

ABDOMINAL

ANTIREFLUX PROCEDURE: OPEN

CPT Code	Description
39502	Repair, paraesophageal hiatus hernia, transabdominal, with or without fundoplasty, vagotomy, and/or pyloroplasty, except neonatal
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)

ANTIREFLUX PROCEDURE: SCOPE

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

ANY GASTROSTOMY/JEJUNOSTOMY: OPEN

CPT Code	Description
43830	Gastrostomy, open; without construction of gastric tube (eg, Stamm procedure) (separate procedure)
43831	Gastrostomy, open; neonatal, for feeding
43832	Gastrostomy, open; with construction of gastric tube (eg, Janeway procedure)

ANY GASTROSTOMY/JEJUNOSTOMY:SCOPE

CPT Code	Description
43246	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube
43750	Percutaneous placement of gastrostomy tube

APPENDECTOMY: OPEN

CPT Code	Description
44950	Appendectomy;
44955	Appendectomy; when done for indicated purpose at time of other major procedure(not as separate procedure) (List separately in addition to code for primary procedure)
44960	Appendectomy; for ruptured appendix with abscess or generalized peritonitis

APPENDECTOMY: SCOPE

CPT Code	Description
44970	Laparoscopy, surgical, appendectomy

ABDOMINAL

BOWEL RESECTION FOR CROHN'S DISEASE

CPT Code	Description
44160	Colectomy, partial, with removal of terminal ileum with ileocolostomy

CLOSURE/REVISION ANY OSTOMY

CPT Code	Description
44340	Revision of colostomy; simple (release of superficial scar) (separate procedure)
44345	Revision of colostomy; complicated (reconstruction in-depth) (separate procedure)
44346	Revision of colostomy; with repair of paracolostomy hernia (separate procedure)
44620	Closure of enterostomy, large or small intestine;
44625	Closure of enterostomy, large or small intestine; with resection and anastomosis other than colorectal

DIAGNOSTIC LAPAROSCOPY

CPT Code	Description
49320	Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

DUODENAL ATRESIA

CPT Code	Description
43810	Gastroduodenostomy

EXCISION NEUROBLASTOMA/ADRENAL/OTHER RETROPER

CPT Code	Description
49201	Tumors Excision or destruction, open, intra -abdominal or retroperitoneal tumors or cysts or endometriomas; extensive
50220	Tumors Nephrectomy, including partial ureterectomy, any open approach including rib resection;
60540	Tumors Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure);
60545	Tumors 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

EXCISION OF OMENTAL/MESENTERIC CYST

CPT Code	Description
44820	Excision of lesion of mesentery (separate procedure)
49200	Excision or destruction, open, intra -abdominal or retroperitoneal tumors or cysts or endometriomas;
49201	Excision or destruction, open, intra -abdominal or retroperitoneal tumors or cysts or endometriomas; extensive

ABDOMINAL

EXCISION SACROCOCCYGEAL TERATOMA

CPT Code	Description
49215	Neonate Excision of presacral or sacrococcygeal tumor

EXPLORATORY LAPAROTOMY WITH OR WITHOUT BIOPSY

CPT Code	Description
49000	Exploratory laparotomy, exploratory celiotomy with or without biopsy (s) (separate procedure)
49002	Reopening of recent laparotomy
49010	Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)
49200	Excision or destruction, open, intra -abdominal or retroperitoneal tumors or cysts or endometriomas;
49201	Excision or destruction, open, intra -abdominal or retroperitoneal tumors or cysts or endometriomas; extensive

GASTROSCHISIS (ANY SURGICAL REPAIR)

CPT Code	Description
49600	Neonate Repair of small omphalocele, with primary closure
49605	Neonate Repair of large omphalocele or gastroschisis; with or without prosthesis
49606	Neonate Repair of large omphalocele or gastroschisis; with removal of prosthesis, final reduction and closure, in operating room
49610	Neonate Repair of omphalocele (Gross type operation); first stage
49611	Neonate Repair of omphalocele (Gross type operation); second stage

INTESTINAL RESECTION (MECKEL'S, DUPLICATION, MECON)

CPT Code	Description
44110	Excision of one or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; single enterotomy
44111	Excision of one or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; multiple enterotomies
44120	Enterectomy, resection of small intestine; single resection and anastomosis
44121	Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)
44125	Enterectomy, resection of small intestine; with enterostomy
44800	Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct

INTESTINAL RESECTION/REPAIR OR OSTOMY FOR INFLAM

CPT Code	Description
44110	Excision of one or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; single enterotomy
44111	Excision of one or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; multiple enterotomies

ABDOMINAL

INTESTINAL RESECTION/REPAIR OR OSTOMY FOR INFLAM

CPT Code	Description
44120	Enterectomy, resection of small intestine; single resection and anastomosis
44121	Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)
44125	Enterectomy, resection of small intestine; with enterostomy

INTESTINAL RESECTION/REPAIR OR OSTOMY FOR NECROT

CPT Code	Description
44110	Neonate Excision of one or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; single enterotomy
44111	Neonate Excision of one or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; multiple enterotomies
44120	Neonate Enterectomy, resection of small intestine; single resection and anastomosis
44121	Neonate Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)
44125	Neonate Enterectomy, resection of small intestine; with enterostomy
44140	Neonate Colectomy, partial; with anastomosis

INTESTINAL RESECTION/REPAIR OR OSTOMY FOR TRAUMA

CPT Code	Description
44110	Excision of one or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; single enterotomy
44111	Excision of one or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; multiple enterotomies
44120	Enterectomy, resection of small intestine; single resection and anastomosis
44121	Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)
44125	Enterectomy, resection of small intestine; with enterostomy
44602	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; single perforation
44603	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; multiple perforations
44604	Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); without colostomy
44605	Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); with colostomy

LAPAROTOMY OR RESECTION FOR INTUSSUSCEPTION

CPT Code	Description
44050	Reduction of volvulus, intussusception, internal hernia, by laparotomy

ABDOMINAL

OMPHALOCELE (ANY SURGICAL REPAIR)

CPT Code		Description
49600	Neonate	Repair of small omphalocele, with primary closure
49605	Neonate	Repair of large omphalocele or gastroschisis; with or without prosthesis
49606	Neonate	Repair of large omphalocele or gastroschisis; with removal of prosthesis, final reduction and closure, in operating room
49610	Neonate	Repair of omphalocele (Gross type operation); first stage
49611	Neonate	Repair of omphalocele (Gross type operation); second stage

OPERATION FOR MALROTATION

CPT Code		Description
44050	Neonate	Reduction of volvulus, intussusception, internal hernia, by laparotomy
44055	Neonate	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (eg, Ladd procedure)

OSTOMY FOR ANORECTAL MALFORMATION

CPT Code		Description
44320	Neonate	Colostomy or skin level cecostomy; (separate procedure)

