Optum

Desk Reference

Coders' Desk Reference for Procedures

Answers to your toughest CPT® coding questions

2027

optumcoding.com

Contents

Introduction

Coding is a complicated business. It's not enough to have a current copy of a CPT® book. Medical coders also need dictionaries and specialty texts if they are to accurately translate physicians' operative reports or patient charts into CPT codes.

That's why Optum originally developed *Coders' Desk Reference*—now known as *Coders' Desk Reference for Procedures*—to provide a resource with answers to CPT coding questions. We polled the medical reimbursement community and our technical staff to determine the issues causing bottlenecks in a coder's workload.

We know that experienced coders are frustrated by limited definitions accompanying many CPT codes. Beginning coders need guidelines on the use of CPT codes and basic information about medical and reimbursement issues. Everyone requires up-to-date information about the anticipated changes in procedural coding.

Coders' Desk Reference for Procedures (CDR) answers the questions of both experienced and novice medical coders. Coders, physicians, registered nurses, physician assistants, and physical therapists contributed to the technical information contained in CDR. The result is a compendium of answers to a wide variety of CPT coding questions.

Since the first release of CDR in 1995, coders' corrections, suggestions, and tips have been incorporated into every printing, making this book as informative and useful as possible. Changes reflecting the dynamic world of coding are ongoing, and Optum encourages input for inclusion in future editions of the book. Information in CDR has been updated to reflect 2026 CPT codes.

Format

CDR is divided into convenient sections for easy use, with each section organized in alphabetic or numeric order. Simply access the section by thumbing through the convenient tabbing system to find the specific item of interest.

Using CPT Codes

For the new coder, and even for the veteran, this chapter provides an overview of the CPT book: what it is and how best to use this coding system for identifying procedures.

Using CPT Modifiers

Modifiers augment CPT codes to the satisfaction of private and government payers. Optum coding experts interpret CPT modifiers and identify their advantage in reimbursement.

Using E/M Codes

Although some of the most commonly used codes by physicians of all specialties, evaluation and management (E/M) codes are amongst the least understood. These codes, introduced in the 1992 CPT book, were designed to increase accuracy and consistency in the reporting of non-procedural encounters. This section contains the official 2026 guidelines.

Place of Service/Type of Service

This section contains place-of-service codes that should be used on professional claims and type-of-service codes used by the Medicare Common Working File.

Reimbursement Terms

In order to get reimbursed in a timely manner, it is important to have a clear understanding of the terminology used by major insurers and the federal government. This section includes up-to-date terminology that will help coders have a better understanding of the complex reimbursement climate.

Clinical Abbreviations, Prefixes, Suffixes, and Acronyms

The medical profession has its own shorthand for documentation. Here, acronyms, abbreviations, and symbols commonly seen on operative reports or medical charts are listed for easy reference.

The uniquely efficient language of medicine is based on prefixes and suffixes attached to root words to modify the meaning. Medical prefixes and suffixes evolved from the Greek and Latin used by pioneering physicians.

Procedural Eponyms

What is the Mitrofanoff operation? What is the Binet test? Eponyms honor the developer of a procedure or test, but do little to clarify what the procedure is. Subject matter experts have researched the procedural eponyms found in the index of the CPT book or used by surgeons and other medical personnel in medical reports, and provide simplified explanations of what the procedures are, along with applicable CPT codes.

Surgical and Laboratory Terms

Operative reports contain words and phrases that not only communicate the importance and urgency of surgery, but the techniques as well. Laboratory reports contain specialized terminology that reflect the various testing methods employed as well as diverse techniques for specimen collection. The glossary of surgical and laboratory terms in *Coders' Desk Reference for Procedures* includes terms most used in operative reports to describe techniques and tools, as well as those often seen on laboratory reports and requisitions that identify collection technique and methodology.

Anatomical Illustrations

Illustrations are included by body system with additional plates showing the planes of the body and Rule of Nines for burns.

CPT Lay Descriptions

The lay descriptions contained in the *Coders' Desk Reference for Procedures* are written to provide a common or generally accepted method of accomplishing the service indicated by the CPT code description. In cases where more than one procedure or method is reported by a single code, one example of those methods or procedures may be given in the lay description. No lay description in this product is intended to give an absolute, required method of performing the service described in the CPT code. Reflecting the full spectrum of variations in technology and of professional techniques would be impossible in a book this size. Each CPT code is followed by a detailed description of the procedure that code represents.

Coders' Desk Reference for Procedures was developed to help providers comply with the emerging standards by which medical services are coded, reported, and paid. Remember that *Coders' Desk Reference for Procedures* is a post-treatment medical reference and, as such, it is inappropriate to use this manual to select medical treatment.

Using CPT® Codes

The codes of the *Current Procedural Terminology* (CPT®) book constitute procedural and medical service components. The CPT book is in its fourth edition with revisions occurring every year.

The CPT coding system was selected as one of the National Code Sets mandatory for use to facilitate electronic transactions, including health claims, enrollments, eligibility, payment/remittance, and referral authorization. CPT codes are divided into three categories to enhance the use of the CPT system by practicing physicians, managed care and other payer organizations, and researchers. Category I codes refer to the current five-digit numerical system. Category II codes are a set of optional tracking codes, developed principally for performance measurement. The CPT Category III codes are temporary codes to identify new and emerging technologies.

The CPT Book Conventions

The CPT book is self-referencing. Its introductory material provides information about its rules, format, and guidelines. The introduction to the CPT book should be carefully studied at least once by medical coders and reviewed annually for changes. Classes and correspondence courses teach medical coding and several introductory coding books convey the CPT book fundamentals. Additionally, the AMA and private consultants sponsor coding seminars to discuss changes and methods to implement these changes into regular coding practice.

