OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUN 25 2009

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE (COMPTROLLER)

SUBJECT: Medical, Dental, and Cosmetic Surgery Reimbursement Rates

The attached document contains the updated Calendar Year (CY) 2009 Department of Defense (DoD) Medical, Dental, and Cosmetic Surgery Reimbursement Rates. The rates are to be used by military treatment facilities, effective July 1, 2009, until superseded. The CY 2008 rates will be superseded by these CY 2009 rates.

The TRICARE Management Activity (TMA) requests this package be posted to DoD Comptroller's Web site: http://www.defenselink.mil/comptroller/rates/fy2009.html.

My point of contact for this action is Mr. Thomas Sadauskas, TMA Uniform Business Office, who may be reached at (703) 681-5827 or Thomas.Sadauskas@tma.osd.mil.

Ellen P. Embrey
Performing the Duties of the
Assistant Secretary of Defense
(Health Affairs)

Attachment:
As stated

Department of Defense Uniform Business Office
Medical, Dental and Cosmetic Surgery
Reimbursement Rates
Calendar Year 2009

1. Introduction

1.1. In accordance with Title 10, United States Code, Section 1095, the Department of Defense (DoD) Uniform Business Office (UBO) developed the Calendar Year (CY) 2009 medical, dental, and cosmetic surgery reimbursement rates. These are charges for professional and institutional health care services provided in military treatment facilities (MTFs) operated as part of the Defense Health Program. These rates are used to submit claims for reimbursement of the costs of the health care services provided by MTFs in accordance with the various MTF Cost Recovery Programs: Medical Services Account (MSA), Third Party Collections Program and Medical Affirmative Claims.

1.1.1. The Fiscal Year (FY) 2009 inpatient rates released October 1, 2008, remain in effect until further notice.

1.2. The CY 2009 outpatient medical and dental rates and CY 2009 cosmetic surgery rates are effective for health care services provided on or after July 1, 2009.

1.3. This CY 2009 Outpatient Medical, Dental and Cosmetic Surgery Reimbursement Rate Package contains the following rates:

- Section 3.2: Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC) Rate Tables
- Section 3.3: Dental Rates
- Section 3.4: Immunization/Injectables Rates
- Section 3.5: Anesthesia Rate
- Section 3.6: Durable Medical Equipment/Durable Medical Supplies Rates
- Section 3.7: Transportation Rates
- Section 3.8: Other Rates
- Section 4.0: Cosmetic Surgery Rates
- Appendix A: Elective Cosmetic Surgery Procedures

1.4. Due to size, the sections containing the CHAMPUS CMAC and dental rates

modified for UBO use are not included in this package. These rates are available from the TRICARE Management Activity (TMA) UBO Web site: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

2. Government Billing Calculation Factors

2.1. Full Outpatient Rate (FOR) and Full Inpatient Reimbursement Rate (FRR). The FOR and FRR, when appropriate, are used for claims submission to third party payers and to all other applicable payers not included within International Military Education and Training (IMET) and Interagency/Other Federal Agency Sponsored Rate (IOR) billing guidance. FOR and FRR discounts for IMET and IOR are calculated based on an analysis of FY 2008 expense and workload data from all DoD MTFs that offered outpatient and inpatient services. The data analysis included processing to identify and eliminate poor quality data. It also included adjustments of the FY 2008 data to account for FY 2009 military and civilian pay raises, an asset use charge, distribution of expenses between payroll and non-payroll expense categories, and a DoD inflation adjustment. Discount rates for IMET and IOR are calculated by removing from the FOR and FRR those types of expenses, which are specifically excluded from consideration in IMET and Interagency billing. The rates included in section 3 represent the FOR (unless otherwise specified). IOR rates exclude the "Miscellaneous Receipts" (asset use charge percentage for military pay, civilian pay and other) portion of the FOR/FRR price computation. IMET rates exclude both the "Miscellaneous Receipts" portion and the "Military Personnel" portion of the FOR/FRR price computation.

2.2. Discount. A government billing calculation factor (percentage discount) is applied to the FOR when billing for services as described below.

