

**20206 Biopsy, muscle, percutaneous needle**

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(If imaging guidance is performed, see 76942, 77012, 77021)

(For fine needle aspiration, use 10021 or 10022)

(For evaluation of fine needle aspirate, see 88172 - 88173)

(For excision of muscle tumor, deep, see specific anatomic section)

**CATEGORY NOTES****Excision****General****Musculoskeletal System**

Cast and strapping procedures appear at the end of this section.

The services listed below include the application and removal of the first cast or traction device only. Subsequent replacement of cast and/or traction device may require an additional listing.

**Definitions**

The terms "closed treatment," "open treatment," and "percutaneous skeletal fixation" have been carefully chosen to accurately reflect current orthopaedic procedural treatments. Treatment is used when a fracture is stabilized by an intramedullary implant, as this procedure may be performed either "open" or "closed". In "closed" intramedullary nailing, the fracture fragments are not visualized, but an intramedullary nail is inserted across the fracture site, with the aid of x-ray imaging. As such, a closed nailing procedure is neither open (where the fracture site is visualized and reduced under direct vision) nor is it strictly closed (because the fracture hematoma can communicate with the outside environment).

***Closed treatment***

Specifically means that the fracture site is not surgically opened (exposed to the external environment and directly visualized). This terminology is used to describe procedures that treat fractures by three methods: 1) without manipulation 2) with manipulation 3) with or without traction.

***Open Treatment***

Is used when the fractured bone is either (1) surgically opened (exposed to the external environment) and the fracture (bone ends) visualized and internal fixation may be used or (2) the fractured is opened remote from the fracture site in order to insert an intramedullary nail across the fractured site (the fracture site is not opened and visualized).

***Percutaneous Skeletal Fixation***

Describes fracture treatment which is neither open nor closed. In this procedure, the fracture fragments are not visualized, but fixation (eg, pins) is placed across the fracture site, usually under x-ray imaging.

The type of fracture (eg, open, compound, closed) does not have any coding correlations with the type of treatment (eg, closed, open, percutaneous) provided.

The codes for treatment of fractures and joint injuries (dislocations) are categorized by the type of manipulation (reduction) and stabilization (fixation or immobilization). These codes can apply to either open (compound) or closed fractures or joint injuries.

Skeletal traction is the application of a force (distracting or traction force) to a limb segment through a wire, pin, screw, or clamp that is attached (eg, penetrates) to bone.

Skin is the application of a force (longitudinal) to a limb using felt or strapping applied directly to skin only.

External fixation is the use of skeletal pins plus an attaching mechanism/device used for temporary or

definitive treatment of acute or chronic bony deformity.

Codes for obtaining autogenous bone grafts, cartilage, tendon, fascia lata grafts or other tissues through separate incisions are to be used only when the graft is not already listed as a part of the basic procedure.

Re-reduction of a fracture and/or dislocation performed by the primary physician may be identified by the addition of modifier '76' to the usual procedure number to indicate "Repeat Procedure by Same Physician." (see guidelines)

Codes for external fixation are to be used only when external fixation is not already listed as a part of the basic procedure.

All codes for suction irrigation have been deleted. To report, list only the primary surgical procedure performed (eg, sequestrectomy, deep incision).

#### **Manipulation**

Is used throughout the musculoskeletal fracture and dislocation subsections to specifically mean the attempted reduction or restoration of a fracture or joint dislocation to its normal anatomic alignment by the application of manually applied forces.

(For computer assisted musculoskeletal surgical navigational orthopedic procedures, report 0054T-0056T)

### [SECTION NOTES](#)

## **Surgery Guidelines**

Items used by all physicians in reporting their services are presented in the Introduction. Some of the commonalities are repeated here for the convenience of those physicians referring to this section on Surgery. Other definitions and items unique to Surgery are also listed.

## **Physicians' Services**

Physicians' services rendered in the office, home, or hospital, consultations, and other medical services are listed in the section entitled Evaluation and Management Services (99201 - 99499) found in the front of the book, beginning on page 9. "Special Services and Reports" (99000 series) is presented in the Medicine section.

## **CPT Surgical Package Definition**

The services provided by the physician to any patient by their very nature are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services "included" in a given CPT surgical code, the following services are always included in addition to the operation per se:

- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia;
- Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical);
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians;
- Writing orders;
- Evaluating the patient in the postanesthesia recovery area;
- Typical postoperative follow-up care.