OSTOMY FOR HIRSCHSPRUNG'S

CPT Code		Description
44143	Neonate	Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)
44144	Neonate	Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula
44310	Neonate	Ileostomy or jejunostomy, non-tube (separate procedure)
44320	Neonate	Colostomy or skin level cecostomy; (separate procedure)
44322	Neonate	Colostomy or skin level cecostomy; with multiple biopsies (eg, for congenital megacolon) (separate procedure)

OSTOMY FOR OTHER

CPT Code		Description
44144		Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula

OTHER

CPT Code		Description
45100		Biopsy of anorectal wall, anal approach (eg, congenital megacolon)
49215		Excision of presacral or sacrococcygeal tumor

ABDOMINAL

PERINEAL PROCEDURE FOR IMPERFORATE ANUS

CPT Code		Description
46715	IPGS	Repair of low imperforate anus; with anoperineal fistula (cut-back procedure)
46716	IPGS	Repair of low imperforate anus; with transposition of anoperineal or anovestibular fistula
46730	IPGS	Repair of high imperforate anus without fistula; perineal or sacroperineal approach
46735	IPGS	Repair of high imperforate anus without fistula; combined transabdominal and sacroperineal approaches
46740	IPGS	Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach
46742	IPGS	Repair of high imperforate anus with rectourethral or rectovaginal fistula; combined transabdominal and sacroperineal approaches

PULL THROUGH FOR HIRSCHSPRUNG'S: OPEN

CPT Code		Description
45120	IPGS	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull-through procedure and anastomosis(eg, Swenson, Duhamel, or Soave type operation)
45121	IPGS	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with subtotal or total colectomy, with multiple biopsies

PULL THROUGH FOR HIRSCHSPRUNG'S: SCOPE

CPT Code		Description
45121	IPGS	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with subtotal or total colectomy, with multiple biopsies

PULL THROUGH FOR IBD OR POLYPOSIS: OPEN

CPT Code		Description
44152		Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, with or without loop ileostomy
44153		Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy
45112		Proctectomy, combined abdominoperineal, pull-through procedure(eg, colo-anal anastomosis)
45113		Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy
45114		Proctectomy, partial, with anastomosis; abdominal and transsacral approach

PULL THROUGH FOR IBD OR POLYPOSIS: SCOPE

CPT Code		Description
44153		Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy

ABDOMINAL

PYLOROMYOTOMY

CPT Code	Description
43520	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)

PYLOROPLASTY/GASTRIC RESECTION WITH OR WITHOUT

CPT Code	Description
43605	Biopsy of stomach; by laparotomy
43610	Excision, local; ulcer or benign tumor of stomach
43611	Excision, local; malignant tumor of stomach
43621	Gastrectomy, total; with Roux-en-Y reconstruction
43631	Gastrectomy, partial, distal; with gastroduodenostomy
43632	Gastrectomy, partial, distal; with gastrojejunostomy
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction
43634	Gastrectomy, partial, distal; with formation of intestinal pouch
43635	Vagotomy when performed with partial distal gastrectomy (List separately in addition to code(s) for primary procedure)
43638	Gastrectomy, partial, proximal, thoracic or abdominal approach including esophagogastrostomy, with vagotomy;
43639	Gastrectomy, partial, proximal, thoracic or abdominal approach including esophagogastrostomy, with vagotomy; with pyloroplasty or pyloromyotomy
43640	Vagotomy including pyloroplasty, with or without gastrostomy; truncal or selective
43800	Pyloroplasty

REPAIR INTESTINAL ATRESIA, STENOSIS OR WEB

CPT Code	Description
44120	Neonate Enterectomy, resection of small intestine; single resection and anastomosis
44121	Neonate Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)
44125	Neonate Enterectomy, resection of small intestine; with enterostomy
44130	Neonate Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure)
44144	Neonate Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula
44615	Neonate Intestinal stricturoplasty (enterotomy and enterorrhaphy) with or without dilation, for intestinal obstruction

RESECTION OMPHALOMESENTERIC DUCT/CYST

CPT Code	Description
44800	Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct
49200	Excision or destruction, open, intra -abdominal or retroperitoneal tumors or cysts or endometriomas;

ABDOMINAL

RESECTION URACHAL REMNENT

CPT Code	Description
51500	Excision of urachal cyst or sinus, with or without umbilical hernia repair

CARDIOVASCULAR

ANY CLOSED HEART PROCEDURE

CPT Code	Description
33420	Valvotomy, mitral valve; closed heart
33470	Valvotomy, pulmonary valve, closed heart; transventricular

ANY OPEN HEART PROCEDURE

CPT Code	Description
33641	Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch
33645	Direct or patch closure, sinus venosus, with or without anomalous pulmonary venous drainage
33647	Repair of atrial septal defect and ventricular septal defect, with direct or patch closure

AORTOPEXY

CPT Code	Description
33800	Aortic suspension(aortopexy) for tracheal decompression(eg, for tracheomalacia)(separate procedure)

CANNULATE/DECANNULATE ECMO

CPT Code	Description
36822	Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency(ECMO) (separate procedure)
37799	Unlisted procedure, vascular surgery

COARCTATION

CPT Code	Description
33840	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with direct anastomosis
33845	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with graft
33851	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; repair using either left subclavian artery or prosthetic material as gusset for enlargement

CARDIOVASCULAR

CONSTRUCTION OR TAKE DOWN AV FISTULA/SHUNT

CPT Code	Description
36821	Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)
36825	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis(separate procedure); autogenous graft
36830	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis(separate procedure); nonautogenous graft(eg, biological collagen, thermoplastic graft)
36832	Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft(separate procedurè

DIALYSIS ACCESS INSERTION/REMOVAL

CPT Code	Description
36800	Insertion of cannula for hemodialysis, other purpose (separate procedure); vein to vein
36810	Insertion of cannula for hemodialysis, other purpose (separate procedurè; arteriovenous, external (Scribner type)
36815	Insertion of cannula for hemodialysis, other purpose (separate procedurè; arteriovenous, external revision, or closure
36832	Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft(separate procedurè
36860	External cannula declotting (separate procedure); without balloon catheter
36861	External cannula declotting (separate procedure); with balloon catheter

MAJOR VESSEL RECONSTRUCTION

CPT Code	Description
35182	Repair, congenital arteriovenous fistula; thorax and abdomen
35184	Repair, congenital arteriovenous fistula; extremities
35201	Repair blood vessel, direct; neck
35206	Repair blood vessel, direct; upper extremity
35207	Repair blood vessel, direct; hand, finger
35211	Repair blood vessel, direct; intrathoracic, with bypass
35216	Repair blood vessel, direct; intrathoracic, without bypass
35221	Repair blood vessel, direct; intra-abdominal
35226	Repair blood vessel, direct; lower extremity
35231	Repair blood vessel with vein graft; neck
35236	Repair blood vessel with vein graft; upper extremity
35246	Repair blood vessel with vein graft; intrathoracic, without bypass
35251	Repair blood vessel with vein graft; intra-abdominal
35256	Repair blood vessel with vein graft; lower extremity
35261	Repair blood vessel with graft other than vein; neck
35266	Repair blood vessel with graft other than vein; upper extremity
35276	Repair blood vessel with graft other than vein; intrathoracic, without bypass
35281	Repair blood vessel with graft other than vein; intra-abdominal
35286	Repair blood vessel with graft other than vein; lower extremity