2.2.1. International Military Education and Training (IMET) rate:

- IMET discount applied to health care services unless listed separately below:
  - 63.17% of the FOR
- Ambulance: 63.14% of the FOR
- Anesthesia: 61.79% of the FOR
- Dental: 50.00% of the FOR
- Immunization: 62.96% of the FOR
- Aeromedical Evacuation–Ambulatory: 63.00% of the FOR
  Aeromedical Evacuation–Litter: 53.94% of the Inpatient FRR

2.2.2. Interagency/Other Federal Agency Sponsored Rate (IOR):

- IOR discount applied to health care services unless listed separately below:
    - 94.31% of the FOR
- Ambulance: 94.07% of the FOR
- Anesthesia: 94.23% of the FOR
- Dental: 95.00% of the FOR
- Immunization: 94.44% of the FOR
- Aeromedical Evacuation–Ambulatory: 94.00% of the FOR
- Aeromedical Evacuation–Litter: 94.83% of the Inpatient FRR

3. Outpatient Medical and Dental Services Rates/Charges

3.1. Terminology.

3.1.1. Ambulatory Procedure Visit (APV). An APV is defined in DoD Instruction 6025.8, Ambulatory Procedure Visit (APV), September 23, 1996, as a procedure or surgical intervention that requires pre-procedure care, a procedure to be performed, and immediate post-procedure care as directed by a qualified health care provider. Minor procedures that are performed in an outpatient clinic setting that do not require post-procedure care by a medical professional are not be considered APVs. The nature of the procedure and the medical status of the patient combine for a requirement for short-term care, but not inpatient care. These procedures are appropriate for all types of patients (obstetrical, surgical and non surgical) who by virtue of the procedure or anesthesia require post-procedure care and/or monitoring by medical personnel.

3.1.2. Ambulatory Procedure Unit (APU). An APU is a location or organization within an MTF (or freestanding outpatient clinic) that is specially equipped, staffed, and designated for the purpose of providing the intensive level of care associated with APVs.

3.1.3. Emergency Department Services. MTF ambulatory services furnished in the Emergency Department are strictly institutional charges.

3.1.4. Observation Services. MTF ambulatory services furnished in Observation (OBS) Units are strictly institutional charges.

3.1.5. Outpatient Services. Services rendered in a location other than the observation unit, the Emergency Department, or APU.

3.2. CMAC Rate Tables.

3.2.1. Professional Component.

3.2.1.1. CHAMPUS CMAC reimbursement rates, established under Title 32, Code of Federal Regulations, Section 199.14(h) are used to determine the appropriate charge for the professional and technical components of services based on the Healthcare Common Procedure Coding System (HCPCS) methodology, which includes the Current Procedural Terminology (CPT) codes. CMAC rates pertain to outpatient services (e.g., office and clinic visits), and ancillary services (e.g., laboratory and radiology). UBO CMAC rates differ from standard TMA CMAC rates in that UBO CMAC rates include charges for additional services not reimbursed by TRICARE.

3.2.1.2. UBO CMAC rates are calculated for 91 distinct "localities." These localities recognize differences in local costs to provide health care services in the many different geographic regions in which MTFs are located. Each MTF Defense Military Information System Identification (DMIS ID) is mapped to its corresponding CMAC locality code to obtain the correct rates. For all military treatment facilities located outside the continental United States and Hawaii (OCONUS), CMAC locality (391) is used. The complete DMIS ID-to-CMAC Locality Table is available at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

3.2.1.3. For each CMAC locality, the UBO creates two sub-tables of rates: CMAC and Component. The CMAC rate table specifies the rates to use as payment for professional services and procedures identified by CPT and HCPCS codes, which cannot be separately provided as Component services. The CMAC table is further categorized by provider class. The Component rate table specifies the rates to use for CPT codes, which can be provided as distinct professional and technical components, or as a combined professional and technical service. A separate rate is provided for each component, further categorized by provider class.

3.2.1.4. CMAC Provider Class. The UBO CMAC rates are computed based on the four provider classes: 1) Physicians, 2) Psychologists, 3) Other Mental Health Providers, and
4) Other Medical Providers. UBO CMAC-based rates described in section 3.2.1.1. are available at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

3.2.2. Institutional Component.

3.2.2.1. Emergency Department (ED). TRICARE Ambulatory Payment Classification (APC) rates for ED Evaluation and Management services are used to determine the DoD ED institutional charges. For CPT codes 99281-99285 only the institutional component is billed.