## Follow-Up Care for Diagnostic Procedures

Follow-up care for diagnostic procedures (eg, endoscopy, arthroscopy, injection procedures for radiography) includes only that care related to recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be listed separately.

## Follow-Up Care for Therapeutic Surgical Procedures

Follow-up care for therapeutic surgical procedures includes only that care which is usually a part of the surgical service. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services should be separately reported.

## Materials Supplied by Physician

Supplies and materials provided by the physician (eg, sterile trays/drugs), over and above those usually included with the procedure(s) rendered are reported separately. List drugs, trays, supplies, and materials provided. Identify as 99070 or specific supply code.

## Reporting More Than One Procedure/Service

When a physician performs more than one procedure/service on the same date, same session or during a post-operative period (subject to the "surgical package" concept), several CPT modifiers may apply. (See Appendix A for definition.)

### -27 Multiple Outpatient Hospital E/M Encounters on the Same Date

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (eg, hospital emergency department, clinic).

Note: This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (eg, hospital emergency department, clinic), see Evaluation and Management, Emergency Department, or Preventive Medicine Services codes.

### -51 Multiple Procedures

When multiple procedures/services (other than evaluation and management) are performed at the same session, report the most significant procedure first, with all other procedures listed with modifier 51 appended. For a list of procedures exempt from the use of modifier 51, see Appendices D and E.

### -58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

When a procedure(s) is prospectively planned as a staged procedure, or when the secondary and subsequent procedure(s) is more extensive, or to indicate therapy following a diagnostic surgical procedure, use modifier 58 with the staged procedure(s).

### -59 Distinct Procedural Service

For procedure(s)/service(s) not ordinarily performed or encountered on the same day by the same physician, but appropriate under certain circumstances (eg, different site or organ system, separate

excision or lesion), use modifier 59.

### **-76 Repeat Procedure by Same Physician**

When a procedure or service is repeated by the same physician subsequent to the original service, use modifier 76.

### **-77 Repeat Procedure by Another Physician**

When a procedure is repeated by another physician subsequent to the original service, use modifier 77.

### **-78 Return to the Operating Room for a Related Procedure During the Postoperative Period**

When a procedure, related to the initial procedure, requires a return to the operating room during the postoperative period of that initial procedure, use modifier 78.

### **-79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period**

When a procedure, unrelated to the initial procedure, is performed by the same physician during the postoperative period of the initial procedure, use modifier 79.

### **-91 Repeat Clinical Diagnostic Laboratory Test**

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

## **Separate Procedure**

Some of the procedures or services listed in CPT that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term "separate procedure." The codes designated as "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

However, when a procedure or service that is designated as a "separate procedure" is carried out independently or considered to be unrelated or distinct from other procedures/services provided at that time, it may be reported by itself, or in addition to other procedures/services by appending modifier 59 to the specific "separate procedure" code to indicate that the procedure is not considered to be a component of another procedure, but is a distinct, independent procedure. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury or area of injury in extensive injuries).

## **Subsection Information**

Several of the subheadings or subsections have special needs or instructions unique to that section. Where these are indicated (eg, "Maternity Care and Delivery"), special "Notes" will be presented preceding those procedural terminology listings, referring to that subsection specifically. If there is an "Unlisted Procedure" code number (see below) for the individual subsection, it will also be shown. Those subsections within the Surgery section that have "Notes" are as follows:

Biopsy	11100-11101
Removal of Skin Tags	11200-11201
Shaving of Lesions	11300-11313