CARDIOVASCULAR

PATENT DUCTUS ARTERIOSIS

CPT Code	Description
33820	Repair of patent ductus arteriosus; by ligation
33822	Repair of patent ductus arteriosus; by division, under 18 years
33824	Repair of patent ductus arteriosus; by division, 18 years and older

PERIPHERAL ARTERY RECONSTRUCTION

CPT Code	Description
35011	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision
35013	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, axillary -brachial artery, by arm incision
35045	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery
35207	Repair blood vessel, direct; hand, finger
35226	Repair blood vessel, direct; lower extremity
35231	Repair blood vessel with vein graft; neck
35236	Repair blood vessel with vein graft; upper extremity
35256	Repair blood vessel with vein graft; lower extremity
35266	Repair blood vessel with graft other than vein; upper extremity
35286	Repair blood vessel with graft other than vein; lower extremity
35556	Bypass graft, with vein; femoral-popliteal
35656	Bypass graft, with other than vein; femoral-popliteal

RENAL ARTERY RECONSTRUCTION

CPT Code	Description
35091	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels (mesenteric, celiac, re
35221	Repair blood vessel, direct; intra-abdominal
35251	Repair blood vessel with vein graft; intra-abdominal
35281	Repair blood vessel with graft other than vein; intra-abdominal
35480	Transluminal peripheral atherectomy, open; renal or other visceral artery
35536	Bypass graft, with vein; splenorenal
35560	Bypass graft, with vein; aortorenal
35631	Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal
35636	Bypass graft, with other than vein; splenorenal (splenic to renal arterial anastomosis)

SURGICAL PLACEMENT/REMOVAL CENTRAL ACCESS LINE

CPT Code	Description
-----------------	--------------------

CARDIOVASCULAR

SURGICAL PLACEMENT/REMOVAL CENTRAL ACCESS LINE

CPT Code	Description
36488	Placement of central venous catheter(subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, age 2 years or under
36489	Placement of central venous catheter(subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2
36490	Placement of central venous catheter(subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); cutdown, age 2 years or under
36491	Placement of central venous catheter(subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); cutdown, over age 2
36530	Insertion of implantable intravenous infusion pump
36531	Revision of implantable intravenous infusion pump
36532	Removal of implantable intravenous infusion pump
36533	Insertion of implantable venous access device, with or without subcutaneous reservoir
36534	Revision of implantable venous access device, and/or subcutaneous reservoir
36535	Removal of implantable venous access device, and/or subcutaneous reservoir

VASCULAR RING

CPT Code	Description
33802	Division of aberrant vessel (vascular ring);
33803	Division of aberrant vessel (vascular ring); with reanastomosis

DIAPHRAGM

OTHER

CPT Code	Description
39501	Repair, laceration of diaphragm, any approach
49010	Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)

PLICATION OF DIAPHRAGM

CPT Code	Description
39545	Imbrication of diaphragm for eventration, transthoracic or transabdominal, paralytic or nonparalytic

REPAIR DIAPHRAGMATIC HERNIA

CPT Code	Description
39503	Neonate Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia
39520	Neonate Repair, diaphragmatic hernia (esophageal hiatal); transthoracic

DIAPHRAGM

REPAIR DIAPHRAGMATIC HERNIA

CPT Code		Description
39530	Neonate	Repair, diaphragmatic hernia (esophageal hiatal); combined, thoracoabdominal
39531	Neonate	Repair, diaphragmatic hernia (esophageal hiata); combined, thoracoabdominal, with dilation of stricture(with or without gastroplasty)
39540	Neonate	Repair, diaphragmatic hernia (other than neonatal), traumatic; acute
39541	Neonate	Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic

TRANSTHORACIC AND/OR RETROPERITONEAL EXPOSURE

CPT Code	Description
32100	Thoracotomy, major; with exploration and biopsy
49010	Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)

ENDOSCOPIC PROCEDURES

BRONCHOSCOPY

CPT Code	Description
31622	Bronchoscopy (rigid or flexible); diagnostic, with or without cell washing (separate procedure)
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
31645	Bronchoscopy, (rigid or flexible); with therapeutic aspiration of tracheobronchial tree, initial (eg, drainage of lung absces§
31646	Bronchoscopy, (rigid or flexible); with therapeutic aspiration of tracheobronchial tree, subsequent

COLONOSCOPY

CPT Code	Description
44388	Colonoscopy through stoma; diagnostic, with or without collection of specimen (s) by brushing or washing(separate procedurø
44389	Colonoscopy through stoma; with biopsy, single or multiple
44390	Colonoscopy through stoma; with removal of foreign body
44391	Colonoscopy through stoma; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44392	Colonoscopy through stoma; with removal of tumor (s), polyp(s), or other lesion (s) by hot biopsy forceps or bipolar cautery
44393	Colonoscopy through stoma; with ablation of tumor (s), polyp(s), or other lesion (s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

ENDOSCOPIC PROCEDURES

COLONOSCOPY

CPT Code	Description
44394	Colonoscopy through stoma; with removal of tumor (s), polyp(s), or other lesion (s) by snare technique
45355	Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45379	Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
45382	Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45383	Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor (s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor (s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor (s), polyp(s), or other lesion(s) by snare technique

CYSTOSCOPY

CPT Code	Description
52000	Cystourethroscopy (separate procedure)
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
52007	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis
55859	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy

DIAGNOSTIC THORACOSCOPY

CPT Code	Description
32601	Thoracoscopy, diagnostic (separate procedure); lungs and pleural space, without biopsy
32602	Thoracoscopy, diagnostic (separate procedure); lungs and pleural space, with biopsy
32603	Thoracoscopy, diagnostic (separate procedure); pericardial sac, without biopsy
32604	Thoracoscopy, diagnostic (separate procedure); pericardial sac, with biopsy
32605	Thoracoscopy, diagnostic (separate procedure); mediastinal space, without biopsy
32606	Thoracoscopy, diagnostic (separate procedure); mediastinal space, with biopsy

ESOPHAGEAL DILATATION

CPT Code	Description
43220	Esophagoscopy, rigid or flexible; with balloon dilation (less than 30 mm diameter)

ENDOSCOPIC PROCEDURES

ESOPHAGEAL DILATATION

CPT Code	Description
43226	Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire
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)
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

ESOPHAGOSCOPY

CPT Code	Description
43200	Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen (s) by brushing or washing(separate procedure)
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
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
43227	Esophagoscopy, rigid or flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
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
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)
43239	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple

OTHER ENDOSCOPY

CPT Code	Description
31575	Laryngoscopy, flexible fiberoptic; diagnostic

REMOVAL FOREIGN BODY ESOPHAGUS OR TRACHEA

CPT Code	Description
31635	Bronchoscopy (rigid or flexible); with removal of foreign body
43215	Esophagoscopy, rigid or flexible; with removal of foreign body

ENDOSCOPIC PROCEDURES

REMOVAL FOREIGN BODY ESOPHAGUS OR TRACHEA

CPT Code	Description
43247	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body

SIGMOIDOSCOPY

CPT Code	Description
45300	Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen (s) by brushing or washing(separate procedurè
45303	Proctosigmoidoscopy, rigid; with dilation (eg, balloon, guide wire, bougie)
45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple
45307	Proctosigmoidoscopy, rigid; with removal of foreign body
45308	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
45309	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique
45315	Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique
45317	Proctosigmoidoscopy, rigid; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45320	Proctosigmoidoscopy, rigid; with ablation of tumor (s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique(eg, laser)
45321	Proctosigmoidoscopy, rigid; with decompression of volvulus
45330	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen (s) by brushing or washing (separate procedurè
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple
45332	Sigmoidoscopy, flexible; with removal of foreign body
45333	Sigmoidoscopy, flexible; with removal of tumor (s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45334	Sigmoidoscopy, flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45337	Sigmoidoscopy, flexible; with decompression of volvulus, any method
45338	Sigmoidoscopy, flexible; with removal of tumor (s), polyp(s), or other lesion(s) by snare technique
45339	Sigmoidoscopy, flexible; with ablation of tumor (s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

GENITO URINARY

BLADDER AUGMENTATION OR REPAIR (ANY)

CPT Code	Description
50780	Ureteroneocystostomy; anastomosis of single ureter to bladder
50845	Cutaneous appendico-vesicostomy

GENITO URINARY

CIRCUMCISION (OR ONLY)

CPT Code	Description
54150	Circumcision, using clamp or other device; newborn
54152	Circumcision, using clamp or other device; except newborn
54160	Circumcision, surgical excision other than clamp, device or dorsal slit; newborn
54161	Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn

CYSTECTOMY (PARTIAL OR TOTAL)

CPT Code	Description
51550	Cystectomy, partial; simple
51555	Cystectomy, partial; complicated (eg, postradiation, previous surgery, difficult location)
51565	Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy)
51570	Cystectomy, complete; (separate procedure)
51575	Cystectomy, complete; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
51580	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations;
51585	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
51590	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis;
51595	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
51596	Cystectomy, complete, with continent diversion, any open technique, using any segment of small and/or large intestine to construct neobladder
51597	Pelvic exenteration, complete, for vesical, prostatic or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy and/or abdominoperineal resection of rectum and colon and colostomy, or any combination ther

ENTERIC CONDUIT (ANY)

CPT Code	Description
44316	Continent ileostomy (Kock procedure) (separate procedure)
50800	Ureteroenterostomy, direct anastomosis of ureter to intestine
50810	Ureterosigmoidostomy, with creation of sigmoid bladder and establishment of abdominal or perineal colostomy, including intestine anastomosis
50815	Ureterocolon conduit, including intestine anastomosis
50820	Ureteroileal conduit (ileal bladder), including intestine anastomosis (Bricker operation)
50825	Continent diversion, including intestine anastomosis using any segment of small and /or large intestine (Kock pouch or Camey enterocystoplasty)

HYSTERECTOMY/SALPINGECTOMY

CPT Code	Description
-----------------	--------------------

GENITO URINARY

HYSTERECTOMY/SALPINGECTOMY

CPT Code	Description
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube (s), with or without removal of ovary (s);
58152	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube (s), with or without removal of ovary (s); with colpo-urethrocystopexy(eg, Marshall -Marchetti-Krantz, Burch)
58180	Supracervical abdominal hysterectomy(subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary (s)
58200	Total abdominal hysterectomy, including partial vaginectomy, with para -aortic and pelvic lymph node sampling, with or without removal of tube (s), with or without removal of ovary (s)
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para -aortic lymph node sampling (biopsy), with or without removal of tube (s), with or without removal of ovary(s)
58240	Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube (s), with or without removal of ovary (s), with removal of bladder and ureteral transplantations, and/or abdominoperineal res
58260	Vaginal hysterectomy, for uterus 250 grams or less;
58262	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s), and/or ovary(s)
58263	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube (s), and/or ovary(s), with repair of enterocele
58267	Vaginal hysterectomy, for uterus 250 grams or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	Vaginal hysterectomy, for uterus 250 grams or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy;
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
58285	Vaginal hysterectomy, radical (Schauta type operation)
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

NEPHRECTOMY (TOTAL OR PARTIAL): CYSTIC DYSPLASIA

CPT Code	Description
50280	Excision or unroofing of cyst(s) of kidney
50290	Excision of perinephric cyst

NEPHRECTOMY (TOTAL OR PARTIAL): OTHER

CPT Code	Description
50290	Excision of perinephric cyst

NEPHRECTOMY (TOTAL OR PARTIAL): TRAUMA

CPT Code	Description
50220	Nephrectomy, including partial ureterectomy, any open approach including rib resection;

GENITO URINARY

NEPHRECTOMY (TOTAL OR PARTIAL): TRAUMA

CPT Code	Description
50230	Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and /or vena caval thrombectomy
50240	Nephrectomy, partial

NEPHRECTOMY (TOTAL OR PARTIAL): TUMOR

CPT Code	Description
50220	Tumors Nephrectomy, including partial ureterectomy, any open approach including rib resection;
50225	Tumors Nephrectomy, including partial ureterectomy, any open approach including rib resection; complicated because of previous surgery on same kidney
50230	Tumors Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and /or vena caval thrombectomy
50234	Tumors Nephrectomy with total ureterectomy and bladder cuff; through same incision
50240	Tumors Nephrectomy, partial

NEPHROSTOMY

CPT Code	Description
50040	Nephrostomy, nephrotomy with drainage
50125	Pyelotomy; with drainage, pyelostomy
50135	Pyelotomy; complicated (eg, secondary operation, congenital kidney abnormality)

OOPHORECTOMY (PARTIAL OR TOTAL)

CPT Code	Description
58720	Tumors Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58900	Tumors Biopsy of ovary, unilateral or bilateral (separate procedure)
58940	Tumors Oophorectomy, partial or total, unilateral or bilateral;
58943	Tumors Oophorectomy, partial or total, unilateral or bilateral; for ovarian, tubal or primary peritoneal malignancy, with para -aortic and pelvic lymph node biopsies, peritoneal washings, peritoneal biopsies, diaphragmatic assessments, with or without salpingect
58950	Tumors Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy;
58951	Tumors Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para -aortic lymphadenectomy
58952	Tumors Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with radical dissection for debulking (ie, radical excision or destruction, intra -abdominal or retroperitoneal tumors)