The heart of this chapter is a glossary of the CPT book terminology. Consult these listings as needed to solve procedural coding problems. However, a brief primer to conventions, rules, and anomalies is presented below.

The six major sections of Category 1 codes in the CPT book are:

- Evaluation and Management (E/M)
- Anesthesiology
- Surgery
- Radiology (including nuclear medicine and diagnostic ultrasound)
- Pathology and Laboratory
- Medicine

The CPT book instructions for use indicate that as medical techniques have continued to evolve so have the distinctions between surgery and medical procedures. As a result, when a service or procedure is identified within a certain area of the book, the user should not take this to mean that the service is limited to that specific section, whether it is for insurance or other purposes such as limiting that service to use by only a particular specialty. Many times codes are placed in a particular section for historical or other reasons; for example, peripheral vascular endovascular intervention codes are listed in the Cardiovascular subsection in the surgery section, while other coronary interventions are placed in the Cardiovascular subsection in the medicine section. Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies).

The use of the phrase "physician or other qualified health care professional" was adopted to identify other health care providers in addition to physicians. This type of provider is further described in CPT as an individual "qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable)." State licensure guidelines determine the scope of practice and a qualified health care professional must practice within these guidelines, even if more restrictive than the CPT guidelines. The qualified health care professional may report services independently or under incident-to guidelines. The professionals within this definition are separate from "clinical staff" and are able to practice independently. CPT defines clinical staff as "a person who works under the supervision of a physician or other qualified health care professional and who is allowed, by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service." Keep in mind that there may be other policies or guidance that can also affect who may report a specific service.

Note that the use of the terms "physician," "other qualified health care professional," or "individual" in a code descriptor or guidelines within CPT does not preclude other entities from the reporting of that particular service or procedure.

Although required by almost all third-party payers, the existence of a CPT procedure code does not in any way guarantee payment when the work is performed. Insurance plans vary widely in reimbursement.

Format

The printed format is designed to save space while still making a great deal of sense. A key to interpreting this space-saving scheme involves the use of the semicolon (;).

A main code is typically a single-sentence description, constructed so that pertinent adjunct information follows the semicolon. The following indented codes appear only as brief adjunct information. An important coding axiom is that an indented code always includes the common portion of the preceding main code description as it appears up to and including the semicolon.

25500 Closed treatment of radial shaft fracture; without manipulation
25505 with manipulation

The complete description of code 25505 is: Closed treatment of radial shaft fracture; with manipulation. Although 25505 appears under 25500, it stands alone to describe a treatment requiring manipulation.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a five-character numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the case where the existing codes were not changed or had only minimal changes, the AMA assigns a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence. The AMA provides a summary of resequenced codes in Appendix N of the CPT book.

CPT codes within *Coders' Desk Reference for Procedures* are most often displayed in the resequenced order found in the CPT book, although there are slight differences in cases where more than one code applies to a given lay description or when the CPT book resequenced code follows an unlisted code, which this book does not include. Resequenced codes are enclosed in brackets for easy identification.

32998 [32994]
In 32998, the physician uses the heat created from high-frequency radio waves to destroy one or more tumors in the lung, pleura, or chest wall. A small incision is made in the skin of the chest and the lesion is accessed by inserting an ablation probe connected to a radiofrequency generator between the ribs. Under imaging guidance, the ablation probe is advanced into the lesion of the lung, pleura, or chest wall. Treatment with the heat probe usually takes several minutes and may include repositioning the probe within the lesion so that overlapping ablations treat the entire tumor. The incision is closed with sutures. This process may be repeated for multiple lesions within the same lung. Report 32994 when the procedure is performed using cryoablation. Imaging guidance is included in these procedures, when performed.

The following table identifies CPT codes that are not found in numerical order in *Coders' Desk Reference for Procedures*. The code that precedes the resequenced code is given to help find the correct placement in this book. **Note:** *Coders' Desk Reference* contains new codes that have been approved by the CPT Editorial Panel but are not included in the 2026 CPT book. Their placement coincides with that provided by the CPT Editorial Panel at the time this book was published.

Reimbursement Terms

AAPC. National organization for coders and billers offering certification examinations based on physician-, facility-, or payer-specific guidelines or coding documentation. Upon successful completion of the selected examination, the credential for that examination is obtained.

AAPCC. Adjusted average per capita cost. Estimated average cost of Medicare benefits for an individual based upon criteria such as age, sex, institutional status, Medicaid, disability, and end-stage renal failure.

abstractor. Person who selects and extracts specific data from the medical record and enters the information into computer files.

accountable care organization. Recognized legal entity under state law comprised of providers of services and suppliers with an established mechanism for shared governance who work together to coordinate care for Medicare fee-for-service beneficiaries. Section 3022 of the Affordable Care Act required CMS to develop a shared savings program to promote coordination and cooperation among providers for the purposes of improving the quality of care for Medicare fee-for-service beneficiaries and minimize costs.

accreditation. Evaluative process in which a health care organization undergoes an examination of its policies, procedures, and performance by an external organization to ensure it is meeting predetermined criteria. It usually involves both on- and off-site surveys.

Accredited Standards Committee. Organization accredited by the American National Standards Institute (ANSI) for the development of American national standards.

accrual. Amount of money set aside to cover a health care benefit plan's expenses based upon estimates using a combination of data, including the claims system and the plan's prior history. In facility accounting, accrual accounting records the expenses as they are incurred and the revenue as it is generated. This contrasts with cash accounting where expenses are recorded only when payment is made or revenues are recorded only when payment is received.