Excision-Benign Lesions	11400-11471
Excision-Malignant Lesions	11600-11646
Repair (Closure)	12001-13160
Adjacent Tissue Transfer or Rearrangement	14000-14350
<b>Skin Replacement Surgery and Skin Substitutes</b>	<b>15002-15431</b>
Allograft and Tissue Cultured	
Allogeneic Skin Substitutes	15300-15366
Xenograft	15400-15431
Flaps (Skin and/or Deep Tissue)	15570-15999
<b>Burns, Local Treatment</b>	<b>16000-16036</b>
<b>Destruction</b>	<b>17000-17286</b>
<b>Mohs Micrographic Surgery</b>	<b>17311-17315</b>
Breast - Excision	19100-19272
Musculoskeletal	20000-29999
Wound Exploration-Trauma	20100-20103
Grafts (or Implants)	20900-20999
Spine: (Vertabral Column)	22100-22855
Spine: Excision	22100-22116
Spine: Osteotomy	22210-22226
Spine: Fracture/Dislocation	22305-22328
Spine: Arthrodesis	22548-22812
Spine: Exploration	22830
Spinal Instrumentation	22840-22855
Casting and Strapping	29000-29750
Cardiovascular System	33010-37799
Musculoskeletal:	
Endoscopy/Arthroscopy	29800-29999
Respiratory: Endoscopy	31231-31294
	31505-31579
	31615-31656
	32601-32665
Cardiovascular System	33010-37799
Pacing Cardioverter- Pacemaker or Defibrillator	33200-33249
<b>Electrophysiologic Procedures</b>	<b>33250-33266</b>
Venous-CABG	33510-33516
Arteries and Veins	34001-35907
Endovascular Repair of Abdominal Aortic Aneurysm	34800-34826
Endovascular Repair of Iliac Aneurysm	34900
Transluminal Angioplasty	35450-35476
Transluminal Atherectomy	35480-35495
Bypass Grafts	35500-35572
Composite Grafts	35681-35683
Adjuvant Techniques	35685-35686
Vascular Injection Procedures;	
Intravenous	36000-36015
Central Venous Access Procedures	36555-36597
Transcatheter Procedures:	
Intravenous	37195-37216
Intravascular Ultrasound	37250-37251
Bone Marrow or Stem Cell Services/Procedures	38204-38242
Hemic and Lymphatic Systems:	
Laparoscopy	35870-38589

Digestive:	
Endoscopy/Laparoscopy	43200-43272
	43280-43289
	43651-43659
	43770-43774
	44180-44238
	44360-44397
	44970-44979
	45300-45387
	45395-45397
	45400-45402
	46600-46615
	47370-47379
	47550-47556
	47560-47562
	49320-49329
	49650-49659
Pancreas Transplantation	48550-48556
Herniotomy	49491-49611
Renal Transplantation	50300-50380
Urodynamics	51725-51798
Endoscopy/Laparoscopy	
Urinary	50541-50545
	50945-50980
	51990 -52648
Male Genital	54690-54699
	55500-55559
	55866
Female Genital	58454-58579
	58660-58679
Endocrine	60650-60659
Maternity Care and Delivery	59000-59899
Nervous System:	
Surgery of Skull Base	61580-61619
Neurostimulators	
(Intracranial)	61850-61888
	62160-62319
Neurostimulators (Spinal)	63650-63688
Neurostimulators	
(Peripheral Nerve)	64553-64595
Secondary Implants(s)	65125-65175
Removal Cataract	66830-66999
Prophylaxis	67141-67145
Excision	67800-67820
Reconstruction	67930-67899
Operating Microscope	69990

## Unlisted Service or Procedure

A service or procedure may be provided that is not listed in this edition of CPT. When reporting such a service, the appropriate "Unlisted Procedure" code may be used to indicate the service, identifying it by "Special Report" as discussed in the section below. The "Unlisted Procedures" and accompanying codes for Surgery are as follows:

- 15999 Unlisted procedure, excision pressure ulcer
- 17999 Unlisted procedure, skin, mucous membrane and subcutaneous tissue
- 19499 Unlisted procedure, breast
- 20999 Unlisted procedure, musculoskeletal system, general
- 21089 Unlisted maxillofacial prosthetic procedure
- 21299 Unlisted craniofacial and maxillofacial procedure
- 21499 Unlisted musculoskeletal procedure, head
- 21899 Unlisted procedure, neck or thorax

