

ACCESSORY SINUSES

ENDOSCOPY (SINUSES)

CPT Code	Description
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
31233	Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncturè)
31235	Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy(via puncture of sphenoidal face or cannulation of ostium)
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)
31238	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage
31239	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection
31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)
31255	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy;
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy;
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus
31290	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region
31291	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; sphenoid region
31292	Nasal/sinus endoscopy, surgical; with medial or inferior orbital wall decompression
31293	Nasal/sinus endoscopy, surgical; with medial orbital wall and inferior orbital wall decompression
31294	Nasal/sinus endoscopy, surgical; with optic nerve decompression

EXCISION (SINUSES)

CPT Code	Description
31200	Ethmoidectomy; intranasal, anterior
31201	Ethmoidectomy; intranasal, total
31205	Ethmoidectomy; extranasal, total
31225	Maxillectomy; without orbital exenteration
31230	Maxillectomy; with orbital exenteration (en bloc)

INCISION (SINUSES)

CPT Code	Description
31000	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)
31002	Lavage by cannulation; sphenoid sinus
31020	Sinusotomy, maxillary (antrotomy); intranasal
31030	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyps

ACCESSORY SINUSES

INCISION (SINUSES)

CPT Code	Description
31032	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) with removal of antrochoanal polyps
31040	Pterygomaxillary fossa surgery, any approach
31050	Sinusotomy, sphenoid, with or without biopsy;
31051	Sinusotomy, sphenoid, with or without biopsy; with mucosal stripping or removal of polyp(s)
31070	Sinusotomy frontal; external, simple (trephine operation)
31075	Sinusotomy frontal; transorbital, unilateral (for mucocele or osteoma, Lynch type)
31080	Sinusotomy frontal; obliterative without osteoplastic flap, brow incision (includes ablation)
31081	Sinusotomy frontal; obliterative, without osteoplastic flap, coronal incision (includes ablation)
31084	Sinusotomy frontal; obliterative, with osteoplastic flap, brow incision
31085	Sinusotomy frontal; obliterative, with osteoplastic flap, coronal incision
31086	Sinusotomy frontal; nonobliterative, with osteoplastic flap, brow incision
31087	Sinusotomy frontal; nonobliterative, with osteoplastic flap, coronal incision
31090	Sinusotomy, unilateral, three or more paranasal sinuses (frontal, maxillary, ethmoid, sphenoid)

OTHER (SINUSES)

CPT Code	Description
31299	Unlisted procedure, accessory sinuses

ARTERIES AND VEINS

REPAIR BLOOD VESSEL OTHER THAN FISTULA

CPT Code	Description
35201	Repair blood vessel, direct; neck
35231	Repair blood vessel with vein graft; neck
35261	Repair blood vessel with graft other than vein; neck

CONJUNCTIVA

CONJUNCTIVOPLASTY

CPT Code	Description
68320	Conjunctivoplasty; with conjunctival graft or extensive rearrangement
68325	Conjunctivoplasty; with buccal mucous membrane graft (includes obtaining graft)
68326	Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement
68328	Conjunctivoplasty, reconstruction cul-de-sac; with buccal mucous membrane graft (includes obtaining graft)
68330	Repair of symblepharon; conjunctivoplasty, without graft

CONJUNCTIVA

CONJUNCTIVOPLASTY

CPT Code	Description
68335	Repair of symblepharon; with free graft conjunctiva or buccal mucous membrane (includes obtaining graft)
68340	Repair of symblepharon; division of symblepharon, with or without insertion of conformer or contact lens

EXCISION AND/OR DESTRUCTION (CONJUNCTIVA)

CPT Code	Description
68100	Biopsy of conjunctiva
68110	Excision of lesion, conjunctiva; up to 1 cm
68115	Excision of lesion, conjunctiva; over 1 cm
68130	Excision of lesion, conjunctiva; with adjacent sclera
68135	Destruction of lesion, conjunctiva

INCISION AND DRAINAGE (CONJUNCTIVA)

CPT Code	Description
68020	Incision of conjunctiva, drainage of cyst
68040	Expression of conjunctival follicles (eg, for trachoma)

INJECTION

CPT Code	Description
68200	Subconjunctival injection

LACRIMAL SYSTEM - EXCISION

CPT Code	Description
68500	Excision of lacrimal gland (dacryoadenectomy), except for tumor; total
68505	Excision of lacrimal gland (dacryoadenectomy), except for tumor; partial
68510	Biopsy of lacrimal gland
68520	Excision of lacrimal sac (dacryocystectomy)
68525	Biopsy of lacrimal sac
68530	Removal of foreign body or dacryolith, lacrimal passages
68540	Excision of lacrimal gland tumor; frontal approach
68550	Excision of lacrimal gland tumor; involving osteotomy

LACRIMAL SYSTEM - INCISION

CPT Code	Description
68400	Incision, drainage of lacrimal gland
68420	Incision, drainage of lacrimal sac (dacryocystotomy or dacryocystostomy)
68440	Snip incision of lacrimal punctum

CONJUNCTIVA

LACRIMAL SYSTEM - OTHER

CPT Code	Description
68899	Unlisted procedure, lacrimal system

LACRIMAL SYSTEM - PROBING AND/OR RELATED PROCEDURES

CPT Code	Description
68801	Dilation of lacrimal punctum, with or without irrigation
68810	Probing of nasolacrimal duct, with or without irrigation;
68811	Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia
68815	Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent
68840	Probing of lacrimal canaliculi, with or without irrigation
68850	Injection of contrast medium for dacryocystography

LACRIMAL SYSTEM - REPAIR

CPT Code	Description
68700	Plastic repair of canaliculi
68705	Correction of everted punctum, cautery
68720	Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)
68745	Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); without tube
68750	Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); with insertion of tube or stent
68760	Closure of the lacrimal punctum; by thermocauterization, ligation, or laser surgery
68761	Closure of the lacrimal punctum; by plug, each
68770	Closure of lacrimal fistula (separate procedure)

OTHER (CONJUNCTIVA)

CPT Code	Description
68360	Conjunctival flap; bridge or partial (separate procedure)
68362	Conjunctival flap; total (such as Gunderson thin flap or purse string flap)
68399	Unlisted procedure, conjunctiva

DENTOALVEOLAR STRUCTURES

EXCISION, DESTRUCTION (DENTOALVEOLAR STRUCTURES)

CPT Code	Description
41820	Gingivectomy, excision gingiva, each quadrant
41821	Operculectomy, excision pericoronal tissues
41822	Excision of fibrous tuberosities, dentoalveolar structures
41823	Excision of osseous tuberosities, dentoalveolar structures
41825	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair
41826	Excision of lesion or tumor (except listed above), dentoalveolar structures; with simple repair

DENTOALVEOLAR STRUCTURES

EXCISION, DESTRUCTION (DENTOALVEOLAR STRUCTURES)

CPT Code	Description
41827	Excision of lesion or tumor (except listed above), dentoalveolar structures; with complex repair
41828	Excision of hyperplastic alveolar mucosa, each quadrant (specify)
41830	Alveolectomy, including curettage of osteitis or sequestrectomy
41850	Destruction of lesion (except excision), dentoalveolar structures

INCISION (DENTOALVEOLAR STRUCTURES)

CPT Code	Description
41800	Drainage of abscess, cyst, hematoma from dentoalveolar structures
41805	Removal of embedded foreign body from dentoalveolar structures; soft tissues
41806	Removal of embedded foreign body from dentoalveolar structures; bone

OTHER (DENTOALVEOLAR STRUCTURES)

CPT Code	Description
41870	Periodontal mucosal grafting
41872	Gingivoplasty, each quadrant (specify)
41874	Alveoloplasty, each quadrant (specify)
41899	Unlisted procedure, dentoalveolar structures

ESOPHAGUS

ENDOSCOPY (ESOPHAGUS)

CPT Code	Description
43200	Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen (s) by brushing or washing (separate procedure)
43201	Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance
43202	Esophagoscopy, rigid or flexible; with biopsy, single or multiple
43204	Esophagoscopy, rigid or flexible; with injection sclerosis of esophageal varices
43205	Esophagoscopy, rigid or flexible; with band ligation of esophageal varices
43215	Esophagoscopy, rigid or flexible; with removal of foreign body
43216	Esophagoscopy, rigid or flexible; with removal of tumor (s), polyp(s), or other lesion (s) by hot biopsy forceps or bipolar cautery
43217	Esophagoscopy, rigid or flexible; with removal of tumor (s), polyp(s), or other lesion (s) by snare technique
43219	Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent
43220	Esophagoscopy, rigid or flexible; with balloon dilation (less than 30 mm diameter)
43226	Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire
43227	Esophagoscopy, rigid or flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)