NOTE: Ambulance transport to the ED and from the ED to another location is not part of the ED institutional rate and is billed separately.

3.2.2.2. Observation (OBS). The CPT codes used for Observation services include: 99218-99220. The rates for these Observation services are derived using Medical Expense and Performance Reporting System (MEPRS) cost data to determine the hourly OBS rate. The hourly OBS rate is then multiplied by the average FY 2008 OBS patient stay of 7.07 hours. Only the institutional charge is billed.

3.2.2.3. Ambulatory Procedure Visit (APV) Rate. There is an institutional flat rate for all APV procedures/services. The flat rate is based on the institutional cost of all MTF APVs divided by the total number of APVs and is associated with the 99199 procedure code. The flat rate is $1,783.35.

3.3. Dental Rates.

3.3.1. MTF dental charges are based on a dental flat rate multiplied by a DoD-established relative weight for each of the American Dental Association (ADA) Current Dental Terminology (CDT) codes representing the dental services/procedures performed. The dental flat rate is based on the average DoD cost of dental services at all dental treatment facilities. Table 3.3.1. illustrates the dental rate for IMET, IOR and FOR/Third Party.

Table 3.3.1.

CDT	Clinical Service	IMET	IOR	FOR (Third Party)
	Dental Services CDT code weight multiplier	$51	$97	$102

Example: For CDT code D0270, bitewing single film, the DoD relative weight is 0.24. The relative weight of 0.24 is multiplied by the appropriate rate, IMET, IOR, or FOR/Third Party rate to obtain the charge. If the FOR/Third Party rate is used, then the charge for this CDT code will be $102 x 0.24, which is $24.48.

The list of CY 2009 CDT codes and relative weights for dental services are too large to include in this document. This table may be found on TMA's UBO Web site at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

3.4. Immunization/Injectables Rates.

3.4.1. A separate charge is made for each immunization, injection or medication administered. The charge for immunizations, allergen extracts, allergic

condition tests, and the administration of certain medications, which may be provided in a separate immunization or "shot" clinic, are described below.

3.4.1.1. Immunization rates are based on CMAC rates whenever CMAC rates are available.

3.4.1.2. If there is no CMAC rate, Purchased Care Data is used. Purchased Care Data is derived by using the Military Health System (MHS) Management Analysis and Reporting Tool or M2 system. It is a powerful ad hoc query tool for detailed trend analysis, such as patient and provider profiling; including summary and detailed views of population, clinical, and financial data from all MHS regions worldwide and Direct and Purchased Care Data. Data pulled from previous and current fiscal year (FY) (to date) allows calculation of "Average Amount Allowed" for use.

3.4.1.3. If there is no CMAC rate or Purchased Care Data available, then the National Average Payment (NAP) is used. The NAP represents commercial and/or Medicare national average payment for services, supplies, drugs, and non-physician procedures reported using Healthcare Common Procedure Coding System (HCPCS) Level II codes.

3.4.1.4. If there is no CMAC rate, Purchased Care Data available, or NAP rate, a flat rate of $54, calculated using Medical Expense Performance Reporting System data, is billed. The flat rate is based on the average full cost of these services, exclusive of any costs considered for purposes of any outpatient visit.

3.5. Anesthesia Rate. The flat rate for anesthesia professional services is based on an average DoD cost of service in all MTFs. The flat rate for anesthesia is $1,162.

3.6. Durable Medical Equipment/Durable Medical Supplies Rates. Durable Medical Equipment (DME) and Durable Medical Supplies (DMS) rates are based on the Medicare Fee Schedule floor rate. The HCPCS codes for which rates are provided include: A4206-A9999, E0100-E8002, K0001-K0899, L0112-L9900, and V2020-V5364. This rate table may be found on the TMA UBO Web site at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

3.7. Transportation Rates.

3.7.1. Ground Ambulance Rate. Ambulance charges are based on hours of service, in 15-minute increments. The rates for IMET, IOR and Other (Full/Third Party) listed in the Table 3.7.1. are for 60 minutes (1 hour) of service. MTFs shall calculate the charges based on the number of hours (and/or fractions of an hour) that the ambulance is logged out on a patient run. Fractions of an hour are rounded to the next 15-minute increment (e.g., 31 minutes is charged as 45 minutes).