OPERATION FOR NEPHRO-URETERO LITHIASIS

CPT Code	Description
50060	Nephrolithotomy; removal of calculus

GENITO URINARY

OPERATION FOR NEPHRO-URETERO LITHIASIS

CPT Code	Description
50065	Nephrolithotomy; secondary surgical operation for calculus
50070	Nephrolithotomy; complicated by congenital kidney abnormality
50075	Nephrolithotomy; removal of large staghorn calculus filling renal pelvis and calyces (including anatomic pyelolithotomy)
50561	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50580	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50610	Ureterolithotomy; upper one-third of ureter
50620	Ureterolithotomy; middle one-third of ureter
50630	Ureterolithotomy; lower one-third of ureter
50961	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50980	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
52310	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure; simple
52315	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure; complicated
52317	Litholapaxy : crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)
52318	Litholapaxy : crushing or fragmentation of calculus by any means in bladder and removal of fragments; complicated or large (over 2.5 cm)

OPERATION FOR TORSION TESTIS OR APPENDAGES

CPT Code	Description
54512	Excision of extraparenchymal lesion of testis
54600	Reduction of torsion of testis, surgical, with or without fixation of contralateral testis
54620	Fixation of contralateral testis (separate procedure)

OPERATION FOR VARICOCELE: OPEN

CPT Code	Description
55530	Excision of varicocele or ligation of spermatic veins for varicocele; (separate procedure)
55535	Excision of varicocele or ligation of spermatic veins for varicocele; abdominal approach
55540	Excision of varicocele or ligation of spermatic veins for varicocele; with hernia repair

ORCHIDOPEXY: OPEN

CPT Code	Description
-----------------	--------------------

GENITO URINARY

ORCHIDOPEXY: OPEN

CPT Code		Description
54550	IPGS	Exploration for undescended testis (inguinal or scrotal area)
54560	IPGS	Exploration for undescended testis with abdominal exploration
54600	IPGS	Reduction of torsion of testis, surgical, with or without fixation of contralateral testis
54640	IPGS	Orchiopexy, inguinal approach, with or without hernia repair
54650	IPGS	Orchiopexy, abdominal approach, for intra-abdominal testis (eg, Fowler-Stephens)

ORCHIDOPEXY: SCOPE

CPT Code		Description
54650	IPGS	Orchiopexy, abdominal approach, for intra-abdominal testis (eg, Fowler-Stephens)

ORCHIECTOMY

CPT Code		Description
54520		Orchiectomy, simple (including subcapsula), with or without testicular prosthesis, scrotal or inguinal approach
54530		Orchiectomy, radical, for tumor; inguinal approach
54535		Orchiectomy, radical, for tumor; with abdominal exploration

OTHER

CPT Code		Description
51940		Closure, exstrophy of bladder
54300		Plastic operation of penis for straightening of chordee(eg, hypospadias), with or without mobilization of urethra
54304		Plastic operation on penis for correction of chordee or for first stage hypospadias repair with or without transplantation of prepuce and/or skin flaps
54308		Urethroplasty for second stage hypospadias repair(including urinary diversion); less than 3 cm
54312		Urethroplasty for second stage hypospadias repair(including urinary diversion); greater than 3 cm
54316		Urethroplasty for second stage hypospadias repair(including urinary diversion) with free skin graft obtained from site other than genitalia
54318		Urethroplasty for third stage hypospadias repair to release penis from scrotum(eg, third stage Cecil repair)
54322		One stage distal hypospadias repair(with or without chordee or circumcision); with simple meatal advancement (eg, Magpi, V -flap)
54324		One stage distal hypospadias repair(with or without chordee or circumcision); with urethroplasty by local skin flaps (eg, flip -flap, prepuccial flap)
54326		One stage distal hypospadias repair(with or without chordee or circumcision); with urethroplasty by local skin flaps and mobilization of urethra
54328		One stage distal hypospadias repair(with or without chordee or circumcision); with extensive dissection to correct chordee and urethroplasty with local skin flaps, skin graft patch, and/or island flap

GENITO URINARY

OTHER

CPT Code	Description
54332	One stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap
54336	One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap
54340	Repair of hypospadias complications (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple
54344	Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring mobilization of skin flaps and urethroplasty with flap or patch graft
54348	Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring extensive dissection and urethroplasty with flap, patch or tubed graft(includes urinary diversion)
54352	Repair of hypospadias cripple requiring extensive dissection and excision of previously constructed structures including rerelease of chordee and reconstruction of urethra and penis by use of local skin as grafts and island flaps and skin brought in as
54380	Plastic operation on penis for epispadias distal to external sphincter;
54385	Plastic operation on penis for epispadias distal to external sphincter; with incontinence
54390	Plastic operation on penis for epispadias distal to external sphincter; with exstrophy of bladder

PROCEDURES FOR INTERSEX (VAGINAL RECONSTRUCTION)

CPT Code	Description
55970	IPGS Intersex surgery; male to female
55980	IPGS Intersex surgery; female to male
56800	IPGS Plastic repair of introitus
56805	IPGS Clitoroplasty for intersex state
56810	IPGS Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
57335	IPGS Vaginoplasty for intersex state

PYELOPLASTY/UPJ RECONSTRUCTION

CPT Code	Description
50120	Pyelotomy; with exploration
50125	Pyelotomy; with drainage, pyelostomy
50400	Pyeloplasty (Foley Y -pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; simple
50405	Pyeloplasty (Foley Y -pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; complicated (congenital kidney abnormality, secondary pyeloplasty, solitary kid

RECONSTRUCT CLOACAL EXTROPHY

CPT Code	Description
46744	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach

GENITO URINARY

RECONSTRUCT CLOACAL EXTROPHY

CPT Code	Description
46746	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach;
46748	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach; with vaginal lengthening by intestinal graft or pedicle flaps

RENAL BIOPSY (OPEN)

CPT Code	Description
50205	Renal biopsy; by surgical exposure of kidney

RENAL TRANSPLANT

CPT Code	Description
50340	Recipient nephrectomy (separate procedure)
50360	Renal allotransplantation, implantation of graft; excluding donor and recipient nephrectomy
50365	Renal allotransplantation, implantation of graft; with recipient nephrectomy

REPAIR COMPLEX LACERATION VAGINA/PERINEUM

CPT Code	Description
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
57200	Colporrhaphy, suture of injury of vagina (nonobstetrical)
57210	Colpoperineorrhaphy, suture of injury of vagina and/or perineum (nonobstetrical)

URETERAL RECONSTRUCTION/REIMPLANTATION

CPT Code	Description
50760	Ureteroureterostomy
50780	Ureteroneocystostomy; anastomosis of single ureter to bladder
50782	Ureteroneocystostomy; anastomosis of duplicated ureter to bladder
50783	Ureteroneocystostomy; with extensive ureteral tailoring
50785	Ureteroneocystostomy; with vesico-psoas hitch or bladder flap