ACH. Automated clearinghouse. Entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction, or that receives a standard transaction from another entity and processes or facilitates the processing of that information into nonstandard format or nonstandard data content for a receiving entity.

ACO. Accountable Care Organization.

ACR. ***1)*** Adjusted community rate. Calculation of what premium the plan charges to provide Medicare-covered benefits for greater frequency of use by participants. ***2)*** American College of Radiology. ***3)*** American College of Rheumatology.

activities of daily living. Self-care activities often used to determine a patient's level of function, such as bathing, dressing, using a toilet, transferring in and out of bed or a chair, continence, eating, and walking.

actual charge. Charge a physician or supplier bills for a service rendered or a supply item.

actuarial assumptions. Characteristics used in calculating the risks and costs of a plan, including age, sex, and occupation of enrollees; location; utilization rates; and service costs.

acute care facility. Health care institution primarily engaged in providing treatment to inpatients and diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons who are in an acute phase of illness.

add-on code. Code representing a procedure performed in addition to the primary procedure and is represented with a + in the CPT book. Add-on codes are never reported for stand-alone services but are reported secondarily in addition to the primary procedure.

additional development request. Formal request from a Medicare contractor for additional information needed to determine if a claim is covered and/or payable

additional documentation request. When contractors cannot make a coverage or coding determination based upon the information on the claim and its attachments, the contractors may solicit additional documentation from the provider by issuing an ADR. Contractors must ensure that all records requested are from the period under review. Contractors must specify in the ADR the specific pieces of documentation needed (and ONLY those pieces needed) to make a coverage or coding determination.

ADG. Ambulatory diagnostic group.

adjudication. Processing and review of a submitted claim resulting in payment, partial payment, or denial. In relationship to judicial hearings, it is the process of hearing and settling a case through an objective, judicial procedure.

adjusted average per capita cost. Estimated average cost of Medicare benefits for an individual, based upon criteria including age, sex, institutional status, Medicaid, disability, and end-stage renal failure.

administrative code sets. Code sets that characterize a general business situation, rather than a medical condition or service. Under HIPAA, these are sometimes referred to as nonclinical or nonmedical code sets.

administrative services only. Contractual agreement between a self-funded plan and an insurance company in which the insurance company assumes no risk and provides administrative services only.

administrative simplification. Title II, subtitle of HIPAA, that gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. This is also the name of Title II, subtitle F, part C of HIPAA.

admission. Formal acceptance of a patient by a health care facility.

admission date. Date the patient was admitted to the health care facility for inpatient care, outpatient service, or the start of care.

ADS. Alternative delivery system. Any health care delivery system other than traditional fee-for-service.

advanced alternative payment models. Subset of Alternative Payment Models that gives added incentive payments to clinicians who provide high-quality, cost-efficient care. Advanced APMs encourage participants to earn even more rewards in exchange for taking on greater risk relative to their patients' outcomes. Advanced APMs must meet three specific criteria: require CEHRT use, base payment on MIPS-comparable quality measures, and be a Medicare Medical Home OR require participants to bear more than a nominal amount of risk.

Advanced Beneficiary Notice of Noncoverage. Written communication with a Medicare beneficiary given before Part B services are rendered informing the patient that the provider (including independent laboratories, imaging centers, physicians, practitioners, and/or suppliers) believes Medicare will not pay for some or all of the services to be rendered. Form CMS-R-131 may be used for all situations where Medicare payment is expected to be denied. ***Synonym(s):*** *ABN.*

advanced determination of Medicare coverage. Request by a supplier or beneficiary that a determination be made in advance of delivery of an item as to whether or not it is a covered item. ADMC requests are limited to items that are customized or items that have been specified as not inexpensive by the secretary. This is a voluntary program. Suppliers and beneficiaries are not required to obtain an ADMC prior to delivery of supplies, but may wish to request an ADMC when the item is customized or when the item is on the not inexpensive list.

adverse selection. In health care contracting, the risk of enrolling members who are sicker than assumed and who will utilize expensive services more frequently.

age restriction. In health care contracting, limitation of benefits when a patient reaches a certain age.

age/sex rating. Health care contracting term meaning structuring capitation payments based on members' ages and genders.

aggregate amount. Contracted maximum for which a member is insured for any single event in a health plan.

Procedural Eponyms

The medical custom of honoring a popular procedure's originator by name may prove to be problematic for the coder, who may have no trouble coding a Marshall-Marchetti but be faced with choosing one of the many Maze procedures.

The following list includes many of the procedures described by eponym in operative notes or other medical documentation; several are also included in the CPT® book.

Abbe-Estlander procedure
40527 Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)
40761 Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle
Surgical technique for a lip repair.

Adson test
95870 Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters
Physiological assessment for thoracic outlet syndrome.

Altemeier procedure
45130 Excision of rectal procidentia, with anastomosis; perineal approach
45135 Excision of rectal procidentia, with anastomosis; abdominal and perineal approach
Removal of a rectal prolapse through a perineal approach or through a combined abdominal and perineal approach.

Anderson's method of tibial lengthening
27715 Osteoplasty, tibia and fibula, lengthening or shortening
Technique in which the tibia is severed and screws are affixed to plates supporting the bone across the gap to lengthen the patient's leg.

Aries-Pitanguy mammaplasty
19318 Breast reduction
Procedure to reduce breast size.

Babcock's operation
37700 Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions
Varicose veins are eliminated using a long probe and tying the end of the vein to it to draw out the vein by invagination.

Baker tube
44021 Enterotomy, small intestine, other than duodenum; for decompression (eg, Baker tube)
Tube placed into the jejunum or small bowel for decompression or extensive adhesions.