ESOPHAGUS

ENDOSCOPY (ESOPHAGUS)

CPT Code	Description
43228	Esophagoscopy, rigid or flexible; with ablation of tumor (s), polyp(s), or other lesion (s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
43231	Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination
43232	Esophagoscopy, rigid or flexible; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)
43234	Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure)
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen (s) by brushing or washing (separate procedure)
43236	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection (s), any substance
43239	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple
43240	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transmural drainage of pseudocyst
43241	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic intraluminal tube or catheter placement
43242	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)
43243	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with injection sclerosis of esophageal and/or gastric varices
43244	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of esophageal and/or gastric varices
43245	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation of gastric outlet for obstruction (eg, balloon, guide wire, bougie)
43246	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube
43247	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body
43248	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire
43249	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)
43250	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor (s), polyp(s), or other lesion (s) by hot biopsy forceps or bipolar cautery
43251	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor (s), polyp(s), or other lesion (s) by snare technique
43255	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method
43256	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation)

ESOPHAGUS

ENDOSCOPY (ESOPHAGUS)

CPT Code	Description
43258	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor (s), polyp(s), or other lesion (s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
43259	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination
43260	Endoscopic retrograde cholangiopancreatography(ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple
43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy
43263	Endoscopic retrograde cholangiopancreatography(ERCP); with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct)
43264	Endoscopic retrograde cholangiopancreatography(ERCP); with endoscopic retrograde removal of calculus/calculi from biliary and /or pancreatic ducts
43265	Endoscopic retrograde cholangiopancreatography(ERCP); with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method
43267	Endoscopic retrograde cholangiopancreatography(ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube
43268	Endoscopic retrograde cholangiopancreatography(ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct
43269	Endoscopic retrograde cholangiopancreatography(ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent
43271	Endoscopic retrograde cholangiopancreatography(ERCP); with endoscopic retrograde balloon dilation of ampulla, biliary and /or pancreatic duct(s)
43272	Endoscopic retrograde cholangiopancreatography(ERCP); with ablation of tumor (s), polyp(s), or other lesion (s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

EXCISION (ESOPHAGUS)

CPT Code	Description
43100	Excision of lesion, esophagus, with primary repair; cervical approach
43101	Excision of lesion, esophagus, with primary repair; thoracic or abdominal approach
43107	Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagostomy, with or without pyloroplasty (transhiatal)
43108	Total or near total esophagectomy, without thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis (es)
43112	Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagostomy, with or without pyloroplasty
43113	Total or near total esophagectomy, with thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis (es)
43116	Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction
43117	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagostomy, with or without pyloroplasty (Ivor Lewis)

ESOPHAGUS

EXCISION (ESOPHAGUS)

CPT Code	Description
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 (e
43121	Partial esophagectomy, distal two -thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty
43122	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty
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)
43124	Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy
43130	Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach
43135	Diverticulectomy of hypopharynx or esophagus, with or without myotomy; thoracic approach

INCISION (ESOPHAGUS)

CPT Code	Description
43020	Esophagotomy, cervical approach, with removal of foreign body
43030	Cricopharyngeal myotomy
43045	Esophagotomy, thoracic approach, with removal of foreign body

LAPAROSCOPY (ESOPHAGUS)

CPT Code	Description
43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)
43289	Unlisted laparoscopy procedure, esophagus

MANIPULATION (ESOPHAGUS)

CPT Code	Description
43450	Dilation of esophagus, by unguided sound or bougie, single or multiple passes
43453	Dilation of esophagus, over guide wire
43456	Dilation of esophagus, by balloon or dilator, retrograde
43458	Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia
43460	Esophagogastric tamponade, with balloon (Sengstaaken type)

OTHER (ESOPHAGUS)

CPT Code	Description
43496	Free jejunum transfer with microvascular anastomosis
43499	Unlisted procedure, esophagus

ESOPHAGUS

REPAIR (ESOPHAGUS)

CPT Code	Description
43300	Esophagoplasty (plastic repair or reconstruction), cervical approach; without repair of tracheoesophageal fistula
43305	Esophagoplasty (plastic repair or reconstruction), cervical approach; with repair of tracheoesophageal fistula
43310	Esophagoplasty (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula
43312	Esophagoplasty (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula
43313	Esophagoplasty for congenital defect(plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula
43314	Esophagoplasty for congenital defect(plastic repair or reconstruction), thoracic approach; with repair of congenital tracheoesophageal fistula
43320	Esophagogastrostomy(cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach
43324	Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures)
43325	Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)
43326	Esophagogastric fundoplasty; with gastroplasty (eg, Collis)
43330	Esophagomyotomy (Heller type); abdominal approach
43331	Esophagomyotomy (Heller type); thoracic approach
43340	Esophagojejunostomy (without total gastrectomy); abdominal approach
43341	Esophagojejunostomy (without total gastrectomy); thoracic approach
43350	Esophagostomy, fistulization of esophagus, external; abdominal approach
43351	Esophagostomy, fistulization of esophagus, external; thoracic approach
43352	Esophagostomy, fistulization of esophagus, external; cervical approach
43360	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty
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
43400	Ligation, direct, esophageal varices
43401	Transection of esophagus with repair, for esophageal varices
43405	Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation
43410	Suture of esophageal wound or injury; cervical approach
43415	Suture of esophageal wound or injury; transthoracic or transabdominal approach
43420	Closure of esophagostomy or fistula; cervical approach
43425	Closure of esophagostomy or fistula; transthoracic or transabdominal approach

EXTERNAL EAR

EXCISION (EXTERNAL EAR)

CPT Code	Description
69100	Biopsy external ear
69105	Biopsy external auditory canal

EXTERNAL EAR

EXCISION (EXTERNAL EAR)

CPT Code	Description
69110	Excision external ear; partial, simple repair
69120	Excision external ear; complete amputation
69140	Excision exostosis(es), external auditory canal
69145	Excision soft tissue lesion, external auditory canal
69150	Radical excision external auditory canal lesion; without neck dissection
69155	Radical excision external auditory canal lesion; with neck dissection

INCISION (EXTERNAL EAR)

CPT Code	Description
69000	Drainage external ear, abscess or hematoma; simple
69005	Drainage external ear, abscess or hematoma; complicated
69020	Drainage external auditory canal, abscess
69090	Ear piercing

OTHER (EXTERNAL EAR)

CPT Code	Description
69399	Unlisted procedure, external ear

REMOVAL FOREIGN BODY

CPT Code	Description
69200	Removal foreign body from external auditory canal; without general anesthesia
69205	Removal foreign body from external auditory canal; with general anesthesia
69210	Removal impacted cerumen (separate procedure), one or both ears
69220	Debridement, mastoidectomy cavity, simple (eg, routine cleaning)
69222	Debridement, mastoidectomy cavity, complex (eg, with anesthesia or more than routine cleaning)

REPAIR (EXTERNAL EAR)

CPT Code	Description
69300	Otoplasty, protruding ear, with or without size reduction
69310	Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to injury, infection) (separate procedure)
69320	Reconstruction external auditory canal for congenital atresia, single stage

EXTRACRANIAL NERVES

NEURORRHAPHY

CPT Code	Description
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EXTRACRANIAL NERVES

NEURORRHAPHY

CPT Code	Description
64864	Suture of facial nerve; extracranial
64865	Suture of facial nerve; infratemporal, with or without grafting
64866	Anastomosis; facial-spinal accessory
64868	Anastomosis; facial-hypoglossal
64870	Anastomosis; facial-phrenic

NEURORRHAPHY WITH NERVE GRAFT

CPT Code	Description
64885	Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length
64886	Nerve graft (includes obtaining graft), head or neck; more than 4 cm length

HEAD

EXCISION (HEAD)