URINARY UNDIVERSION

CPT Code	Description
50830	Urinary undiversion (eg, taking down of ureteroileal conduit, ureterosigmoidostomy or ureteroenterostomy with ureteroureterostomy or ureteroneocystostomy)

HEAD & NECK

HEAD & NECK

BRANCHIAL CLEFT CYST/SINUS

CPT Code	Description
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

CLEFT LIP/PALATE REPAIR

CPT Code	Description
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
42200	Palatoplasty for cleft palate, soft and/or hard palate only
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only
42215	Palatoplasty for cleft palate; major revision

CYSTIC HYGROMA/LYMPHANGIOMA

CPT Code	Description
38550	Tumors Excision of cystic hygroma, axillary or cervical; without deep neurovascular dissection
38555	Tumors Excision of cystic hygroma, axillary or cervical; with deep neurovascular dissection

DERMOID/OTHER CYST

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
11440	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
11441	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm
11442	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm
21555	Excision tumor, soft tissue of neck or thorax; subcutaneous
21556	Excision tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular

HEAD & NECK

MAJOR TUMOR (HEAD & NECK)

CPT Code		Description
11623	Tumors	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm
21015	Tumors	Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp
21555	Tumors	Excision tumor, soft tissue of neck or thorax; subcutaneous
21556	Tumors	Excision tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular
21557	Tumors	Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or thorax

OTHER

CPT Code	Description
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

PARATHYROIDECTOMY (ANY)

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

THYROGLOSSAL DUCT CYST/SINUS

CPT Code	Description
60280	Excision of thyroglossal duct cyst or sinus;
60281	Excision of thyroglossal duct cyst or sinus; recurrent

THYROIDECTOMY (ANY)

CPT Code	Description
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

HEAD & NECK

THYROIDECTOMY (ANY)

CPT Code	Description
60270	Thyroidectomy, including substernal thyroid; sternal split or transthoracic approach
60271	Thyroidectomy, including substernal thyroid; cervical approach

HERNIA REPAIR

INFANT (<6 MOS OF AGE) REP. INGUINAL HERNIA (UNI-/BILA

CPT Code	Description
49495	Repair, initial inguinal hernia, full term infant under age 6 months, or preterm infant over 50 weeks postconception age and under age 6 months at the time of surgery, with or without hydrocelectomy; reducible
49496	Repair, initial inguinal hernia, full term infant under age 6 months, or preterm infant over 50 weeks postconception age and under age 6 months at the time of surgery, with or without hydrocelectomy; incarcerated or strangulated
49525	Repair inguinal hernia, sliding, any age

OTHER

CPT Code	Description
49540	Repair lumbar hernia

PEDIATRIC REPAIR INGUINAL HERNIA (UNI- OR BILATERAL

CPT Code	Description
49500	Repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; reducible
49501	Repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; incarcerated or strangulated
49505	Repair initial inguinal hernia, age 5 years or over; reducible
49507	Repair initial inguinal hernia, age 5 years or over; incarcerated or strangulated
49520	Repair recurrent inguinal hernia, any age; reducible
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated
49525	Repair inguinal hernia, sliding, any age

REPAIR UMBILICAL HERNIA

CPT Code	Description
49580	Repair umbilical hernia, under age 5 years; reducible
49582	Repair umbilical hernia, under age 5 years; incarcerated or strangulated
49585	Repair umbilical hernia, age 5 years or over; reducible
49587	Repair umbilical hernia, age 5 years or over; incarcerated or strangulated

HERNIA REPAIR

REPAIR VENTRAL HERNIA

CPT Code	Description
49560	Repair initial incisional or ventral hernia; reducible
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated
49565	Repair recurrent incisional or ventral hernia; reducible
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated
49568	Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to code for the incisional or ventral hernia repair)
49570	Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)
49572	Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated

LIVER/BILIARY

CHOLECYSTECTOMY WITH/WITHOUT COMMON BILE DUCT

CPT Code	Description
47600	Cholecystectomy;
47605	Cholecystectomy; with cholangiography
47610	Cholecystectomy with exploration of common duct;
47612	Cholecystectomy with exploration of common duct; with choledochoenterostomy
47620	Cholecystectomy with exploration of common duct; with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography

CHOLECYSTECTOMY WITH/WITHOUT COMMON BILE DUCT

CPT Code	Description
47562	Laparoscopy, surgical; cholecystectomy
47563	Laparoscopy, surgical; cholecystectomy with cholangiography
47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct

EXCISION CHOLEDOCHAL CYST

CPT Code	Description
47715	Excision of choledochal cyst
47716	Anastomosis, choledochal cyst, without excision
47780	Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract

LIVER BIOPSY: OPEN

CPT Code	Description
47000	Biopsy of liver, needle; percutaneous
47100	Biopsy of liver, wedge

LIVER/BILIARY

LIVERHARVEST

CPT Code	Description
47133	Donor hepatectomy, with preparation and maintenance of allograft; from cadaver donor
47134	Donor hepatectomy, with preparation and maintenance of allograft; partial, from living donor

LIVER TRANSPLANT

CPT Code	Description
47135	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age
47136	Liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age

LYSIS OF ADHESIONS

CPT Code	Description
44005	Enterolysis (freeing of intestinal adhesion) (separate procedure)

MAJOR HEPATIC RESECTION/REPAIR: OTHER

CPT Code	Description
47300	Marsupialization of cyst or abscess of liver

MAJOR HEPATIC RESECTION/REPAIR: TRAUMA

CPT Code	Description
47350	Management of liver hemorrhage; simple suture of liver wound or injury
47360	Management of liver hemorrhage; complex suture of liver wound or injury, with or without hepatic artery ligation
47361	Management of liver hemorrhage; exploration of hepatic wound, extensive debridement, coagulation and/or suture, with or without packing of liver
47362	Management of liver hemorrhage; re-exploration of hepatic wound for removal of packing

MAJOR HEPATIC RESECTION/REPAIR: TUMOR

CPT Code	Description
47120	Tumors Hepatectomy, resection of liver; partial lobectomy
47122	Tumors Hepatectomy, resection of liver; trisegmentectomy
47125	Tumors Hepatectomy, resection of liver; total left lobectomy
47130	Tumors Hepatectomy, resection of liver; total right lobectomy

OPERATIONS FOR PSEUDOCYST

CPT Code	Description
48000	Placement of drains, peripancreatic, for acute pancreatitis;

LIVER/BILIARY

OPERATIONS FOR PSEUDOCYST

CPT Code	Description
48005	Resection or debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis
48150	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy(Whipple-type procedure); with pancreatojejunostomy
48500	Marsupialization of pancreatic cyst
48510	External drainage, pseudocyst of pancreas; open
48520	Internal anastomosis of pancreatic cyst to gastrointestinal tract; direct
48540	Internal anastomosis of pancreatic cyst to gastrointestinal tract; Roux-en-Y