Table 3.7.1.

CDT/CPT	Clinical Service	IMET	IOR	FOR (Third Party)
A0999	Ambulance	$149.00	$222.00	$236.00

3.7.2. Aeromedical Evacuation Rate.

Air in-flight medical care reimbursement charges are determined by the status of the patient (ambulatory or litter) and are per patient per trip during a 24-hour period. A trip encompasses the time from patient pickup to drop off at the appropriate facility. For example, transportation from Base A to Base B, which consists of three legs, is charged as a single trip within a 24-hour period. The appropriate charges are billed only by the Global Patient Movement Requirements Center (GPMRC). These charges are only for the cost of providing medical care, a separate charge for transportation may be generated by GPMRC. For CY 2009, the in-flight medical care reimbursement rates are calculated based on the FOR (ambulatory patients) and FRR (litter patients). The ambulatory and litter rates were adjusted to compensate for inflation since CY 2002. The CY 2009 in-flight rates for IMET, IOR and FOR/FRR (Third Party) are listed below in Table 3.7.2.

Table 3.7.2.

Clinical Service	IMET	IOR	FOR/FRR (Third Party)
Aeromedical Evac Services – Ambulatory	$422	$630	$668
Aeromedical Evac Services – Litter	$1,234	$1,882	$1,998

3.8. Other Rates.

3.8.1. Subsistence Rate. The Standard Rate that is established by the Office of the Under Secretary of Defense (Comptroller) is used as the subsistence rate. The Standard Rate is available from the DoD Comptrollers Web site, Tab G: http://www.dod.mil/comptroller/rates/. The effective date for this rate is prescribed by the comptroller.

NOTE:
Subsistence charges are billed under the MSA Program only. Please refer to DoD 6010.15-M, Military Treatment Facility UBO Manual, November 2006, and the DoD 7000.14-R, "Department of Defense Financial Management Regulation," Volume 12, Chapter 19, for guidance on the use of this rate.

The subsistence rate is different from the Family Member Rate, which is addressed in each FY ASA Inpatient policy letter. The letter is available from the UBO Web site: http://www.tricare.mil/ocfo/_docs/ FY09%20Direct%20Care%20Inpatient%20Billing%20Rates%20Memo.pdf

3.8.2. OCONUS Prepaid Elective Pregnancy Termination Rate.

3.8.2.1. The Department of Defense Appropriations Act for FY 1996 and the Department of Defense Authorization Act for FY 1996 revised the DoD policy concerning provision of prepaid elective pregnancy termination in overseas MTFs, such that the authority of those MTFs to provide prepaid elective pregnancy termination is limited to cases in which the pregnancy is the result of an act of rape or incest.

3.8.2.2. When an overseas MTF provides prepaid elective pregnancy termination services under the limited authority identified above, the rate charged is the FRR for services performed for an inpatient. If the services are provided as an APV, the prepaid charge is calculated using an estimate of the Professional Component rate described in paragraph 3.2, plus the APV Institutional rate identified in paragraph 3.2.2.3, plus the anesthesia rate (if anesthesia is required) identified in paragraph 3.5 above. If the services are provided on an outpatient basis, the prepaid rate is calculated using CMAC locality 391 rates plus the charge for any associated pharmaceuticals.

4. Elective Cosmetic Surgery Rates

4.1. Availability of Elective Cosmetic Surgery. Elective cosmetic surgery procedures provided in MTFs are restricted to TRICARE-eligible beneficiaries, including TRICARE for Life, on a "space-available" basis. Active Duty personnel undergoing cosmetic surgery procedures must have written permission from their unit commander. For more information on the availability of elective cosmetic surgery, please refer to HA 05-020: Policy for Cosmetic Procedures in the Military Health System. The policy can be downloaded from http://www.tricare.mil/ocfo/_docs/05-0201.pdf.

4.2. List of Procedures. The procedures listed in Appendix A are those procedures identified as elective cosmetic surgery procedures when performed without documentation of medical necessity.

4.2.1. Laser Vision Correction. Neither Photorefractive Keratectomy nor Laser In-Situ Keratomileusis procedures are approved as part of the health care benefit under TRICARE. For information on these procedures, please to refer to Health Affairs policy on Vision Correction via Laser Surgery for Non-Active Duty Beneficiaries. The policy can be downloaded from: http://www.health.mil/Content/docs/ pdfs/policies/2000/00-003.pdf.