CPT Code	Description
21015	Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp
21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible
21026	Excision of bone (eg, for osteomyelitis or bone abscess); facial bone(s)
21029	Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)
21030	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage
21031	Excision of torus mandibularis
21032	Excision of maxillary torus palatinus
21034	Excision of malignant tumor of maxilla or zygoma
21040	Excision of benign tumor or cyst of mandible, by enucleation and/or curettage
21044	Excision of malignant tumor of mandible;
21045	Excision of malignant tumor of mandible; radical resection
21046	Excision of benign tumor or cyst of mandible; requiring intra -oral osteotomy (eg, locally aggressive or destructive lesion(s))
21047	Excision of benign tumor or cyst of mandible; requiring extra -oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion(s))
21048	Excision of benign tumor or cyst of maxilla; requiring intra -oral osteotomy (eg, locally aggressive or destructive lesion(s))
21049	Excision of benign tumor or cyst of maxilla; requiring extra -oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion(s))
21050	Condylectomy, temporomandibular joint (separate procedure)
21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)
21070	Coronoidectomy (separate procedure)

FRACTURE AND/OR DISLOCATION (HEAD)

CPT Code	Description
21300	Closed treatment of skull fracture without operation

HEAD

FRACTURE AND/OR DISLOCATION (HEAD)

CPT Code	Description
21310	Closed treatment of nasal bone fracture without manipulation
21315	Closed treatment of nasal bone fracture; without stabilization
21320	Closed treatment of nasal bone fracture; with stabilization
21325	Open treatment of nasal fracture; uncomplicated
21330	Open treatment of nasal fracture; complicated, with internal and/or external skeletal fixation
21335	Open treatment of nasal fracture; with concomitant open treatment of fractured septum
21336	Open treatment of nasal septal fracture, with or without stabilization
21337	Closed treatment of nasal septal fracture, with or without stabilization
21338	Open treatment of nasoethmoid fracture; without external fixation
21339	Open treatment of nasoethmoid fracture; with external fixation
21340	Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus
21343	Open treatment of depressed frontal sinus fracture
21344	Open treatment of complicated (eg, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches
21345	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint
21346	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and /or local fixation
21347	Open treatment of nasomaxillary complex fracture (LeFort II type); requiring multiple open approaches
21348	Open treatment of nasomaxillary complex fracture (LeFort II type); with bone grafting (includes obtaining graft)
21355	Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation
21356	Open treatment of depressed zygomatic arch fracture (eg, Gillies approach)
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod
21365	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fractur(e)s of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches
21366	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fractur(e)s of malar area, including zygomatic arch and malar tripod; with bone grafting (includes obtaining graft)
21385	Open treatment of orbital floor blowout fracture; transantral approach(Caldwell-Luc type operation)
21386	Open treatment of orbital floor blowout fracture; periorbital approach
21387	Open treatment of orbital floor blowout fracture; combined approach
21390	Open treatment of orbital floor blowout fracture; periorbital approach, with alloplastic or other implant
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)
21400	Closed treatment of fracture of orbit, except blowout; without manipulation
21401	Closed treatment of fracture of orbit, except blowout; with manipulation
21406	Open treatment of fracture of orbit, except blowout; without implant
21407	Open treatment of fracture of orbit, except blowout; with implant

HEAD

FRACTURE AND/OR DISLOCATION (HEAD)

CPT Code	Description
21408	Open treatment of fracture of orbit, except blowout; with bone grafting(includes obtaining graft)
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint
21422	Open treatment of palatal or maxillary fracture (LeFort I type);
21423	Open treatment of palatal or maxillary fracture (LeFort I type); complicated (comminuted or involving cranial nerve foramina), multiple approaches
21431	Closed treatment of craniofacial separation(LeFort III type) using interdental wire fixation of denture or splint
21432	Open treatment of craniofacial separation(LeFort III type); with wiring and /or internal fixation
21433	Open treatment of craniofacial separation(LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches
21435	Open treatment of craniofacial separation(LeFort III type); complicated, utilizing internal and/or external fixation techniques (eg, head cap, halo device, and/or intermaxillary fixation)
21436	Open treatment of craniofacial separation(LeFort III type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21445	Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21450	Closed treatment of mandibular fracture; without manipulation
21451	Closed treatment of mandibular fracture; with manipulation
21452	Percutaneous treatment of mandibular fracture, with external fixation
21453	Closed treatment of mandibular fracture with interdental fixation
21454	Open treatment of mandibular fracture with external fixation
21461	Open treatment of mandibular fracture; without interdental fixation
21462	Open treatment of mandibular fracture; with interdental fixation
21465	Open treatment of mandibular condylar fracture
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and /or wiring of dentures or splints
21480	Closed treatment of temporomandibular dislocation; initial or subsequent
21485	Closed treatment of temporomandibular dislocation; complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent
21490	Open treatment of temporomandibular dislocation
21493	Closed treatment of hyoid fracture; without manipulation
21494	Closed treatment of hyoid fracture; with manipulation
21495	Open treatment of hyoid fracture
21497	Interdental wiring, for condition other than fracture

INCISION (HEAD)

CPT Code	Description
21010	Arthrotomy, temporomandibular joint

HEAD

INTRODUCTION OR REMOVAL (HEAD)

CPT Code	Description
21076	Impression and custom preparation; surgical obturator prosthesis
21077	Impression and custom preparation; orbital prosthesis
21079	Impression and custom preparation; interim obturator prosthesis
21080	Impression and custom preparation; definitive obturator prosthesis
21081	Impression and custom preparation; mandibular resection prosthesis
21082	Impression and custom preparation; palatal augmentation prosthesis
21083	Impression and custom preparation; palatal lift prosthesis
21084	Impression and custom preparation; speech aid prosthesis
21085	Impression and custom preparation; oral surgical splint
21086	Impression and custom preparation; auricular prosthesis
21087	Impression and custom preparation; nasal prosthesis
21088	Impression and custom preparation; facial prosthesis
21089	Unlisted maxillofacial prosthetic procedure
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)
21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
21116	Injection procedure for temporomandibular joint arthrography

OTHER (HEAD)

CPT Code	Description
21299	Unlisted craniofacial and maxillofacial procedure
21499	Unlisted musculoskeletal procedure, head

REPAIR REVISION, AND/OR RECONSTRUCTION (HEAD)

CPT Code	Description
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, two or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft

HEAD

REPAIR REVISION, AND/OR RECONSTRUCTION (HEAD)

CPT Code	Description
21142	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft
21143	Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, without bone graft
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts(includes obtaining autografts)
21146	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts(includes obtaining autografts)(eg, ungrafted unilateral alveolar cleft)
21147	Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, requiring bone grafts(includes obtaining autografts)(eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement(eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement(eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21181	Reconstruction by contouring of benign tumor of cranial bones(eg, fibrous dysplasia), extracranial
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra - and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts(includes obtaining grafts); total area of bone grafting les
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 gre
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 gre
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts(includes obtaining autografts)
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)

HEAD**REPAIR REVISION, AND/OR RECONSTRUCTION (HEAD)**

CPT Code	Description
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21198	Osteotomy, mandible, segmental;
21199	Osteotomy, mandible, segmental; with genioglossus advancement
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21215	Graft, bone; mandible (includes obtaining graft)
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)
21242	Arthroplasty, temporomandibular joint, with allograft
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro -ophthalmia)
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
21261	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra - and extracranial approach
21263	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra - and extracranial approach
21270	Malar augmentation, prosthetic material
21275	Secondary revision of orbitocraniofacial reconstruction
21280	Medial canthopexy (separate procedure)
21282	Lateral canthopexy
21295	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach
21296	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); intraoral approach

INNER EAR

INNER EAR

EXCISION (INNER EAR)

CPT Code	Description
69905	Labyrinthectomy; transcanal
69910	Labyrinthectomy; with mastoidectomy
69915	Vestibular nerve section, translabyrinthine approach

INCISION AND/OR DESTRUCTION (INNER EAR)

CPT Code	Description
69801	Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drug(single or multiple perfusions); transcanal
69802	Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drug(single or multiple perfusions); with mastoidectomy
69805	Endolymphatic sac operation; without shunt
69806	Endolymphatic sac operation; with shunt
69820	Fenestration semicircular canal
69840	Revision fenestration operation

INTRODUCTION (INNER EAR)

CPT Code	Description
69930	Cochlear device implantation, with or without mastoidectomy

OTHER (INNER EAR)

CPT Code	Description
69949	Unlisted procedure, inner ear

LARYNX

DESTRUCTION (LARYNX)