Bankart procedure
23455 Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)
Procedure used to treat recurrent dislocation of the shoulder requiring reconstruction of the avulsed capsule and labrum at the glenoid lip.

Barany caloric test
92533 Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests)
Extent of nystagmus is determined by irrigating the external auditory meatus with hot or cold water.

Barkan operation
65820 Goniotomy
Technique corrects glaucoma by opening Schlemm's canal.

Barsky's operation
26580 Repair cleft hand
Cleft hand repaired by closing the cleft, bringing the ring and index fingers closer together, and correcting webbing between the fingers.

Batch-Spittler-McFaddin operation
27598 Disarticulation at knee
Leg is severed at the knee joint, which offers an alternative to severing a long bone.

Belsey procedure
43328 Esophagogastric fundoplasty partial or complete; thoracotomy
43334 Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis
43335 Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis
Open surgical procedure using a thoracic incision to resolve reflux.

Bender-Gestalt test
96130 Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96131 Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)
96136 Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
96137 Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
96138 Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
96139 Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
96146 Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only
Psychological test gauges perceptual-motor coordination to assess personality dynamics, review organic brain impairment, and measure neurological maturity.

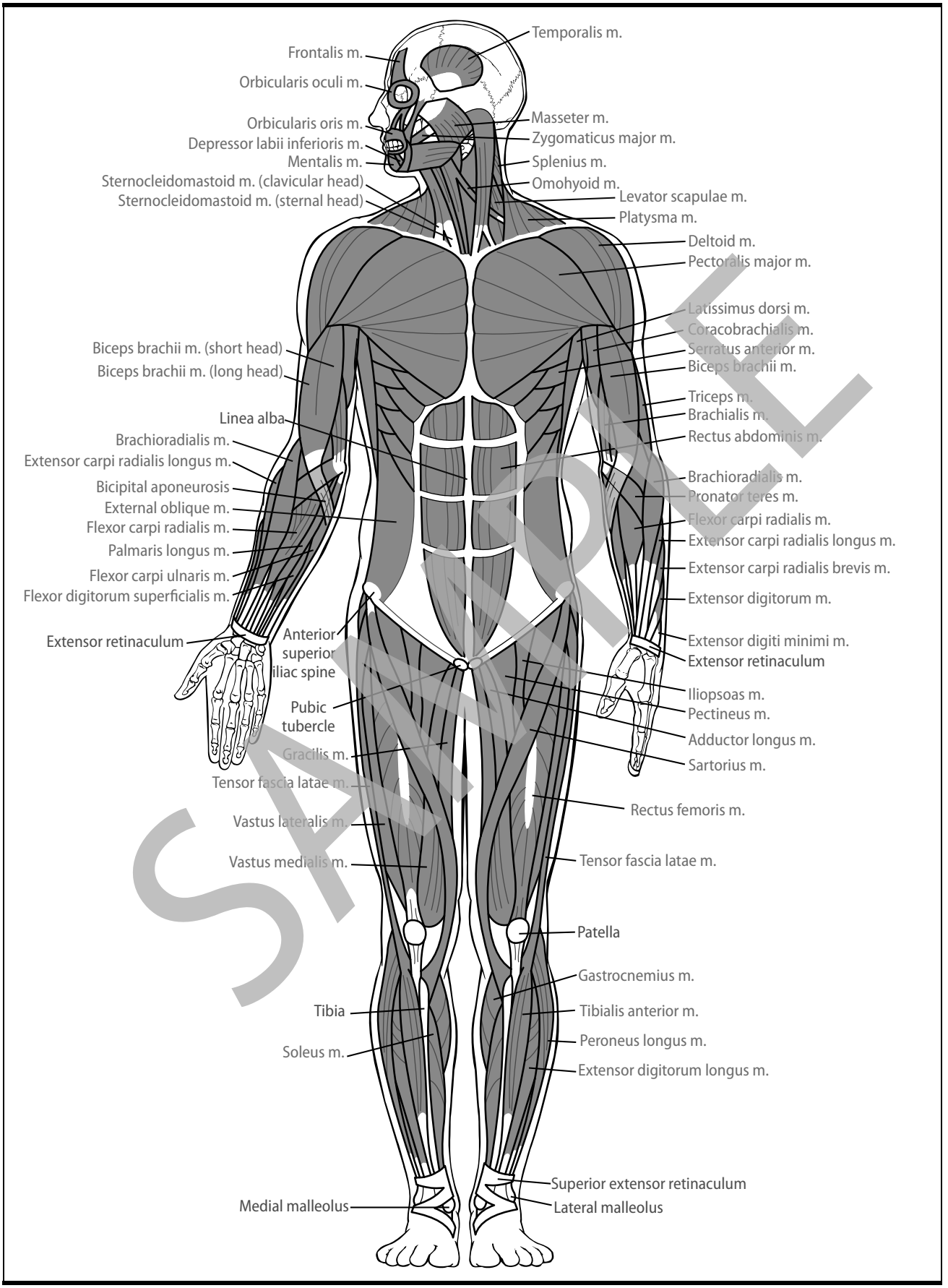
Benedict test
81005 Urinalysis; qualitative or semiquantitative, except immunoassays
Test using sodium or potassium citrate and sodium carbonate in a reagent to determine dextrose content of urine.

Bennett procedure
27430 Quadricepsplasty (eg, Bennett or Thompson type)
Correction of a shortened or fibrotic quadriceps muscle.

Bernstein test
91013 Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure)
91030 Esophagus, acid perfusion (Bernstein) test for esophagitis
Acid perfusion test used to differentiate substernal chest pain due to gastroesophageal reflux disease (GERD).