4.3. Patient Payment. Elective cosmetic surgery is not a TRICARE covered benefit. Patients receiving cosmetic procedures (e.g., Active Duty personnel, retirees, family members, and survivors) are fully responsible for charges for all services (including implants, cosmetic injectables, and other separately billable items) associated with the elective surgical procedure. Separately billable items are billed at the FOR. Even if the patient has valid other health insurance (OHI), the patient is still responsible for paying the entire cost associated with cosmetic procedures (e.g., institutional, professional, anesthesia, and implant fees). However, the patient may separately file a claim with his or her insurance company.

4.4. Professional Charges for Elective Cosmetic Surgery.

4.4.1. When a CMAC rate has been established for a given procedure, cosmetic rates for the professional charges are based on the CY 2009 CMAC national average. Rates are not based on the treating MTF's geographical location.

4.4.2. The CMAC CY 2009 "facility physician" category is used for the professional component for services furnished by the provider in a hospital operating room or APU.

4.4.3. The CMAC CY 2009 "non-facility physician" category is used for the professional component for services furnished in the provider's office.

4.5. Institutional Rates for Elective Cosmetic Surgery.

4.5.1. Elective cosmetic surgery fees are based on the procedure performed and the location of the service provided (i.e., provider's office/minor surgery room, hospital operating room (or APU) outpatient service, operating room inpatient stay).

4.5.1.1. For elective cosmetic surgery conducted in a provider's office the institutional fee is included in the "non-facility physician" professional category per paragraph 4.4.3.

4.5.1.2. The institutional fee for cosmetic surgery for outpatients using a hospital operating room or APU is based on APC rate associated with the principal procedure, and 50 percent of the APC rate for each additional procedure.

4.5.1.3. Institutional prices are rounded to the nearest $10.00.

4.5.1.4. Most ancillary services (e.g., laboratory, radiology, and routine preoperative testing) are included in the pricing methodology. Ancillary services and supplies not included are billed at FOR.

4.6. Anesthesia Rate for Elective Cosmetic Surgery. The anesthesia professional rate for elective cosmetic surgery is the median TRICARE Physician Conversion Factor ($20.88), multiplied by sum of the number of base units and the number of time units (measured in 15-minute increments) for each service, and rounded to the nearest $10.

4.7. Inpatient Rate for Elective Cosmetic Surgery.

4.7.1. Inpatient charges. The inpatient rate for elective cosmetic surgery is the FY 2009 TRICARE Adjusted Standardized Amount ($4,696.60) multiplied by the relative weighted product associated with the Diagnostic Related Group for each cosmetic procedure plus the applicable professional and anesthesia fees associated with the procedure as described above.

APPENDIX A: ELECTIVE COSMETIC SURGERY PROCEDURES

** New Cosmetic Procedures Added for CY 2009*

CPT CODE	CPT DESCRIPTION
BLEPHAROPLASTY, BLEPHAROPTOSIS, CANTHOPLASTY	
15820	Blepharoplasty, lower eyelid;
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid;
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67950	Canthoplasty (reconstruction of canthus)
BREAST/CHEST AUGMENTATION	
19300	Mastectomy for Gynecomastia
19316	Mastopexy (Breast Lift)
19318	Reduction mammaplasty
19324	Mammaplasty, augmentation; without prosthetic implant
19325	Mammaplasty, augmentation; with prosthetic implant
19328	Removal of intact mammary implant
19330	Removal of mammary implant material
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
21899	Pectoral Augmentation; male chest, with implant
19350-E	Nipple enlargement
19350-R	Nipple reduction
CHEMODENERVATION	
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)
64613	Chemodenervation of muscle(s); neck muscle(s) (e.g., for spasmodic torticollis, spasmodic dysphonia)
64614	Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (e.g., for dystonia, cerebral palsy, multiple sclerosis)
64650*	Chemodenervation of eccrine glands; both axillae
64653*	Chemodenervation of eccrine glands; other area(s) (e.g., scalp, face, neck), per day
EYE SURGERY (CORNEA REFREACTION)	
65760*	Keratomileusis
65765*	Keratophakia
65767*	Epikeratoplasty
65770*	Keratoprosthesis
EXCISION OF EXCESSIVE SKIN	