CPT Code	Description
31595	Section recurrent laryngeal nerve, therapeutic (separate procedure), unilateral

ENDOSCOPY (LARYNX)

CPT Code	Description
31505	Laryngoscopy, indirect; diagnostic (separate procedure)
31510	Laryngoscopy, indirect; with biopsy
31511	Laryngoscopy, indirect; with removal of foreign body
31512	Laryngoscopy, indirect; with removal of lesion
31513	Laryngoscopy, indirect; with vocal cord injection
31515	Laryngoscopy direct, with or without tracheoscopy; for aspiration

LARYNX

ENDOSCOPY (LARYNX)

CPT Code	Description
31520	Laryngoscopy direct, with or without tracheoscopy; diagnostic, newborn
31525	Laryngoscopy direct, with or without tracheoscopy; diagnostic, except newborn
31526	Laryngoscopy direct, with or without tracheoscopy; diagnostic, with operating microscope
31527	Laryngoscopy direct, with or without tracheoscopy; with insertion of obturator
31528	Laryngoscopy direct, with or without tracheoscopy; with dilation, initial
31529	Laryngoscopy direct, with or without tracheoscopy; with dilation, subsequent
31530	Laryngoscopy, direct, operative, with foreign body removal;
31531	Laryngoscopy, direct, operative, with foreign body removal; with operating microscope
31535	Laryngoscopy, direct, operative, with biopsy;
31536	Laryngoscopy, direct, operative, with biopsy; with operating microscope
31540	Laryngoscopy, direct, operative, with excision of tumor and /or stripping of vocal cords or epiglottis;
31541	Laryngoscopy, direct, operative, with excision of tumor and /or stripping of vocal cords or epiglottis; with operating microscope
31560	Laryngoscopy, direct, operative, with arytenoidectomy;
31561	Laryngoscopy, direct, operative, with arytenoidectomy; with operating microscope
31570	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic;
31571	Laryngoscopy, direct, with injection into vocal cord (s), therapeutic; with operating microscope
31575	Laryngoscopy, flexible fiberoptic; diagnostic
31576	Laryngoscopy, flexible fiberoptic; with biopsy
31577	Laryngoscopy, flexible fiberoptic; with removal of foreign body
31578	Laryngoscopy, flexible fiberoptic; with removal of lesion
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy

EXCISION (LARYNX)

CPT Code	Description
31300	Laryngotomy (thyrotomy, laryngofissure); with removal of tumor or laryngocele, cordectomy
31320	Laryngotomy (thyrotomy, laryngofissure); diagnostic
31360	Laryngectomy; total, without radical neck dissection
31365	Laryngectomy; total, with radical neck dissection
31367	Laryngectomy; subtotal supraglottic, without radical neck dissection
31368	Laryngectomy; subtotal supraglottic, with radical neck dissection
31370	Partial laryngectomy (hemilaryngectomy); horizontal
31375	Partial laryngectomy (hemilaryngectomy); laterovertical
31380	Partial laryngectomy (hemilaryngectomy); anterovertical
31382	Partial laryngectomy (hemilaryngectomy); antero-latero-vertical
31390	Pharyngolaryngectomy, with radical neck dissection; without reconstruction
31395	Pharyngolaryngectomy, with radical neck dissection; with reconstruction
31400	Arytenoidectomy or arytenoidopexy, external approach
31420	Epiglottidectomy

LARYNX

INTRODUCTION (LARYNX)

CPT Code	Description
31500	Intubation, endotracheal, emergency procedure
31502	Tracheotomy tube change prior to establishment of fistula tract

OTHER (LARYNX)

CPT Code	Description
31599	Unlisted procedure, larynx

REPAIR (LARYNX)

CPT Code	Description
31580	Laryngoplasty; for laryngeal web, two stage, with keel insertion and removal
31582	Laryngoplasty; for laryngeal stenosis, with graft or core mold, including tracheotomy
31584	Laryngoplasty; with open reduction of fracture
31585	Treatment of closed laryngeal fracture; without manipulation
31586	Treatment of closed laryngeal fracture; with closed manipulative reduction
31587	Laryngoplasty, cricoid split
31588	Laryngoplasty, not otherwise specified(eg, for burns, reconstruction after partial laryngectomy)
31590	Laryngeal reinnervation by neuromuscular pedicle

LIPS

EXCISION (LIPS)

CPT Code	Description
40490	Biopsy of lip
40500	Vermilionectomy (lip shave), with mucosal advancement
40510	Excision of lip; transverse wedge excision with primary closure
40520	Excision of lip; V-excision with primary direct linear closure
40525	Excision of lip; full thickness, reconstruction with local flap (eg, Estlander or fan)
40527	Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)
40530	Resection of lip, more than one-fourth, without reconstruction

OTHER (LIPS)

CPT Code	Description
40799	Unlisted procedure, lips

REPAIR (LIPS)

CPT Code	Description
40650	Repair lip, full thickness; vermilion only

LIPS

REPAIR (LIPS)

CPT Code	Description
40652	Repair lip, full thickness; up to half vertical height
40654	Repair lip, full thickness; over one-half vertical height, or complex
40700	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral
40701	Plastic repair of cleft lip/nasal deformity; primary bilateral, one stage procedure
40702	Plastic repair of cleft lip/nasal deformity; primary bilateral, one of two stages
40720	Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure
40761	Plastic repair of cleft lip /nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle

LYMPH NODES AND LYMPHATIC CHANNELS

EXCISION (LYMPH NODES)

CPT Code	Description
38500	Biopsy or excision of lymph node(s); open, superficial
38505	Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)
38510	Biopsy or excision of lymph node(s); open, deep cervical node(s)
38520	Biopsy or excision of lymph node (s); open, deep cervical node(s) with excision scalene fat pad
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)
38530	Biopsy or excision of lymph node(s); open, internal mammary node(s)
38542	Dissection, deep jugular node(s)
38550	Excision of cystic hygroma, axillary or cervical; without deep neurovascular dissection
38555	Excision of cystic hygroma, axillary or cervical; with deep neurovascular dissection

INCISION (LYMPH NODES)

CPT Code	Description
38300	Drainage of lymph node abscess or lymphadenitis; simple
38305	Drainage of lymph node abscess or lymphadenitis; extensive
38308	Lymphangiectomy or other operations on lymphatic channels
38380	Suture and/or ligation of thoracic duct; cervical approach
38381	Suture and/or ligation of thoracic duct; thoracic approach
38382	Suture and/or ligation of thoracic duct; abdominal approach

INTRODUCTION (LYMPH NODES)

CPT Code	Description
38790	Injection procedure; lymphangiography
38792	Injection procedure; for identification of sentinel node
38794	Cannulation, thoracic duct

LYMPH NODES AND LYMPHATIC CHANNELS

LAPAROSCOPY (LYMPH NODES)

CPT Code	Description
38570	Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple
38571	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy
38572	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri -aortic lymph node sampling (biopsy), single or multiple
38589	Unlisted laparoscopy procedure, lymphatic system

LIMITED LYMPHADENECTOMY FOR STAGING

CPT Code	Description
38562	Limited lymphadenectomy for staging (separate procedure); pelvic and para-aortic
38564	Limited lymphadenectomy for staging (separate procedure); retroperitoneal (aortic and/or splenic)

OTHER (LYMPH NODES)

CPT Code	Description
38999	Unlisted procedure, hemic or lymphatic system

RADICAL LYMPHADENECTOMY

CPT Code	Description
38700	Suprahyoid lymphadenectomy
38720	Cervical lymphadenectomy (complete)
38724	Cervical lymphadenectomy (modified radical neck dissection)
38740	A xillary lymphadenectomy; superficial
38745	A xillary lymphadenectomy; complete
38746	Thoracic lymphadenectomy, regional, including mediastinal and peritracheal nodes (List separately in addition to code for primary procedure)
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)
38760	Inguinofemoral lymphadenectomy, superficial, including Cloquets node (separate procedure)
38765	Inguinofemoral lymphadenectomy, superficial, in continuity with pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedurè)
38770	Pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)
38780	Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes(separate procedurè)

MIDDLE EAR

EXCISION (MIDDLE EAR)

CPT Code	Description
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MIDDLE EAR

EXCISION (MIDDLE EAR)