Betke-Kleihauer test
85460 Hemoglobin or RBCs, fetal, for fetomaternal hemorrhage; differential lysis (Kleihauer-Betke)
Venipuncture blood test taken to determine the amount of Rh immune globulin an Rh-negative woman should receive in order to prevent formation of antibodies against her fetus.

Muscles



CPT® Lay Descriptions

CPT® descriptions are written for people with medical training but may not offer the details needed to choose a code based on a patient's chart or an operative report. The following overview of the procedures listed in CPT describes the most common methods of each in general terms. Where possible, descriptions are in lay terms for coders' use. Key words used in the operative report are included to facilitate coding.

Unlisted procedures are excluded from this chapter. Be aware insurance payers usually review unlisted procedure codes manually, increasing processing time and the need for documentation.

Because some consecutive codes describe similar procedures, their descriptions have been combined under one heading, which indicates the range of codes described. If a satisfactory code description cannot be matched with the patient's chart, consult the physician.

Integumentary

10021 [10004, 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012]
Fine needle aspiration (FNA) is a diagnostic percutaneous procedure that uses a fine gauge needle (often 22 or 25 gauge) and a syringe to sample fluid from a cyst or remove clusters of cells from a solid mass. The skin is cleansed. If a lump can be felt, the radiologist or surgeon guides a needle into the area by palpating the lump. If the lump is non-palpable, the FNA procedure is performed using ultrasound, fluoroscopy, computed tomography (CT), or MR imaging with the patient positioned according to the area of concern. Ultrasonography-guided aspiration biopsy involves inserting an aspiration catheter needle device through the accessory channel port of the echoendoscope; the needle is placed into the area to be sampled under endoscopic ultrasonographic guidance. After the needle is placed into the region of the lesion, a vacuum is created and multiple in and out needle motions are performed. Several needle insertions are usually required to ensure that an adequate tissue sample is taken. In fluoroscopic guidance, intermittent fluoroscopy guides the advancement of the needle. CT image guidance allows computer-assisted targeting of the area to be sampled. At the completion of the procedure, the needle is withdrawn and a small bandage is placed over the area. MR image guidance involves the use of a magnetic field, radiowaves, and computer-assisted targeting to identify the area for biopsy without the use of ionizing radiation. Report 10021 for fine needle aspiration of the initial lesion performed without imaging guidance; for each subsequent lesion, report 10004. Report 10005 for FNA of the first lesion using ultrasound guidance; for each additional lesion, report 10006. Report 10007 for FNA of the first lesion using fluoroscopy; for each additional lesion, report 10008. Report 10009 for FNA of the first lesion utilizing CT imaging; for each subsequent lesion, report 10010. Report 10011 when MR imaging is used for the initial lesion; for each additional lesion, report 10012.

10030
A fluid collection in the soft tissue, such as a hematoma, seroma, abscess, lymphocele, or cyst, is drained using a catheter. The area over the abnormal tissue is cleansed and local anesthesia is administered. Imaging is performed to assist in the insertion of a needle or guidewire into the fluid collection. Small tissue samples may be collected from the site for pathological examination. A catheter is inserted to drain and collect the fluid for analysis. More imaging may be performed to ensure hemostasis. In some cases, the catheter may be attached to a drainage system to allow for further drainage over the course of days. Once the fluid has completely drained, the catheter is removed. A bandage is applied. Report 10030 for each fluid collection drained using a separate catheter.

10035-10036
The physician places a soft tissue localization device prior to a biopsy. Using image guidance, the physician places a metallic clip, pellet, wire, needle, or radioactive seed adjacent to a soft tissue lesion to mark the site for an open soft tissue procedure or a percutaneous soft tissue biopsy to be performed during the same or a different encounter. Report 10035 for the first lesion and 10036 for each additional lesion, whether on the same or the contralateral side, marked using imaging guidance.

10040
The physician makes a small incision through the skin overlying a lesion, or multiple lesions, such as comedones (blackheads), cysts, or pustules for acne surgery. The skin over the lesion is removed. The lesion is opened with a surgical instrument and the fluid is drained for secondary healing. The lesion may be removed or marsupialized by exteriorizing the cyst and making a pouch where it used to be enclosed. No sutures are needed. Do not report a benign lesion excision code (11400-11446) and chemical exfoliation for acne (17360) on same date of service with 10040.

10060-10061
The physician makes a small incision through the skin overlying an abscess for incision and drainage (e.g., carbuncle, cyst, furuncle, paronychia, hidradenitis). The abscess or cyst is opened with a surgical instrument, allowing the contents to drain. The lesion may be curetted and irrigated. The physician leaves the surgical wound open to allow for continued drainage or the physician may place a Penrose latex drain or gauze strip packing to allow continued drainage. Report 10060 for incision and drainage of a simple or single abscess. Report 10061 for complex or multiple cysts. Complex or multiple cysts may require surgical closure at a later date.

10080-10081
The physician incises and drains a pilonidal cyst. A pilonidal cyst is an abnormal pocket in the skin and subcutaneous tissue that may contain hair follicles, skin debris, fluid, and exudate. The cyst is usually located in the sacrococcygeal region near the tailbone and cleft of the buttocks. An incision overlying the pocket is made to allow drainage of the contents. The wound may be left open and packed until the cyst heals. Report 10081 if the procedure is more complicated and requires marsupialization, approximation of the wound's edges, and/or primary closure.

10120-10121
The physician removes a foreign body embedded in subcutaneous tissue. The physician makes a simple incision in the skin overlying the foreign body. The foreign body is retrieved using hemostats or forceps. The skin may be sutured or allowed to heal secondarily. Report 10121 if the procedure is more complicated, requiring dissection of underlying tissues.