CPT CODE	CPT DESCRIPTION
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh lift
15833*	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg lift
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip lift
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock lift
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm lift—brachioplasty
15837*	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839*	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin &subcutaneous tissue (includes lipectomy), abdomen (includes umbilical transposition &fascial plication); Panniculectomy with Abdominoplasty
17999-Y5831	Abdominoplasty
FACIAL RECONSTRUCTION	
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122*	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
21123*	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137*	Reduction forehead; contouring only
21138*	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139*	Reduction forehead; contouring and setback of anterior frontal sinus wall
21141	Reconstruction midface, lefort i; single piece, segment movement in any direction (e.g., for long face syndrome), without bone graft
21142*	Reconstruction midface, lefort i; 2 pieces, segment movement in any direction, without bone graft
21143*	Reconstruction midface, lefort i; 3 or more pieces, segment movement in any direction, without bone graft
21145*	Reconstruction midface, lefort i; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
21146*	Reconstruction midface, lefort i; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)
21147*	Reconstruction midface,lefort i;3/more pieces,segment movement in any direction,requiring bone grafts (includes obtaining autografts) (e.g.,ungrafted bilateral alveolar cleft/multiple osteotomies)
21150*	Reconstruction midface, lefort ii; anterior intrusion (e.g., treacher-collins

CPT CODE	CPT DESCRIPTION
	syndrome)
21151*	Reconstruction midface, lefort ii; any direction, requiring bone grafts (includes obtaining autografts)
21154*	Reconstruction midface, lefort iii (extracranial), any type, requiring bone grafts (includes obtaining autografts); without lefort i
21155*	Reconstruction midface, lefort iii (extracranial), any type, requiring bone grafts (includes obtaining autografts); with lefort i
21159*	Reconstruction midface, lefort iii (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without lefort i
21160*	Reconstruction midface, lefort iii (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); with lefort i
21172*	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175*	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), w w/o grafts (inc obtaining autografts)
21179*	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180*	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21181*	Reconstruction by contouring of benign tumor of cranial bones (e.g., fibrous dysplasia), extracranial
21182*	Reconstruction, orbital walls, rims, forehead, nasoethmoid complex following intra-& extracranial excision, benign tumor, cranial bone, w multiple autografts; total area, bone grafting < 40 sq cm
21183*	Reconstruction, orbital walls, rims, forehead, nasoethmoid complex foll intra-&extracranial excision, benign tumor, cranial bone, w multi autografts; total area, bone graft > 40 sq cm but < 80 sq cm
21184*	Reconstruction, orbital walls, rims, forehead, nasoethmoid complex following intra-&extracranial excision, benign tumor, cranial bone, w multiple autografts; total area, bone grafting > 80 sq cm
21188*	Reconstruction midface, osteotomies (other than lefort type) and bone grafts (includes obtaining autografts)
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21198	Osteotomy, mandible, segmental;
21199	Osteotomy, mandible, segmental; with genioglossus advancement
21206	Osteotomy, maxilla, segmental (e.g., wassmund or schuchard)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)

CPT CODE	CPT DESCRIPTION
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; malar/maxilla/nasal augmentation
21215*	Graft, bone; mandible (includes obtaining graft)
21230*	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21235*	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21240*	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)
21242*	Arthroplasty, temporomandibular joint, with allograft
21243*	Arthroplasty, temporomandibular joint, with prosthetic joint replacement
21244*	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)
21245*	Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246*	Reconstruction of mandible or maxilla, subperiosteal implant; complete
21247*	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia)
21248*	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
21249*	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete
21255*	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21256*	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (e.g., micro-ophthalmia)
21260*	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
21261*	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach
21263*	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement
21267*	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
21268*	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach
21270	Malar augmentation, prosthetic material
21275*	Secondary revision of orbitocraniofacial reconstruction
21280*	Medial canthopexy (separate procedure)
21282	Canthopexy, lateral
21295*	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach
21296*	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); intraoral approach
69300	Otoplasty, protruding ear, with or without size reduction
FAT TRANSFER	
17999-Y5000	Microlipoinjection/fat transfer; lips
17999-Y5001	Microlipoinjection/fat transfer; melolabial folds