CPT Code	Description
69501	Transmastoid antrotomy (simple mastoidectomy)
69502	Mastoidectomy; complete
69505	Mastoidectomy; modified radical
69511	Mastoidectomy; radical
69530	Petrous apicectomy including radical mastoidectomy
69535	Resection temporal bone, external approach
69540	Excision aural polyp
69550	Excision aural glomus tumor; transcanal
69552	Excision aural glomus tumor; transmastoid
69554	Excision aural glomus tumor; extended (extratemporal)

INCISION (MIDDLE EAR)

CPT Code	Description
69420	Myringotomy including aspiration and/or eustachian tube inflation
69421	Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia
69424	Ventilating tube removal requiring general anesthesia
69433	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia
69440	Middle ear exploration through postauricular or ear canal incision
69450	Tympanolysis, transcanal

OTHER (MIDDLE EAR)

CPT Code	Description
69700	Closure postauricular fistula, mastoid (separate procedure)
69710	Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone
69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69715	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69718	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy
69720	Decompression facial nerve, intratemporal; lateral to geniculate ganglion
69725	Decompression facial nerve, intratemporal; including medial to geniculate ganglion
69740	Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion

MIDDLE EAR

OTHER (MIDDLE EAR)

CPT Code	Description
69745	Suture facial nerve, intratemporal, with or without graft or decompression; including medial to geniculate ganglion
69799	Unlisted procedure, middle ear

REPAIR (MIDDLE EAR)

CPT Code	Description
69601	Revision mastoidectomy; resulting in complete mastoidectomy
69602	Revision mastoidectomy; resulting in modified radical mastoidectomy
69603	Revision mastoidectomy; resulting in radical mastoidectomy
69604	Revision mastoidectomy; resulting in tympanoplasty
69605	Revision mastoidectomy; with apicectomy
69610	Tympanic membrane repair, with or without site preparation or perforation for closure, with or without patch
69620	Myringoplasty (surgery confined to drumhead and donor area)
69631	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction
69632	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg, postfenestration)
69633	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis(PORP), total ossicular rep
69635	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction
69636	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction
69637	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction and synthetic prosthesis(eg, partial ossicular replacement prosthesis(PORP), tota
69641	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction
69643	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction
69644	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction
69645	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction
69646	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction
69650	Stapes mobilization
69660	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material;
69661	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material; with footplate drill out

MIDDLE EAR

REPAIR (MIDDLE EAR)

CPT Code	Description
69662	Revision of stapedectomy or stapedotomy
69666	Repair oval window fistula
69667	Repair round window fistula
69670	Mastoid obliteration (separate procedure)
69676	Tympanic neurectomy

MUSCULOSKELETAL

GRAFTS (OR IMPLANTS)

CPT Code	Description
20910	Cartilage graft; costochondral
20912	Cartilage graft; nasal septum

NECK

EXCISION (NECK)

CPT Code	Description
21550	Biopsy, soft tissue of neck or thorax
21555	Excision tumor, soft tissue of neck or thorax; subcutaneous
21556	Excision tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular
21557	Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or thorax
21600	Excision of rib, partial
21610	Costotransversectomy (separate procedure)
21615	Excision first and/or cervical rib;
21616	Excision first and/or cervical rib; with sympathectomy
21620	Ostectomy of sternum, partial
21627	Sternal debridement
21630	Radical resection of sternum;
21632	Radical resection of sternum; with mediastinal lymphadenectomy

FRACTURE AND/OR DISLOCATION (NECK)

CPT Code	Description
21800	Closed treatment of rib fracture, uncomplicated, each
21805	Open treatment of rib fracture without fixation, each
21810	Treatment of rib fracture requiring external fixation (flail chest)
21820	Closed treatment of sternum fracture
21825	Open treatment of sternum fracture with or without skeletal fixation

NECK

INCISION (NECK)

CPT Code	Description
21501	Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax;
21502	Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax; with partial rib ostectomy
21510	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax

OTHER (NECK)

CPT Code	Description
21899	Unlisted procedure, neck or thorax

REPAIR, REVISION AND/OR RECONSTRUCTION (NECK)

CPT Code	Description
21700	Division of scalenus anticus; without resection of cervical rib
21705	Division of scalenus anticus; with resection of cervical rib
21720	Division of sternocleidomastoid for torticollis, open operation; without cast application
21725	Division of sternocleidomastoid for torticollis, open operation; with cast application
21740	Reconstructive repair of pectus excavatum or carinatum; open
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy
21750	Closure of median sternotomy separation with or without debridement (separate procedure)

NOSE

DESTRUCTION (NOSE)

CPT Code	Description
30801	Cautery and/or ablation, mucosa of turbinates, unilateral or bilateral, any method, (separate procedure); superficial
30802	Cautery and/or ablation, mucosa of turbinates, unilateral or bilateral, any method, (separate procedure); intramural

EXCISION (NOSE)

CPT Code	Description
30100	Biopsy, intranasal
30110	Excision, nasal polyp(s), simple
30115	Excision, nasal polyp(s), extensive
30117	Excision or destruction (eg, laser), intranasal lesion; internal approach
30118	Excision or destruction (eg, laser), intranasal lesion; external approach (lateral rhinotomy)
30120	Excision or surgical planing of skin of nose for rhinophyma

NOSE

EXCISION (NOSE)

CPT Code	Description
30124	Excision dermoid cyst, nose; simple, skin, subcutaneous
30125	Excision dermoid cyst, nose; complex, under bone or cartilage
30130	Excision turbinate, partial or complete, any method
30140	Submucous resection turbinate, partial or complete, any method
30150	Rhinectomy; partial
30160	Rhinectomy; total

INCISION (NOSE)

CPT Code	Description
30000	Drainage abscess or hematoma, nasal, internal approach
30020	Drainage abscess or hematoma, nasal septum

INTRODUCTION (NOSE)

CPT Code	Description
30200	Injection into turbinate(s), therapeutic
30210	Displacement therapy (Proetz type)
30220	Insertion, nasal septal prosthesis (button)

OTHER (NOSE)

CPT Code	Description
30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method
30903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method
30905	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial
30906	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent
30915	Ligation arteries; ethmoidal
30920	Ligation arteries; internal maxillary artery, transantral
30930	Fracture nasal turbinate(s), therapeutic
30999	Unlisted procedure, nose

REMOVAL FOREIGN BODY (NOSE)

CPT Code	Description
30300	Removal foreign body, intranasal; office type procedure
30310	Removal foreign body, intranasal; requiring general anesthesia
30320	Removal foreign body, intranasal; by lateral rhinotomy

NOSE

REPAIR (NOSE)

CPT Code	Description
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30540	Repair choanal atresia; intranasal
30545	Repair choanal atresia; transpalatine
30560	Lysis intranasal synechia
30580	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)
30600	Repair fistula; oronasal
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)
30630	Repair nasal septal perforations

OCULARADNEXA

EYELIDS - EXCISION

CPT Code	Description
67800	Excision of chalazion; single
67801	Excision of chalazion; multiple, same lid
67805	Excision of chalazion; multiple, different lids
67808	Excision of chalazion; under general anesthesia and/or requiring hospitalization, single or multiple
67810	Biopsy of eyelid
67820	Correction of trichiasis; epilation, by forceps only
67825	Correction of trichiasis; epilation by other than forceps (eg, by electrocautery, cryotherapy, laser surgery)
67830	Correction of trichiasis; incision of lid margin
67835	Correction of trichiasis; incision of lid margin, with free mucous membrane graft
67840	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure
67850	Destruction of lesion of lid margin (up to 1 cm)

EYELIDS - INCISION

CPT Code	Description
67700	Blepharotomy, drainage of abscess, eyelid

OCULARADNEXA

EYELIDS - INCISION

CPT Code	Description
67710	Severing of tarsorrhaphy
67715	Canthotomy (separate procedure)

EYELIDS - OTHER

CPT Code	Description
67999	Unlisted procedure, eyelids

EYELIDS - RECONSTRUCTION

CPT Code	Description
67930	Suture of recent wound, eyelid, involving lid margin, tarsus, and /or palpebral conjunctiva direct closure; partial thickness
67935	Suture of recent wound, eyelid, involving lid margin, tarsus, and /or palpebral conjunctiva direct closure; full thickness
67938	Removal of embedded foreign body, eyelid
67950	Canthoplasty (reconstruction of canthus)
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
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 onefourth of lid margin
67971	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; up to two -thirds of eyelid, one stage or first stage
67973	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, lower, one stage or first stage
67974	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, upper, one stage or first stage
67975	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; second stage