PANCREATIC RESECTION FOR: HYPERINSULINISM

CPT Code	Description
48146	Pancreatectomy, distal, near-total with preservation of duodenum (Child-type procedure)

PANCREATIC RESECTION FOR: TRAUMA

CPT Code	Description
48120	Excision of lesion of pancreas (eg, cyst, adenoma)
48140	Pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostomy
48145	Pancreatectomy, distal subtotal, with or without splenectomy; with pancreaticojejunostomy
48545	Pancreatorrhaphy for injury
48547	Duodenal exclusion with gastrojejunostomy for pancreatic injury

PANCREATIC RESECTION FOR: TUMOR

CPT Code	Description
48120	Excision of lesion of pancreas (eg, cyst, adenoma)
48140	Pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostomy
48145	Pancreatectomy, distal subtotal, with or without splenectomy; with pancreaticojejunostomy
48146	Pancreatectomy, distal, near-total with preservation of duodenum (Child-type procedure)
48150	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy(Whipple-type procedure); with pancreatojejunostomy
48152	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy(Whipple-type procedure); without pancreatojejunostomy
48153	Pancreatectomy, proximal subtotal with near -total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy
48154	Pancreatectomy, proximal subtotal with near -total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); without pancreatojejunostomy

LIVER/BILIARY

PANCREATIC RESECTION FOR: TUMOR

CPT Code	Description
48155	Pancreatectomy, total
48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells
48180	Pancreaticojejunostomy, side-to-side anastomosis (Puestow-type operation)

PORTOENTEROSTOMY

CPT Code	Description
47612	Cholecystectomy with exploration of common duct; with choledochoenterostomy
47701	Portoenterostomy (eg, Kasai procedure)

PORTOSYSTEMIC SHUNTS OR OTHER OPERATIONS FOR PO

CPT Code	Description
35536	Bypass graft, with vein; splenorenal
35636	Bypass graft, with other than vein; splenorenal (splenic to renal arterial anastomosis)
37140	Venous anastomosis, open; portocaval
37145	Venous anastomosis, open; renoportal
37160	Venous anastomosis, open; caval-mesenteric
37180	Venous anastomosis, open; splenorenal, proximal
37181	Venous anastomosis, open; splenorenal, distal (selective decompression of esophagogastric varices, any technique)

SPLENECTOMY: OPEN

CPT Code	Description
38100	Splenectomy; total (separate procedure)
38101	Splenectomy; partial (separate procedure)
38102	Splenectomy; total, en bloc for extensive disease, in conjunction with other procedure (List in addition to code for primary procedure)

SPLENECTOMY: SCOPE

CPT Code	Description
38100	Splenectomy; total (separate procedure)
38101	Splenectomy; partial (separate procedure)
38115	Repair of ruptured spleen (splenorrhaphy) with or without partial splenectomy
38120	Laparoscopy, surgical, splenectomy

SPLENORRAPHY

CPT Code	Description
38115	Repair of ruptured spleen (splenorrhaphy) with or without partial splenectomy

SKIN/SOFT TISSUE/MUSCULOSKELETAL

BURN DEBRIDEMENT OR GRAFTING

CPT Code	Description
15000	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children
15050	Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area (except on face, up to defect size 2 cm diameter)
15100	Split graft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)
15101	Split graft, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
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)
15121	Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and /or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to c
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
15241	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and /or feet; each additional 20 sq cm (List separately in addition to code for primary procedure)
15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and /or lips; 20 sq cm or less
15261	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and /or lips; each additional 20 sq cm (List separately in addition to code for primary procedure)
15350	Application of allograft, skin; 100 sq cm or less
15400	Application of xenograft, skin; 100 sq cm or less
16000	Initial treatment, first degree burn, when no more than local treatment is required
16010	Dressings and/or debridement, initial or subsequent; under anesthesia, small
16015	Dressings and/or debridement, initial or subsequent; under anesthesia, medium or large, or with major debridement
16020	Dressings and/or debridement, initial or subsequent; without anesthesia, office or hospital, small
16025	Dressings and/or debridement, initial or subsequent; without anesthesia, medium (eg, whole face or whole extremity)
16035	Escharotomy; initial incision

COMPLEX WOUND CLOSURE

CPT Code	Description
13100	Repair, complex, trunk; 1.1 cm to 2.5 cm
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm
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

SKIN/SOFT TISSUE/MUSCULOSKELETAL

COMPLEX WOUND CLOSURE

CPT Code	Description
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
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
13160	Secondary closure of surgical wound or dehiscence, extensive or complicated

MAJOR EXCISION SOFT TISSUE TUMOR

CPT Code	Description
19260	Tumors Excision of chest wall tumor including ribs
19271	Tumors Excision of chest wall tumor involving ribs, with plastic reconstruction; without mediastinal lymphadenectomy
21015	Tumors Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp
21557	Tumors Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or thorax
21930	Tumors Excision, tumor, soft tissue of back or flank
21935	Tumors Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank
22900	Tumors Excision, abdominal wall tumor, subfascial (eg, desmoid)
23077	Tumors Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area
24077	Tumors Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area
25077	Tumors Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area
26117	Tumors Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger
27047	Tumors Excision, tumor, pelvis and hip area; subcutaneous tissue
27048	Tumors Excision, tumor, pelvis and hip area; deep, subfascial, intramuscular
27049	Tumors Radical resection of tumor, soft tissue of pelvis and hip area (eg, malignant neoplasm)
27327	Tumors Excision, tumor, thigh or knee area; subcutaneous
27328	Tumors Excision, tumor, thigh or knee area; deep, subfascial, or intramuscular
27329	Tumors Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area
27615	Tumors Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area

MAJOR SOFT TISSUE REPAIR FOR TRAUMA

CPT Code	Description
11010	Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin and subcutaneous tissues
11011	Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, and muscle
11012	Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, muscle, and bone
11040	Debridement; skin, partial thickness
11041	Debridement; skin, full thickness
11042	Debridement; skin, and subcutaneous tissue

SKIN/SOFT TISSUE/MUSCULOSKELETAL

MAJOR SOFT TISSUE REPAIR FOR TRAUMA

CPT Code	Description
11043	Debridement; skin, subcutaneous tissue, and muscle
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
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
15756	Free muscle or myocutaneous flap with microvascular anastomosis

OTHER

CPT Code	Description
20520	Removal of foreign body in muscle or tendon sheath; simple
20525	Removal of foreign body in muscle or tendon sheath; deep or complicated

PILONIDAL CYST EXCISION

CPT Code	Description
11770	Excision of pilonidal cyst or sinus; simple
11771	Excision of pilonidal cyst or sinus; extensive
11772	Excision of pilonidal cyst or sinus; complicated