10140
The physician makes an incision in the skin to decompress and drain a hematoma, seroma, or other collection of fluid. A hemostat bluntly penetrates the fluid pockets, allowing the fluid to evacuate. A latex drain or gauze packing may be placed into the incision site. This will allow the escape of any fluids that may continue to enter the pocket. A pressure dressing may be placed over the region. Any drain or packing is removed within 48 hours. The incision can be closed primarily or may be left to granulate without closure.

10160
The physician performs a puncture aspiration of an abscess, hematoma, bulla, or cyst. The palpable collection of fluid is located subcutaneously. The physician cleanses the overlying skin and introduces a large bore needle on a syringe into the fluid space. The fluid is aspirated into the syringe, decompressing the fluid space. A pressure dressing may be placed over the site.

10180
This procedure treats an infected postoperative wound. A more complex than usual incision and drainage procedure is necessary to remove the fluid and allow the surgical wound to heal. The physician first removes the surgical sutures or staples and/or makes additional incisions into the skin. The wound is drained of infected fluid. Any necrotic tissue is removed from the surgical site and the wound is irrigated. The wound may be sutured closed or packed open with gauze to allow additional drainage. If closed, the surgical site may have suction or latex drains placed into the wound. If packed open, the wound may be sutured again during a later procedure.

11000-11001
The physician surgically removes extensive diseased or infected skin. The skin may be of an eczematous nature possessing erythema, vesicles, and scales. Bacteria or fungus may be causing the skin infection. Wet compresses are used initially to remove scaly skin. Abrasive techniques may be employed to remove remaining scales. A scalpel may be used to decompress vesicles and excise dead skin. After debridement, topical lubricants and antibiotic preparations are placed on the skin. Report 11000 for up to 10 percent of the body surface. Report 11001 once for each additional 10 percent of the body surface, or part thereof, in addition to the primary procedure.

11004-11006
Debridement is carried out for a severe type of tissue infection that causes gangrenous changes, systemic disease, and tissue death. These types of infections are caused by virulent strains of bacteria, such as "flesh-eating" *Streptococcus*, and affect the skin, subcutaneous fat, fascia, and muscle tissue. Surgery is performed immediately upon diagnosis to open and drain the infected area and excise the dead or necrotic tissue. Report 11004 for surgical debridement of necrotic soft tissue of the external genitalia and perineum; 11005

34101
To remove a blood clot in the axillary, brachial, innominate, or subclavian artery, the physician makes an incision in the skin of the arm at the site of the blood clot or above it. The artery is isolated and dissected from critical structures. The artery may be clamped above and below the clot, and incised. The physician removes the blood clot and repairs the artery. The clamps are removed. If a catheter is required, it is threaded past the clot and a small balloon at its tip is inflated. The catheter is withdrawn, capturing and retrieving the clot. The physician may make several passes to remove all of the clot. The blood vessel is repaired with sutures and the skin incision is repaired with a layered closure.

34111
To remove a blood clot in the radial or ulnar artery, the physician makes an incision in the skin of the arm, over the site of the clot or immediately above it. The artery is isolated and dissected from adjacent critical structures. The artery may be clamped above and below the clot, and incised. The physician removes the blood clot and repairs the artery. The clamps are removed. If a catheter is required, it is threaded past the clot and a small balloon at its tip is inflated. The catheter is withdrawn, capturing and retrieving the clot. The physician may make several passes to remove all of the clot. The blood vessel is repaired with sutures and the skin incision is repaired with a layered closure.

34151
To remove a blood clot in the renal, celiac, mesentery, or aortoiliac artery, the physician makes an incision in the skin of the abdomen over the site of the clot or immediately above or below it. The artery is isolated and dissected from adjacent critical structures. The artery may be clamped above and below the clot and incised. The physician removes the blood clot. The clamps are removed. If a catheter is required, it is threaded past the clot and a small balloon at its tip is inflated. The catheter is withdrawn, capturing and retrieving the clot. The physician may make several passes to remove the entire clot. The blood vessel is repaired with sutures and the skin incision is repaired with a layered closure.

34201
To remove a blood clot in the femoropopliteal or aortoiliac artery, the physician makes an incision in the skin of the leg over the femoral artery. The artery is isolated and dissected from adjacent critical structures. The artery may be clamped above and below the clot and incised. The physician removes the blood clot and repairs the vessel. The clamps are removed. If a catheter is required, it is threaded past the clot and a small balloon at its tip is inflated. The catheter is withdrawn, capturing and retrieving the clot. The physician may make several passes to remove all of the clot. The blood vessel is repaired with sutures and the skin incision is repaired with a layered closure.

34203
To remove a blood clot in the popliteal-tibio-peroneal artery, the physician makes an incision in the skin of the leg over the femoral or popliteal artery. The artery is isolated and dissected from adjacent critical structures. The artery may be clamped above and below the clot and incised. The physician removes the blood clot. The clamps are removed. If a catheter is required, it is threaded past the clot and a small balloon at its tip is inflated. The catheter is withdrawn, capturing and retrieving the clot. The physician may make several passes to remove all of the clot. The blood vessel is repaired with sutures and the skin incision is repaired with a layered closure.

34401
The physician exposes the vena cava or iliac vein by making an abdominal incision. The physician identifies the thrombus by venogram and may perform a contralateral femoral venogram to rule out inferior vena caval involvement. The physician makes an incision in the vena cava or iliac vein. The physician withdraws the clot by passing a Fogarty balloon catheter beyond the clot, inflating and withdrawing the balloon. The physician may attempt to reduce the risk of pulmonary embolism by increasing intrathoracic pressure in a ventilated patient. The physician may establish proof of patency by repeat venography. The physician sutures the venotomy closed and closes the wound.