EYELIDS - REPAIR

CPT Code	Description
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material
67902	Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling(includes obtaining fascia)

OCULARADNEXA

EYELIDS - REPAIR

CPT Code	Description
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle -levator resection(eg, Fasanella-Servat type)
67909	Reduction of overcorrection of ptosis
67911	Correction of lid retraction
67914	Repair of ectropion; suture
67915	Repair of ectropion; thermocauterization
67916	Repair of ectropion; blepharoplasty, excision tarsal wedge
67917	Repair of ectropion; blepharoplasty, extensive (eg, Kuhnt-Szymanowski or tarsal strip operations)
67921	Repair of entropion; suture
67922	Repair of entropion; thermocauterization
67923	Repair of entropion; blepharoplasty, excision tarsal wedge
67924	Repair of entropion; blepharoplasty, extensive (eg, Wheeler operation)

EYELIDS - TARSORRHAPHY

CPT Code	Description
67875	Temporary closure of eyelids by suture (eg, Frost suture)
67880	Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy;
67882	Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy; with transposition of tarsal plate

ORBIT - EXPLORATION, EXCISION, DECOMPRESSION

CPT Code	Description
67400	Orbitotomy without bone flap (frontal or transconjunctival approach); for exploration, with or without biopsy
67405	Orbitotomy without bone flap (frontal or transconjunctival approach); with drainage only
67412	Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of lesion
67413	Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of foreign body
67414	Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of bone for decompression
67415	Fine needle aspiration of orbital contents
67420	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of lesion
67430	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of foreign body
67440	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with drainage
67445	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of bone for decompression
67450	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); for exploration, with or without biopsy

OCULARADNEXA

ORBIT - OTHER

CPT Code	Description
67500	Retrolbulbar injection; medication (separate procedure, does not include supply of medication)
67505	Retrolbulbar injection; alcohol
67515	Injection of medication or other substance into Tenon's capsule
67550	Orbital implant (implant outside muscle cone); insertion
67560	Orbital implant (implant outside muscle cone); removal or revision
67570	Optic nerve decompression (eg, incision or fenestration of optic nerve sheath)
67599	Unlisted procedure, orbit

PALATE AND UVULA

EXCISION, DESTRUCTION (PALATE)

CPT Code	Description
42100	Biopsy of palate, uvula
42104	Excision, lesion of palate, uvula; without closure
42106	Excision, lesion of palate, uvula; with simple primary closure
42107	Excision, lesion of palate, uvula; with local flap closure
42120	Resection of palate or extensive resection of lesion
42140	Uvulectomy, excision of uvula
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)
42160	Destruction of lesion, palate or uvula (thermal, cryo or chemical)

INCISION (PALATE)

CPT Code	Description
42000	Drainage of abscess of palate, uvula

OTHER (PALATE)

CPT Code	Description
42299	Unlisted procedure, palate, uvula

REPAIR (PALATE)

CPT Code	Description
42180	Repair, laceration of palate; up to 2 cm
42182	Repair, laceration of palate; over 2 cm or complex
42200	Palatoplasty for cleft palate, soft and/or hard palate only
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only
42210	Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)
42215	Palatoplasty for cleft palate; major revision

PALATE AND UVULA

REPAIR (PALATE)

CPT Code	Description
42220	Palatoplasty for cleft palate; secondary lengthening procedure
42225	Palatoplasty for cleft palate; attachment pharyngeal flap
42226	Lengthening of palate, and pharyngeal flap
42227	Lengthening of palate, with island flap
42235	Repair of anterior palate, including vomer flap
42260	Repair of nasolabial fistula
42280	Maxillary impression for palatal prosthesis
42281	Insertion of pin-retained palatal prosthesis

PARATHYROID, THYMUS, ADRENAL GLANDS, AND CAROTII

EXCISION (PARATHYROID)

CPT Code	Description
60500	Parathyroidectomy or exploration of parathyroid(s);
60502	Parathyroidectomy or exploration of parathyroid(s); re-exploration
60505	Parathyroidectomy or exploration of parathyroid (s); with mediastinal exploration, sternal split or transthoracic approach
60512	Parathyroid autotransplantation (List separately in addition to code for primary procedure)
60520	Thymectomy, partial or total; transcervical approach (separate procedure)
60521	Thymectomy, partial or total; sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure)
60522	Thymectomy, partial or total; sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)
60540	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure);
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
60600	Excision of carotid body tumor; without excision of carotid artery
60605	Excision of carotid body tumor; with excision of carotid artery

LAPAROSCOPY (PARATHYROID)

CPT Code	Description
60650	Laparoscopy, surgical, with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal
60659	Unlisted laparoscopy procedure, endocrine system

OTHER (PARATHYROID)

CPT Code	Description
60699	Unlisted procedure, endocrine system

PHARYNX, ADENOIDS, AND TONSILS

EXCISION, DESTRUCTION (PHARYNX)

CPT Code	Description
42800	Biopsy; oropharynx
42802	Biopsy; hypopharynx
42804	Biopsy; nasopharynx, visible lesion, simple
42806	Biopsy; nasopharynx, survey for unknown primary lesion
42808	Excision or destruction of lesion of pharynx, any method
42809	Removal of foreign body from pharynx
42810	Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues
42815	Excision branchial cleft cyst, vestige, or fistula, extending beneath subcutaneous tissues and/or into pharynx
42820	Tonsillectomy and adenoidectomy; under age 12
42821	Tonsillectomy and adenoidectomy; age 12 or over
42825	Tonsillectomy, primary or secondary; under age 12
42826	Tonsillectomy, primary or secondary; age 12 or over
42830	Adenoidectomy, primary; under age 12
42831	Adenoidectomy, primary; age 12 or over
42835	Adenoidectomy, secondary; under age 12
42836	Adenoidectomy, secondary; age 12 or over
42842	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure
42844	Radical resection of tonsil, tonsillar pillars, and /or retromolar trigone; closure with local flap (eg, tongue, buccal)
42845	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap
42860	Excision of tonsil tags
42870	Excision or destruction lingual tonsil, any method (separate procedure)
42890	Limited pharyngectomy
42892	Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and posterior pharyngeal walls
42894	Resection of pharyngeal wall requiring closure with myocutaneous flap

INCISION (PHARYNX)

CPT Code	Description
42700	Incision and drainage abscess; peritonsillar
42720	Incision and drainage abscess; retropharyngeal or parapharyngeal, intraoral approach
42725	Incision and drainage abscess; retropharyngeal or parapharyngeal, external approach

OTHER (PHARYNX)

CPT Code	Description
42955	Pharyngostomy (fistulization of pharynx, external for feeding)
42960	Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy); simple
42961	Control oropharyngeal hemorrhage, primary or secondary(eg, post-tonsillectomy); complicated, requiring hospitalization
42962	Control oropharyngeal hemorrhage, primary or secondary(eg, post-tonsillectomy); with secondary surgical intervention

PHARYNX, ADENOIDS, AND TONSILS

OTHER (PHARYNX)

CPT Code	Description
42970	Control of nasopharyngeal hemorrhage, primary or secondary(eg, postadenoidectomy); simple, with posterior nasal packs, with or without anterior packs and /or cautery
42971	Control of nasopharyngeal hemorrhage, primary or secondary(eg, postadenoidectomy); complicated, requiring hospitalization
42972	Control of nasopharyngeal hemorrhage, primary or secondary(eg, postadenoidectomy); with secondary surgical intervention
42999	Unlisted procedure, pharynx, adenoids, or tonsils

REPAIR (PHARYNX)

CPT Code	Description
42900	Suture pharynx for wound or injury
42950	Pharyngoplasty (plastic or reconstructive operation on pharynx)
42953	Pharyngoesophageal repair

SALIVARY GLAND AND DUCTS

EXCISION (SALIVARY)

CPT Code	Description
42400	Biopsy of salivary gland; needle
42405	Biopsy of salivary gland; incisional
42408	Excision of sublingual salivary cyst (ranula)
42409	Marsupialization of sublingual salivary cyst (ranula)
42410	Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection
42415	Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve
42425	Excision of parotid tumor or parotid gland; total, en bloc removal with sacrifice of facial nerve
42426	Excision of parotid tumor or parotid gland; total, with unilateral radical neck dissection
42440	Excision of submandibular (submaxillary) gland
42450	Excision of sublingual gland