22899 Unlisted procedure, spine  
22999 Unlisted procedure, abdomen, musculoskeletal system  
23929 Unlisted procedure, shoulder  
24999 Unlisted procedure, humerus or elbow  
25999 Unlisted procedure, forearm or wrist  
26989 Unlisted procedure, hands or fingers  
27299 Unlisted procedure, pelvis or hip joint  
27599 Unlisted procedure, femur or knee  
27899 Unlisted procedure, leg or ankle  
28899 Unlisted procedure, foot or toes  
29799 Unlisted procedure, casting or strapping  
29999 Unlisted procedure, arthroscopy  
30999 Unlisted procedure, nose  
31299 Unlisted procedure, accessory sinuses  
31599 Unlisted procedure, larynx  
31899 Unlisted procedure, trachea, bronchi  
32999 Unlisted procedure, lungs and pleura  
33999 Unlisted procedure, cardiac surgery  
36299 Unlisted procedure, vascular injection  
37501 Unlisted vascular endoscopy procedure  
37799 Unlisted procedure, vascular surgery  
38129 Unlisted laparoscopy procedure, spleen  
38589 Unlisted laparoscopy procedure, lymphatic system  
38999 Unlisted procedure, hemic or lymphatic system  
39499 Unlisted procedure, mediastinum  
39599 Unlisted procedure, diaphragm  
40799 Unlisted procedure, lips  
40899 Unlisted procedure, vestibule of mouth  
41599 Unlisted procedure, tongue, floor of mouth  
41899 Unlisted procedure, dentoalveolar structures  
42299 Unlisted procedure, palate, uvula  
42699 Unlisted procedure, salivary glands or ducts  
42999 Unlisted procedure, pharynx, adenoids, or tonsils  
43289 Unlisted laparoscopy procedure, esophagus  
43499 Unlisted procedure, esophagus  
43659 Unlisted laparoscopy procedure, stomach  
43999 Unlisted procedure, stomach  
44238 Unlisted laparoscopy procedure, intestine (except rectum)  
44799 Unlisted procedure, intestine  
44899 Unlisted procedure, Meckel's diverticulum and the mesentery  
44979 Unlisted laparoscopy procedure, appendix  
45499 Unlisted laparoscopy procedure, rectum  
45999 Unlisted procedure, rectum  
46999 Unlisted procedure, anus  
47379 Unlisted laparoscopic procedure, liver  
47399 Unlisted procedure, liver  
47579 Unlisted laparoscopy procedure, biliary tract  
47999 Unlisted procedure, biliary tract  
48999 Unlisted procedure, pancreas  
49329 Unlisted laparoscopy procedure, abdomen, peritoneum and omentum  
49659 Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy  
49999 Unlisted procedure, abdomen, peritoneum and omentum  
50549 Unlisted laparoscopy procedure, renal  
50949 Unlisted laparoscopy procedure, ureter  
51999 Unlisted laparoscopy procedure, bladder  
53899 Unlisted procedure, urinary system  
54699 Unlisted laparoscopy procedure, testis  
55559 Unlisted laparoscopy procedure, spermatic cord  
55899 Unlisted procedure, male genital system  
58578 Unlisted laparoscopy procedure, uterus  
58579 Unlisted hysteroscopy procedure, uterus  
58679 Unlisted laparoscopy procedure, oviduct, ovary

58999 Unlisted procedure, female genital system (nonobstetrical)  
59897 Unlisted fetal invasive procedure, including ultrasound guidance  
59898 Unlisted laparoscopy procedure, maternity care and delivery  
59899 Unlisted procedure, maternity care and delivery  
60659 Unlisted laparoscopy procedure, endocrine system  
60699 Unlisted procedure, endocrine system  
64999 Unlisted procedure, nervous system  
66999 Unlisted procedure, anterior segment of eye  
67299 Unlisted procedure, posterior segment  
67399 Unlisted procedure, ocular muscle  
67599 Unlisted procedure, orbit  
67999 Unlisted procedure, eyelids  
68399 Unlisted procedure, conjunctiva  
68899 Unlisted procedure, lacrimal system  
69399 Unlisted procedure, external ear  
69799 Unlisted procedure, middle ear  
69949 Unlisted procedure, inner ear  
69979 Unlisted procedure, temporal bone, middle fossa approach

## Results/Testing/Reports

Results are the technical component of a service. Testing leads to results; results lead to interpretation. Reports are the work product of the interpretation of numerous test results.

## Special Report

A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service. Additional items which may be included are:

- Complexity of symptoms
- Final diagnosis
- Pertinent physical findings (such as size, locations, and number of lesion(s), if appropriate)
- Diagnostic and therapeutic procedures (including major and supplementary surgical procedures, if appropriate)
- Concurrent problems
- Follow-up care

## Surgical Destruction

Surgical destruction is a part of a surgical procedure and different methods of destruction are not ordinarily listed separately unless the technique substantially alters the standard management of a problem or condition. Exceptions under special circumstances are provided for by separate code numbers.