34421
To remove a blood clot in the vena cava, iliac, or femoropopliteal vein, the physician makes an incision in the skin of the upper leg over the site of the clot or immediately above or below it. The vein is isolated and dissected from adjacent critical structures. The vein may be clamped above and below the clot and incised. The physician removes the blood clot. The clamps are removed. If a catheter is required, it is threaded past the clot and a small balloon at its tip is inflated. The catheter is withdrawn, capturing and retrieving the clot. The physician may make several passes to remove all of the clot. The blood vessel is repaired with sutures and the skin incision is repaired with a layered closure.

34451
The physician exposes the vena cava, iliac, or femoropopliteal veins by making abdominal and leg incisions. The physician identifies the thrombus by venogram and may perform a contralateral femoral venogram to rule out inferior vena caval involvement. An incision is made over the site of the clot or immediately above or below it. The vein is isolated and dissected from adjacent critical structures. The vein may be clamped above and below the clot and incised. The physician removes the blood clot. The clamps are removed. The physician may cut down and introduce a Fogarty catheter via the popliteal vein, advancing the catheter toward the femoral vein while extruding thrombus through the femoral venotomy. The physician withdraws the clot by passing a Fogarty balloon catheter beyond the clot, inflating, and withdrawing the balloon. The physician may establish proof of patency by repeat venography. The physician sutures the venotomy closed and closes the wound.

34471
To remove a blood clot in the subclavian vein, the physician makes an incision in the skin of the neck over the site of the clot or immediately above or below it. The vein is isolated and dissected from adjacent critical structures. The vein may be clamped above and below the clot and incised. The physician removes the blood clot. The clamps are removed. If a catheter is required, it is threaded past the clot and a small balloon at its tip is inflated. The catheter is withdrawn, capturing and retrieving the clot. The physician may make several passes to remove the entire clot. The blood vessel is repaired with sutures and the skin incision is repaired with layered closure.

34490
To remove a blood clot in the axillary and subclavian vein, the physician makes an incision in the skin of the arm over the site of the clot or immediately above or below it. The vein is isolated and dissected from adjacent critical structures. The vein may be clamped above and below the clot and incised. The physician removes the blood clot. The clamps are removed. If a catheter is required, it is threaded past the clot and a small balloon at its tip is inflated. The catheter is withdrawn, capturing and retrieving the clot. The physician may make several passes to remove the entire clot. The blood vessel is repaired with sutures and the skin incision is repaired with layered closure.

34501
The physician makes an incision in the skin overlying the site of the incompetent valve. The femoral vein is isolated and dissected from adjacent critical structures. The physician affixes vessel clamps above and below the malfunctioning valve. The physician opens the vein and repairs the valve leaflets by suture plication (tacking the excess valve material). The vein is repaired with sutures. The clamps are removed and the skin incision is repaired with a layered closure.

34502
The physician exposes the inferior vena cava by making an incision in the anterior abdomen. Clamps are placed on the vena cava proximally and any defects are sutured closed. Abnormal vena caval tissue may be replaced or bypassed with synthetic graft material. An injection of intravenous contrast may be administered under fluoroscopy to demonstrate appropriate flow. The clamps are removed and the abdominal wall incision is closed. A surgical drain may be left in place at the conclusion of the procedure.

34510
The physician makes an incision in the skin overlying the site of the malfunctioning valve. The vein is isolated and dissected from adjacent critical structures. The physician affixes vessel clamps above and below the vein and excises the section of vein containing the malfunctioning valve. A section of harvested vein containing functional valves is sutured end-to-end to the vein. The clamps are removed and the skin incision is repaired with a layered closure.

34520
The physician makes an incision in the skin overlying the site of the incompetent valve. The incompetent vein is isolated and dissected from adjacent critical structures. The physician affixes vessel clamps above and below the vein. The divided section of incompetent vein is connected to a nearby vein with functioning valves, placing competent valves above the incompetent vein. Both the vein and the skin incision are closed with sutures.

34530
The physician makes an incision in the skin overlying the site of the greater saphenous vein just below the knee. The vein is isolated and dissected from adjacent critical structures. The physician affixes vessel clamps above and below the incision site. The dissected section of saphenous vein is connected to the popliteal vein in an end-to-side anastomosis. The other end of the saphenous vein is closed with sutures. Once the saphenous vein and the popliteal vein are connected, the clamps are removed and the skin incision is repaired with layered closure.

34701-34702
The physician introduces, positions, and deploys an endograft to treat abdominal aortic conditions, with or without rupture, such as an aneurysm, pseudoaneurysm, dissection, penetrating ulcer, or traumatic disruption located in the infrarenal abdominal aorta that may or may not extend into the iliac

69970
A vertical incision is made just anterior to the auricle and is extended superiorly to expose the temporalis muscle. The muscle is divided. A section of the skull (craniotomy) is removed to expose the dura over the temporal lobe of the brain. The dura is elevated off the floor of the middle fossa. The physician isolates and dissects a tumor of the temporal bone. The internal auditory canal may be decompressed. A muscle graft is placed over the internal auditory canal. The bone plug is returned to the skull, the incision is sutured, and a dressing is applied.

69990
The physician uses a surgical microscope when the services are performed using the techniques of microsurgery, except when the microscopy is part of the procedure (such as in 15756). This code is reported in addition to the primary procedure.