INCISION (SALIVARY)

CPT Code	Description
42300	Drainage of abscess; parotid, simple
42305	Drainage of abscess; parotid, complicated
42310	Drainage of abscess; submaxillary or sublingual, intraoral
42320	Drainage of abscess; submaxillary, external
42325	Fistulization of sublingual salivary cyst (ranula);
42326	Fistulization of sublingual salivary cyst (ranula); with prosthesis
42330	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral

SALIVARY GLAND AND DUCTS

INCISION (SALIVARY)

CPT Code	Description
42335	Sialolithotomy; submandibular (submaxillary), complicated, intraoral
42340	Sialolithotomy; parotid, extraoral or complicated intraoral

OTHER (SALIVARY)

CPT Code	Description
42550	Injection procedure for sialography
42600	Closure salivary fistula
42650	Dilation salivary duct
42660	Dilation and catheterization of salivary duct, with or without injection
42665	Ligation salivary duct, intraoral
42699	Unlisted procedure, salivary glands or ducts

REPAIR (SALIVARY)

CPT Code	Description
42500	Plastic repair of salivary duct, sialodochoplasty; primary or simple
42505	Plastic repair of salivary duct, sialodochoplasty; secondary or complicated
42507	Parotid duct diversion, bilateral (Wilke type procedure);
42508	Parotid duct diversion, bilateral (Wilke type procedure); with excision of one submandibular gland
42509	Parotid duct diversion, bilateral (Wilke type procedure); with excision of both submandibular glands
42510	Parotid duct diversion, bilateral (Wilke type procedure); with ligation of both submandibular (Wharton's) ducts

SKIN, SUBCUTANEOUS AND ACCESSORY STRUCTURES

ADJACENT TISSUE TRANSFER OR REARRANGEMENT

CPT Code	Description
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
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
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14061	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm
14300	Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area

SKIN, SUBCUTANEOUS AND ACCESSORY STRUCTURES

EXCISION BENIGN LESIONS

CPT Code	Description
11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
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
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
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
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
11426	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm
11440	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
11446	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm

EXCISION MALIGNANT LESIONS

CPT Code	Description
11620	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11621	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm
11622	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm
11623	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm
11624	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm
11626	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm
11640	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less
11641	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm
11642	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm
11643	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm
11644	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm
11646	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm

SKIN, SUBCUTANEOUS AND ACCESSORY STRUCTURES

FLAPS (SKIN AND/OR DEEP TISSUE)

CPT Code	Description
15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
15576	Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral
15620	Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet
15630	Delay of flap or sectioning of flap (division and inset); at eyelids, nose, ears, or lips
15732	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)

FREE SKIN GRAFTS

CPT Code	Description
15120	Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and /or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)
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
15350	Application of allograft, skin; 100 sq cm or less

OTHER (SKIN)

CPT Code	Description
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15820	Blepharoplasty, lower eyelid;
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid;
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15840	Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)
15841	Graft for facial nerve paralysis; free muscle graft (including obtaining graft)
15842	Graft for facial nerve paralysis; free muscle flap by microsurgical technique
15845	Graft for facial nerve paralysis; regional muscle transfer
15876	Suction assisted lipectomy; head and neck

OTHER FLAPS AND GRAFTS

CPT Code	Description
15756	Free muscle or myocutaneous flap with microvascular anastomosis

SKIN, SUBCUTANEOUS AND ACCESSORY STRUCTURES

OTHER FLAPS AND GRAFTS

CPT Code	Description
15757	Free skin flap with microvascular anastomosis
15758	Free fascial flap with microvascular anastomosis
15760	Graft; composite (eg, full thickness of external ear or nasal ala), including primary closure, donor area
15770	Graft; derma-fat-fascia

REPAIR, COMPLEX

CPT Code	Description
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm
13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm
13122	Repair, complex, scalp, arms, and /or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and /or feet; 1.1 cm to 2.5 cm
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and /or feet; 2.6 cm to 7.5 cm
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)
13150	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less
13151	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm
13152	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm
13153	Repair, complex, eyelids, nose, ears and /or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)

REPAIR, INTERMEDIATE

CPT Code	Description
12031	Layer closure of wounds of scalp, axillae, trunk and /or extremities (excluding hands and feet); 2.5 cm or less
12032	Layer closure of wounds of scalp, axillae, trunk and /or extremities (excluding hands and feet); 2.6 cm to 7.5 cm
12034	Layer closure of wounds of scalp, axillae, trunk and /or extremities (excluding hands and feet); 7.6 cm to 12.5 cm
12035	Layer closure of wounds of scalp, axillae, trunk and /or extremities (excluding hands and feet); 12.6 cm to 20.0 cm
12036	Layer closure of wounds of scalp, axillae, trunk and /or extremities (excluding hands and feet); 20.1 cm to 30.0 cm
12037	Layer closure of wounds of scalp, axillae, trunk and /or extremities (excluding hands and feet); over 30.0 cm
12041	Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less
12042	Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm
12044	Layer closure of wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm
12045	Layer closure of wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm
12046	Layer closure of wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm

SKIN, SUBCUTANEOUS AND ACCESSORY STURCTURES

REPAIR, INTERMEDIATE

CPT Code	Description
12047	Layer closure of wounds of neck, hands, feet and/or external genitalia; over 30.0 cm
12051	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12052	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm
12053	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm
12054	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm
12055	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm
12056	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm
12057	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm

REPAIR, SIMPLE

CPT Code	Description
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
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
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
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
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
12007	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and /or extremities (including hands and feet); over 30.0 cm
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm
12014	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm
12015	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm
12016	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm
12017	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm
12018	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm

SKULL, MENINGES, AND BRAIN

CRANIECTOMY OR CRANIOTOMY

CPT Code	Description
61526	Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor;

SURGERY OF SKULL BASE

APPROACH PROCEDURES

CPT Code	Description
61580	Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration
61581	Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, orbital exenteration, ethmoidectomy, sphenoidectomy and/or maxillectomy
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
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
61584	Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe (s); without orbital exenteration
61585	Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe (s); with orbital exenteration
61586	Bicoronal, transzygomatic and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft
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
61591	Infratemporal postauricular 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
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
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
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
61597	Transcondylar (far lateral) approach to posterior cranial fossa, jugular foramen or midline skull base, including occipital condylectomy, mastoidectomy, resection of C 1-C3 vertebral body(s), decompression of vertebral artery, with or without mobilization
61598	Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus

DEFINITIVE PROCEDURES

CPT Code	Description
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SURGERY OF SKULL BASE

DEFINITIVE PROCEDURES

CPT Code	Description
61600	Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; extradural
61601	Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; intradural, including dural repair, with or without graft
61605	Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; extradural
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
61607	Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; extradural
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
61609	Transection or ligation, carotid artery in cavernous sinus; without repair (List separately in addition to code for primary procedure)
61610	Transection or ligation, carotid artery in cavernous sinus; with repair by anastomosis or graft (List separately in addition to code for primary procedure)
61611	Transection or ligation, carotid artery in petrous canal; without repair (List separately in addition to code for primary procedure)
61612	Transection or ligation, carotid artery in petrous canal; with repair by anastomosis or graft (List separately in addition to code for primary procedure)
61613	Obliteration of carotid aneurysm, arteriovenous malformation, or carotid-cavernous fistula by dissection within cavernous sinus
61615	Resection or excision of neoplastic, vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or C 1-C3 vertebral bodies; extradural
61616	Resection or excision of neoplastic, vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or C 1-C3 vertebral bodies; intradural, including dural repair, with or without graft

TEMPORAL BONE

OTHER (TEMPORAL BONE)

CPT Code	Description
69979	Unlisted procedure, temporal bone, middle fossa approach

TEMPORAL BONE, MIDDLE FOSSA APPROACH

CPT Code	Description
69950	Vestibular nerve section, transcranial approach
69955	Total facial nerve decompression and/or repair (may include graft)
69960	Decompression internal auditory canal
69970	Removal of tumor, temporal bone

THYROID GLAND

THYROID GLAND

EXCISION (THYROID)