CPT CODE	CPT DESCRIPTION
17999-Y5002	Microlipoinjection/fat transfer; marrionette lines
17999-Y5003	Microlipoinjection/fat transfer; forehead
17999-Y5004	Microlipoinjection/fat transfer; glabella
17999-Y5005	Microlipoinjection/fat transfer; tear troughs
17999-Y5006	Microlipoinjection/fat transfer; crow's feet
HAIR REMOVAL	
17380	Electrolysis Epilation, 30 minute session
17999-Y0020	Laser hair removal; lip
17999-Y0021	Laser hair removal; lip and chin
17999-Y0022	Laser hair removal; back
17999-Y0023	Laser hair removal; arms
17999-Y0024	Laser hair removal; underarms
17999-Y0025	Laser hair removal; bikini
17999-Y0026	Laser hair removal; legs
17999-Y0027	Laser hair removal; beard
17999-Y0028	Laser hair removal; ears
HAIR TRANSPLANT	
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
17999-Y5775	Micro/mini grafts 1- 500 hairs
INTRALESIONAL INJECTION	
11900	Injection, intralesional; up to and including 7 lesions
11901	Injection, intralesional; more than 7 lesions
LASER VEIN TREATMENT	
17999-Y0050	Laser treatment of leg veins
LESION REMOVAL	
11300*	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less
11301*	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm
11302*	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm
11303*	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm
11305*	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
11306*	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm
11307*	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm
11308*	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm
11310*	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips,

CPT CODE	CPT DESCRIPTION
	mucous membrane; lesion diameter 0.5 cm or less
11311*	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm
11312*	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm
11313*	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less
11401	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm
11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm
11404	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm
11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm
11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm
11422	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm
11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm
11424	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm
11426	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm
11440	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
11441	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm
11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm
11443	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm
11444	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm
11446	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter

CPT CODE	CPT DESCRIPTION
	over 4.0 cm
17106	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm
17107	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 - 50.0 sq cm
17108	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq cm
17110	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
17111	Destruction (e.g., laser surgery, cryosurgery, chemosurgery, surgical curettement),of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions
17250	Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)
LIP AUGMENTATION	
40510*	Excision of lip; transverse wedge excision with primary closure
40520*	Excision of lip; v-excision with primary direct linear closure
40525*	Excision of lip; full thickness, reconstruction with local flap (e.g., estlander or fan)
40527*	Excision of lip; full thickness, reconstruction with cross lip flap (abbe-estlander)
40530*	Resection of lip, more than one-fourth, without reconstruction
40650*	Repair lip, full thickness; vermilion only
40652*	Repair lip, full thickness; up to half vertical height
40654*	Repair lip, full thickness; over one-half vertical height, or complex
40799-Y5834	Lip Augmentation; upper or lower, unpaired
LIPOSUCTION	
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17999-Y5875	Ultrasound assisted lipectomy; total body; excluding head and neck
17999-Y5876	Ultrasound assisted lipectomy; head and neck
17999-Y5877	Ultrasound assisted lipectomy; trunk
17999-Y5878	Ultrasound assisted lipectomy; upper extremity
17999-Y5879	Ultrasound assisted lipectomy; lower extremity
NECK	
15819	Cervicoplasty
OTHER REVISIONS	
40806*	Incision of labial frenum (frenotomy)
40820*	Destruction of lesion or scar of vestibule of mouth by physical methods (e.g., laser, thermal, cryo, chemical)
40845*	Vestibuloplasty; complex (including ridge extension, muscle repositioning)
41820*	Gingivectomy, excision gingiva, each quadrant