SUBCUTANEOUS MASTECTOMY

CPT Code	Description
19140	Mastectomy for gynecomastia
19182	Mastectomy, subcutaneous

THORACIC

DECORTICATION/PLEURECTOMY/BLEBECTOMY: OPEN

CPT Code	Description
32141	Thoracotomy, major; with excision-plication of bullae, with or without any pleural procedure
32320	Decortication and parietal pleurectomy

THORACIC

DECORTICATION/PLEURECTOMY/BLEBECTOMY: SCOPE

CPT Code	Description
32651	Thoracoscopy, surgical; with partial pulmonary decortication
32652	Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis
32657	Thoracoscopy, surgical; with wedge resection of lung, single or multiple
32663	Thoracoscopy, surgical; with lobectomy, total or segmental

ESOPHAGEAL RESECTION OR REPLACEMENT

CPT Code	Description
43107	IPGS Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagostomy, with or without pyloroplasty(transhiatal)
43108	IPGS Total or near total esophagectomy, without thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis (es)
43112	IPGS Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagostomy, with or without pyloroplasty
43113	IPGS Total or near total esophagectomy, with thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis (es)
43116	IPGS Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction
43300	IPGS Esophagoplasty (plastic repair or reconstruction), cervical approach; without repair of tracheoesophageal fistula
43310	IPGS Esophagoplasty (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula
43320	IPGS Esophagostomy(cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach
43360	IPGS Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty
43361	IPGS 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

ESOPHAGOMYOTOMY

CPT Code	Description
32665	Thoracoscopy, surgical; with esophagomyotomy (Heller type)
43330	Esophagomyotomy (Heller type); abdominal approach
43331	Esophagomyotomy (Heller type); thoracic approach

EXCISION MEDIASTINAL CYST

CPT Code	Description
32662	IPGS Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass
39200	IPGS Excision of mediastinal cyst

THORACIC

EXCISION MEDIASTINAL TUMOR

CPT Code		Description
39010	Tumors	Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; transthoracic approach, including either transthoracic or median sternotomy
39220	Tumors	Excision of mediastinal tumor
60522	Tumors	Thymectomy, partial or total; sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)

LARYNGEAL OR TRACHEAL RESECTION AND/OR RECONSTRUCTION

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
31587	Laryngoplasty, cricoid split
31588	Laryngoplasty, not otherwise specified(eg, for burns, reconstruction after partial laryngectomy)
31590	Laryngeal reinnervation by neuromuscular pedicle
31750	Tracheoplasty; cervical
31755	Tracheoplasty; tracheopharyngeal fistulization, each stage
31760	Tracheoplasty; intrathoracic
31766	Carinal reconstruction
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

LUNG BIOPSY: OPEN

CPT Code	Description
32095	Thoracotomy, limited, for biopsy of lung or pleura
32500	Removal of lung, other than total pneumonectomy; wedge resection, single or multiple

LUNG BIOPSY: SCOPE

CPT Code	Description
32602	Thoracoscopy, diagnostic (separate procedure); lungs and pleural space, with biopsy
32657	Thoracoscopy, surgical; with wedge resection of lung, single or multiple
32663	Thoracoscopy, surgical; with lobectomy, total or segmental

OTHER

CPT Code	Description
31599	Unlisted procedure, larynx

THORACIC

OTHER

CPT Code	Description
60521	Thymectomy, partial or total; sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure)

PULMONARY RESECTION TUMOR, CONGENITAL MALFORM

CPT Code	Description
32035	IPGS Thoracostomy; with rib resection for empyema
32036	IPGS Thoracostomy; with open flap drainage for empyema
32141	IPGS Thoracotomy, major; with excision-plication of bullae, with or without any pleural procedure
32440	IPGS Removal of lung, total pneumonectomy;
32442	IPGS Removal of lung, total pneumonectomy; with resection of segment of trachea followed by bronchotracheal anastomosis(sleeve pneumonectomy)
32445	IPGS Removal of lung, total pneumonectomy; extrapleural
32480	IPGS Removal of lung, other than total pneumonectomy; single lobe (lobectomy)
32482	IPGS Removal of lung, other than total pneumonectomy; two lobes (bilobectomy)
32484	IPGS Removal of lung, other than total pneumonectomy; single segment (segmentectomy)
32486	IPGS Removal of lung, other than total pneumonectomy; with circumferential resection of segment of bronchus followed by bronchobronchial anastomosis (sleeve lobectomy)
32488	IPGS Removal of lung, other than total pneumonectomy; all remaining lung following previous removal of a portion of lung (completion pneumonectomy)
32491	IPGS Removal of lung, other than total pneumonectomy; excision -plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure
32500	IPGS Removal of lung, other than total pneumonectomy; wedge resection, single or multiple
32520	IPGS Resection of lung; with resection of chest wall
32522	IPGS Resection of lung; with reconstruction of chest wall, without prosthesis
32525	IPGS Resection of lung; with major reconstruction of chest wall, with prosthesis
32657	IPGS Thoracoscopy, surgical; with wedge resection of lung, single or multiple

REPAIR CHEST WALL DEFORMITY

CPT Code	Description
21740	IPGS Reconstructive repair of pectus excavatum or carinatum; open
32820	IPGS Major reconstruction, chest wall (posttraumatic)
32905	IPGS Thoracoplasty, Schede type or extrapleural (all stages);
32906	IPGS Thoracoplasty, Schede type or extrapleural (all stages); with closure of bronchopleural fistula

REPAIR ESOPHAGEAL ATRESIA/TRACHEOSOPHAGEAL FISTI

CPT Code	Description
43300	Neonate Esophagoplasty (plastic repair or reconstruction), cervical approach; without repair of tracheoesophageal fistula
43305	Neonate Esophagoplasty (plastic repair or reconstruction), cervical approach; with repair of tracheoesophageal fistula

THORACIC

REPAIR ESOPHAGEAL ATRESIA/TRACHEOSOPHAGEAL FISTI

CPT Code		Description
43310	Neonate	Esophagoplasty (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula
43312	Neonate	Esophagoplasty (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula
43320	Neonate	Esophagogastrostomy(cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach

RESECTION CHEST WALL TUMOR

CPT Code		Description
19260	Tumors	Excision of chest wall tumor including ribs
19271	Tumors	Excision of chest wall tumor involving ribs, with plastic reconstruction; without mediastinal lymphadenectomy
21557	Tumors	Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or thorax
32520	Tumors	Resection of lung; with resection of chest wall
32522	Tumors	Resection of lung; with reconstruction of chest wall, without prosthesis

THORACOTOMY FOR TRAUMA

CPT Code		Description
32110		Thoracotomy, major; with control of traumatic hemorrhage and/or repair of lung tear
32160		Thoracotomy, major; with cardiac massage

TRACHEOSTOMY

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

TRAUMA

NON-OPERATIVE TRAUMA

CPT Code		Description
99199		Unlisted special service, procedure or report