CPT Code	Description
60001	Aspiration and/or injection, thyroid cyst
60100	Biopsy thyroid, percutaneous core needle
60200	Excision of cyst or adenoma of thyroid, or transection of isthmus
60210	Partial thyroid lobectomy, unilateral; with or without isthmusectomy
60212	Partial thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy
60225	Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy
60240	Thyroidectomy, total or complete
60252	Thyroidectomy, total or subtotal for malignancy; with limited neck dissection
60254	Thyroidectomy, total or subtotal for malignancy; with radical neck dissection
60260	Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid
60270	Thyroidectomy, including substernal thyroid; sternal split or transthoracic approach
60271	Thyroidectomy, including substernal thyroid; cervical approach
60280	Excision of thyroglossal duct cyst or sinus;
60281	Excision of thyroglossal duct cyst or sinus; recurrent

INCISION (THYROID)

CPT Code	Description
60000	Incision and drainage of thyroglossal duct cyst, infected

TONGUE AND FLOOR OF MOUTH

EXCISION (TONGUE)

CPT Code	Description
41100	Biopsy of tongue; anterior two-thirds
41105	Biopsy of tongue; posterior one-third
41108	Biopsy of floor of mouth
41110	Excision of lesion of tongue without closure
41112	Excision of lesion of tongue with closure; anterior two-thirds
41113	Excision of lesion of tongue with closure; posterior one-third
41114	Excision of lesion of tongue with closure; with local tongue flap
41115	Excision of lingual frenum (frenectomy)
41116	Excision, lesion of floor of mouth
41120	Glossectomy; less than one-half tongue
41130	Glossectomy; hemiglossectomy
41135	Glossectomy; partial, with unilateral radical neck dissection
41140	Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection

TONGUE AND FLOOR OF MOUTH

EXCISION (TONGUE)

CPT Code	Description
41145	Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection
41150	Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection
41153	Glossectomy; composite procedure with resection floor of mouth, with suprahyoid neck dissection
41155	Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)

INCISION (TONGUE)

CPT Code	Description
41000	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual
41005	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, superficial
41006	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, deep, supramylohyoid
41007	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submental space
41008	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space
41009	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; masticator space
41010	Incision of lingual frenum (frenotomy)
41015	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual
41016	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submental
41017	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submandibular
41018	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space

OTHER (TONGUE)

CPT Code	Description
41500	Fixation of tongue, mechanical, other than suture (eg, K-wire)
41510	Suture of tongue to lip for micrognathia (Douglas type procedure)
41520	Frenoplasty (surgical revision of frenum, eg, with Z-plasty)
41599	Unlisted procedure, tongue, floor of mouth

REPAIR (TONGUE)

CPT Code	Description
41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue

TONGUE AND FLOOR OF MOUTH

REPAIR (TONGUE)

CPT Code	Description
41251	Repair of laceration 2.5 cm or less; posterior one-third of tongue
41252	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex

TRACHEA AND BRONCHI

ENDOSCOPY (TRACHEA)

CPT Code	Description
31615	Tracheobronchoscopy through established tracheostomy incision
31622	Bronchoscopy (rigid or flexible); diagnostic, with or without cell washing (separate procedure)
31623	Bronchoscopy (rigid or flexible); with brushing or protected brushings
31624	Bronchoscopy (rigid or flexible); with bronchial alveolar lavage
31625	Bronchoscopy (rigid or flexible); with biopsy
31628	Bronchoscopy (rigid or flexible); with transbronchial lung biopsy, with or without fluoroscopic guidance
31629	Bronchoscopy (rigid or flexible); with transbronchial needle aspiration biopsy
31630	Bronchoscopy (rigid or flexible); with tracheal or bronchial dilation or closed reduction of fracture
31631	Bronchoscopy (rigid or flexible); with tracheal dilation and placement of tracheal stent
31635	Bronchoscopy (rigid or flexible); with removal of foreign body
31640	Bronchoscopy (rigid or flexible); with excision of tumor
31641	Bronchoscopy, (rigid or flexible); with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)
31643	Bronchoscopy, (rigid or flexible); with placement of catheter(s) for intracavitary radioelement application
31645	Bronchoscopy, (rigid or flexible); with therapeutic aspiration of tracheobronchial tree, initial (eg, drainage of lung abscess)
31646	Bronchoscopy, (rigid or flexible); with therapeutic aspiration of tracheobronchial tree, subsequent
31656	Bronchoscopy, (rigid or flexible); with injection of contrast material for segmental bronchography (fiberscope only)

INCISION (TRACHEA)

CPT Code	Description
31600	Tracheostomy, planned (separate procedure);
31601	Tracheostomy, planned (separate procedure); under two years
31603	Tracheostomy, emergency procedure; transtracheal
31605	Tracheostomy, emergency procedure; cricothyroid membrane
31610	Tracheostomy, fenestration procedure with skin flaps
31611	Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom -Singer prosthesis)
31612	Tracheal puncture, percutaneous with transtracheal aspiration and/or injection
31613	Tracheostoma revision; simple, without flap rotation

TRACHEA AND BRONCHI

INCISION (TRACHEA)

CPT Code	Description
31614	Tracheostoma revision; complex, with flap rotation

INTRODUCTION (TRACHEA)

CPT Code	Description
31700	Catheterization, transglottic (separate procedure)
31708	Instillation of contrast material for laryngography or bronchography, without catheterization
31710	Catheterization for bronchography, with or without instillation of contrast material
31715	Transtracheal injection for bronchography
31717	Catheterization with bronchial brush biopsy
31720	Catheter aspiration (separate procedure); nasotracheal
31725	Catheter aspiration (separate procedure); tracheobronchial with fiberscope, bedside
31730	Transtracheal (percutaneous) introduction of needle wire dilator/stent or indwelling tube for oxygen therapy

OTHER (TRACHEA)

CPT Code	Description
31899	Unlisted procedure, trachea, bronchi

REPAIR (TRACHEA)

CPT Code	Description
31750	Tracheoplasty; cervical
31755	Tracheoplasty; tracheopharyngeal fistulization, each stage
31760	Tracheoplasty; intrathoracic
31770	Bronchoplasty; graft repair
31775	Bronchoplasty; excision stenosis and anastomosis
31780	Excision tracheal stenosis and anastomosis; cervical
31781	Excision tracheal stenosis and anastomosis; cervicothoracic
31785	Excision of tracheal tumor or carcinoma; cervical
31786	Excision of tracheal tumor or carcinoma; thoracic
31800	Suture of tracheal wound or injury; cervical
31805	Suture of tracheal wound or injury; intrathoracic
31820	Surgical closure tracheostomy or fistula; without plastic repair
31825	Surgical closure tracheostomy or fistula; with plastic repair
31830	Revision of tracheostomy scar

VESTIBULE OF MOUTH

EXCISION, DESTRUCTION (VESTIBULE OF MOUTH)

CPT Code	Description
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VESTIBULE OF MOUTH

EXCISION, DESTRUCTION (VESTIBULE OF MOUTH)

CPT Code	Description
40808	Biopsy, vestibule of mouth
40810	Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair
40812	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair
40814	Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair
40816	Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle
40818	Excision of mucosa of vestibule of mouth as donor graft
40819	Excision of frenum, labial or buccal (frenulectomy, frenulectomy, frenectomy)
40820	Destruction of lesion or scar of vestibule of mouth by physical methods(eg, laser, thermal, cryo, chemical)

INCISION (VESTIBULE OF MOUTH)

CPT Code	Description
40800	Drainage of abscess, cyst, hematoma, vestibule of mouth; simple
40801	Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated
40804	Removal of embedded foreign body, vestibule of mouth; simple
40805	Removal of embedded foreign body, vestibule of mouth; complicated
40806	Incision of labial frenum (frenotomy)

OTHER (VESTIBULE OF MOUTH)

CPT Code	Description
40899	Unlisted procedure, vestibule of mouth

REPAIR (VESTIBULE OF MOUTH)

CPT Code	Description
40830	Closure of laceration, vestibule of mouth; 2.5 cm or less
40831	Closure of laceration, vestibule of mouth; over 2.5 cm or complex
40840	Vestibuloplasty; anterior
40842	Vestibuloplasty; posterior, unilateral
40843	Vestibuloplasty; posterior, bilateral
40844	Vestibuloplasty; entire arch
40845	Vestibuloplasty; complex (including ridge extension, muscle repositioning)