031	Silicone toe crest with hallux wedge (both feet)	2.75
∞	09032	Moulded polyurethane toe device, (one or more lesser toes, one foot)	2.00
∞	09033	Moulded polyurethane toe device, (one or more lesser toes, both feet)	3.00
∞	09034	Moulded polyurethane toe device, hallux only (one foot)	2.25
∞	09035	Moulded polyurethane toe device, hallux only (both feet)	3.25
∞	09036	Moulded polyurethane toe device, hallux and lesser toes (one foot)	2.80
∞	09037	Moulded polyurethane toe device, hallux and lesser toes (both feet)	3.80
∞	09038	Moulded polyurethane toe device with plantar extension (one or more lesser toes, one foot)	2.80
∞	09039	Moulded polyurethane toe device with plantar extension (one or more lesser toes, both feet)	3.80
∞	09040	Moulded polyurethane toe device including hallux with plantar extension (one or more lesser toes, one foot)	3.00
∞	09041	With plantar extension (one or more lesser toes, both feet)	4.00
∞	09042	Bunion or bunionette jacket, single	1.50
∞	09043	Bunion or bunionette jacket, multiple (one foot or both feet)	2.00
∞	09044	Orthodigital splint (one or more toes, one foot)	2.00
∞	09045	Orthodigital splint (one or more toes, both feet)	3.00
∞	09046	Foot moulds, balance inlays, supports, etc. (pair)	7.00
∞	09047	Functional rigid appliance, custom made (pair)	11.50
∞	09052	Shoes	BR
∞	09053	Missing parts	BR