CPT CODE	CPT DESCRIPTION
41828*	Excision of hyperplastic alveolar mucosa, each quadrant (specify)
41872*	Gingivoplasty, each quadrant (specify)
17999-Y5835	Buttock Augmentation w/ implant
17999-Y5836	Buttock Augmentation w/o implant
17999-Y5837	Calf Augmentation
17999-Y5838	Umbilicoplasty
PIERCING	
69090	Ear piercing
17999-Y6001	Piercing, Other Body Parts
RHINOPLASTY	
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420*	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460*	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462*	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
RHYTIDECTOMY	
15824	Rhytidectomy; forehead (Brow Lift)
15825	Rhytidectomy; neck with p-flap tightening
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
SCLEROTHERAPY	
36468	Sclerotherapy; Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); trunk
36469	Sclerotherapy; Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face
36470	Sclerotherapy; Injection of sclerosing solution; single vein
36471	Sclerotherapy; Injection of sclerosing solution; multiple veins, same leg
SKIN RESURFACING	
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
15786	Abrasion; single lesion (e.g., keratosis, scar)
15787	Abrasion; each additional four lesions or less (list separately in addition to code for primary procedure)

CPT CODE	CPT DESCRIPTION
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
17999-Y0001	Microdermabrasion; total face
17999-Y0002	Microdermabrasion; segment, facial
17999-Y0003	Laser Skin Resurfacing, Ablative; total face
17999-Y0004	Laser Skin Resurfacing, Ablative; segment, facial
17999-Y0005	Laser Skin Resurfacing, Non-ablative; total face
17999-Y0006	Laser Skin Resurfacing, Non-ablative; segment, facial
17999-Y0007	Laser Skin Resurfacing, Non-ablative; neck
17999-Y0008	Laser Skin Resurfacing, Non-ablative; chest
17999-Y0009	Laser Skin Resurfacing, Non-ablative; back/shoulders
17999-Y0010	Laser Skin Resurfacing, Non-ablative; arms
17999-Y0011	Laser Skin Resurfacing, Non-ablative; hands
17999-Y0012	Laser Skin Resurfacing, Non-ablative; legs
SKIN TAG REMOVAL	
11200*	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
11201*	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (list separately in addition to code for primary procedure)
SOFT TISSUE FILLERS	
11950	Subcutaneous injection of filling material (e.g., collagen) 1 cc or less
11951	Subcutaneous injection of filling material (e.g., collagen) 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (e.g., collagen) 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (e.g., collagen) over 10.00 cc
TATTOO REMOVAL	
17999-Y0030	Laser tattoo removal; ≤ 30 sq. cm, initial session
17999-Y0031	Laser tattoo removal; ≤ 30 sq. cm, each addl session
17999-Y0032	Laser tattoo removal; ≥ 31 sq cm, initial session
17999-Y0033	Laser tattoo removal; ≥ 31 sq cm, each addl session
VEIN STRIPPING	
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions
37718	Ligation, division, and stripping, short saphenous vein
37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below
37765	Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions
37766	Stab phlebectomy of varicose veins, one extremity; more than 20 incisions
WOUND REPAIR	
12001*	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

CPT CODE	CPT DESCRIPTION
12002*	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm
12004*	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm
12005*	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm
12006*	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm
12007*	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm
12011*	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12013*	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm
12014*	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm
12015*	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm
12016*	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm
12017*	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm
12018*	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm
12020*	Treatment of superficial wound dehiscence; simple closure
12021*	Treatment of superficial wound dehiscence; with packing
12031*	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less
12032*	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm
12034*	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm
12035*	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm
12036*	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm
12037*	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); over 30.0 cm
12041*	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less
12042*	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm
12044*	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm
12045*	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm
12046*	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm

CPT CODE	CPT DESCRIPTION
12047*	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; over 30.0 cm
12051*	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12052*	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm
12053*	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm
12054*	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm
12055*	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm
12056*	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm
12057*	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm
13100	Repair, complex, trunk; 1.1 cm to 2.5 cm
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm
13102	Repair, complex, trunk; each additional 5 cm or less (list separately in addition to code for primary procedure)
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm
13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm
13122	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (list separately in addition to code for primary procedure)
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm
13133	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (list separately in addition to code for primary procedure)
13150	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less
13151	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm
13152	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm
13153	Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (list separately in addition to code for primary procedure)
13160*	Secondary closure of surgical wound or dehiscence, extensive or complicated
MODERATE SEDATION	
99144	Moderate Sedation, performed physician performing primary procedure
99149	Moderate Sedation, performed by physician other than primary surgeon
DENTAL	
D9972*	Teeth Whitening; external bleaching, per arch
D9973	Teeth Whitening; external bleaching, per tooth
D9974	Teeth Whitening; internal bleaching, per tooth
D9999	Laser Teeth Whitening, per treatment