Radiology

70010
A radiographic study using fluoroscopy is performed on the posterior fossa when a lesion is suspected, or to detect cerebrospinal fluid (CSF) leaks or normal pressure hydrocephalus (NPH). Contrast medium, usually barium sulfate, may be used to enhance visibility and is instilled in the patient through a lumbar area puncture into the subarachnoid space. The radiologist takes a series of pictures by sending an x-ray beam through the body, using fluoroscopy to view the enhanced structure on a television camera. The patient is angled from an erect position through a recumbent position with the body tilted so as to maintain feet higher than the head to help the flow of contrast into the study area.

70015
A radiographic study is performed that maps the tumor pathology of a mass within the posterior fossa. The brainstem and cerebellum are contained within the posterior fossa and the cerebellopontine angle cistern is often the location of a mass, such as a schwannoma or meningioma. Images are taken sequentially over a period of hours and days after introducing a radiotracer intrathecally by lumbar puncture. Cisternography may also be used to detect cerebrospinal fluid (CSF) leaks or normal pressure hydrocephalus (NPH).

70030
X-rays of the eyes are obtained to determine the location of a foreign body in the eye. After positioning the patient, a one- or two-view x-ray is obtained. Transparent objects such as glass may not be good candidates for x-ray visualization. The physician supervises the procedure and interprets and reports the findings.

70100-70110
The lower jaw bone is x-rayed. In 70100, three or less projections are taken for a partial view of the bone structure and in 70110, four or more projections are taken for a complete view of the bone structure.

70120
Films are taken of the mastoid processes, or lower portion of the temporal bone of the skull, which protrudes just behind the ear. Both mastoid processes are always examined for comparison purposes, and it is essential that the radiographs be exact duplicates in both positioning of the site and technical quality. Several varying views may be taken, but the key element of this procedure is that it reports less than three views per side.

70130
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70134
Films are taken of the petrous portions of the skull to demonstrate internal auditory meati, or organs of hearing. Several different views may be taken, both with varying angulation of the x-ray beam, as well as varying the position of the patient's skull.

70140
X-rays of the facial bones are obtained to determine an injury, fracture, or neoplasm. After positioning the patient, less than three views of the facial bones are obtained. The physician supervises the procedure and interprets and reports the findings.

70150
X-rays of the facial bones are obtained to determine an injury, fracture, or neoplasm. After positioning the patient, a complete series of x-rays of the facial bones, with a minimum of three views, is obtained. The physician supervises the procedure and interprets and reports the findings.

70160
Films are taken of the nasal bones to include a complete exam, or minimum of three views. Typically, this exam would consist of both right and left lateral (side to side) for comparison, as well as a tangential projection in which the x-ray beam is directed from a position above the patient's head down through the nose. This view is primarily used to demonstrate the medial or lateral (side to side) displacement of nasal fractures.

70170
Dacryocystography is the radiographic evaluation of the lacrimal system to localize the site of an obstruction. One cc of a water-soluble contrast medium is injected through the lower canaliculus and x-rays of the excretory system are obtained. The physician supervises the procedure and interprets and reports the findings.

70190
Radiological examination of the optic foramina is useful in the evaluation of trauma, tumors, or foreign bodies. After positioning the patient, the radiologist obtains x-rays of the optic foramina. The physician supervises the procedure and interprets and reports the findings.

70200
Radiological examination of the orbits is useful in the evaluation of trauma, tumors, or foreign bodies. After positioning the patient, the radiologist obtains a minimum of four x-ray views of the orbits. Standard methods include posteroanterior (PA) exposures from two different positions, lateral views, optic canal projections, and oblique views of each side for comparison. The physician supervises the procedure and interprets and reports the findings.

70210
Films are taken of the paranasal sinuses in one or two views. Although there are several sinus projections, each serving a specific purpose, many of them are used only when required to visualize a specific lesion. Typically, but not necessarily, this code calls for a side to side (lateral) view and a back to front (PA) view, depending on the specific sinus in question. The projections are routinely taken with the patient in an erect position to demonstrate presence or absence of fluid.

70220
Films are taken of the paranasal sinuses for a complete study, with a minimum of three views. There are several sinus projections used when required to visualize a specific lesion. Projections routinely taken consist of four to five standard views of the skull, which adequately demonstrate all the paranasal sinuses on most patients. Specific exams may be included to test a particular sinus (e.g., frontal sinus, maxillary sinus, and sphenoid or ethmoid sinuses). These projections are routinely taken with the patient in an erect position to demonstrate presence or absence of fluid.

70240
Films are taken of the sella turcica, the depression within the sphenoid bone that houses the pituitary gland. The patient is placed in the prone semioblique position and the x-ray beam is directed to a spot slightly anterior and superior to the external auditory meatus while the patient's head is maintained in a lateral position.

70250-70260
Films are taken of the skull bones. In 70250, three or less views are taken, and in 70260, a complete exam with a four view minimum is performed. The most common projections for routine skull series are AP axial (front to back), lateral, and PA axial (back to front). X-rays may be taken with the patient placed erect, prone, or supine and either code may include stereoradiography, which is a technique that produces three-dimensional images.

70300-70320
Films are taken of the mouth to show teeth and/or surrounding bone. In dental radiography, the film may be placed inside or outside the mouth. Code 70300 reports a single view only, 70310 reports a partial examination, and 70320 reports a complete full mouth exam.

70328-70330
The temporomandibular joint is x-rayed in two projections on one side only in 70328 and in two projections on both sides in 70330. One film is taken with the mouth open and one with the mouth closed.

70332
A radiographic contrast study is performed on the temporomandibular joint. A contrast material is injected into the joint spaces, followed by x-ray examination of the joint. This allows the physician to see the position of the structures not normally seen on conventional x-rays.

