

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
10022	Fine needle aspiration; with imaging guidance	No	Yes	ACS	Enabled now by better technology.
10061	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple	No	Yes	ACS, ASCRS (C&R), ASSH	ACS - Multiple in child or extensive in adult requires sedation, anesthesia; ASCRS (C&R) - "Complicated" I&D may require anesthesia that is not available in an office setting; ASSH - Can be part of another procedure done in ASC
10081	Incision and drainage of pilonidal cyst; complicated	No	Yes	ACS, ASCRS (C&R)	ACS - Determined by anesthesia needs; ASCRS (C&R) - "Complicated" I&D may require anesthesia that is not available in an office setting.
10120	Incision and removal of foreign body, subcutaneous tissues; simple	No	Yes	ASSH	Can be part of another procedure done in ASC.
10140	Incision and drainage of hematoma, seroma or fluid collection	No	Yes	ASSH	Can be part of another procedure done in ASC.
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst	No	Yes	ASSH	Can be part of another procedure done in ASC.
11000	Debridement of extensive eczematous or infected skin; up to 10% of body surface	No	Yes	ACS, ASSH	ACS - Determined by anesthesia needs and patient age; ASSH - Can be part of another procedure done in ASC.
11001	Debridement of extensive eczematous or infected skin; each additional 10% of the body surface (List separately in addition to code for primary procedure)	No	Yes	ACS	Determined by anesthesia needs and patient age.
11040	Debridement; skin, partial thickness	No	Yes	ASSH	Can be part of another procedure done in ASC.
11041	Debridement; skin, full thickness	No	Yes	ASSH	Can be part of another procedure done in ASC.
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion	No	Yes	ASSH	Can be part of another procedure done in ASC.
11101	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)	No	Yes	ASSH	Can be part of another procedure done in ASC.
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less	No	Yes	ASSH	Can be part of another procedure done in ASC.
11401	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm	No	Yes	ASSH	Can be part of another procedure done in ASC.
11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm	No	Yes	ASSH	Can be part of another procedure done in ASC.
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm	No	Yes	ASSH	Can be part of another procedure done in ASC.
11404	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS ASCRS (C&R), ASSH	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. Although excision of a lesion of this size is possible in an office setting, accompanying reconstruction is more involved and may require procedures, such as wide undermining, that cannot be safely performed in an office setting. Patients may require sedation and may need post-operative monitoring to observe for circulatory compromise of the extremity. Physicians typically need access to suction, electrocautery, appropriate lighting and adequate personnel that is available in an ASC; ASCRS (C&R) - This size of lesion removal may require sedation not available in an office setting; ASSH - Could be combined with another procedure.
11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	No	Yes	ASSH	Can be part of another procedure done in ASC.
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	No	Yes	ASSH	Can be part of another procedure done in ASC.
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	No	Yes	ASSH	Can be part of another procedure done in ASC.
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	No	Yes	ASSH	Can be part of another procedure done in ASC.

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
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	Proposed Deletion - 4	Yes	ACS, ASCRS (C&R), ASSH	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASCRS (C&R) - This size of lesion removal may require sedation not available in an office setting; ASSH - Could be combined with another procedure.
11440	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less	No	Yes	AAO, ASSH, ASCRS	AAO - Should be added to ASC approved procedure list; ASSH - Can be part of another procedure done in ASC.
11441	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm	No	Yes	AAO, ASSH, ASCRS, OOSS	AAO - Should be added to ASC approved procedure list; ASSH - Can be part of another procedure done in ASC.
11442	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm	No	Yes	ASPS, AAO, ASSH, ASCRS, OOSS	AAO - Should be added to ASC approved procedure list; ASSH - Can be part of another procedure done in ASC.
11443	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm	No	Yes	AAO, ASSH, ASCRS, OOSS	AAO - Should be added to ASC approved procedure list; ASSH - Can be part of another procedure done in ASC.
11444	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, AAO, ASCRS, OOSS	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. Although excision of a lesion of this size is possible in an office setting, accompanying reconstruction is more involved for these anatomical regions and may require procedures, such as wide undermining, flaps, or skin grafts, that cannot be safely performed in all office settings. Extensive nerves in the face require particular attention to control bleeding. Patients may require regional or general anesthesia, and physicians typically need access to suction, electrocautery, appropriate lighting and adequate personnel that is available in an ASC; AAO - Should remain on ASC approved procedure list; ASCRS, OOSS - This procedure is more safely and effectively performed in an ASC. Many of the plastic surgery codes involve extensive tissue dissection and should not be performed in the office and their migration to the office or hospital outpatient settings will actually increase Medicare costs.
11446	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, AAO, ASCRS, OOSS	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. Although excision of a lesion of this size is possible in an office setting, accompanying reconstruction is more involved for these anatomical regions and may require procedures, such as wide undermining, flaps, or skin grafts, that cannot be safely performed in all office settings. A lesion this size involves a large portion of the face, thus airway compromise from swelling is an additional concern. In addition, extensive nerves in the face require particular attention to control bleeding. Patients may require regional or general anesthesia, and physicians typically need access to suction, electrocautery, appropriate lighting and adequate personnel that is available in an ASC.; AAO - Should remain on ASC approved procedure list; ASCRS - This procedure is more safely and effectively performed in an ASC.
11600	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.5 cm or less	No	Yes	ASSH	Can be part of another procedure done in ASC.
11601	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm	No	Yes	ASSH	Can be part of another procedure done in ASC.
11602	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm	No	Yes	ASSH	Can be part of another procedure done in ASC.
11603	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm	No	Yes	ASSH	Can be part of another procedure done in ASC.

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
11604	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, ASCRS (C&R), ASSH	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. Although excision of a lesion of this size is possible in an office setting, accompanying reconstruction is more involved for these anatomical regions and may require procedures, such as wide undermining, flaps, or skin grafts, that cannot be safely performed in all office settings. Patients may require regional or general anesthesia and may need post-operative monitoring to observe for circulatory compromise of the extremity. Physicians typically need access to suction, electrocautery, appropriate lighting and adequate personnel that is available in an ASC. Also, a malignant lesion of this size will usually require frozen section analysis before reconstruction. This may only be available in an ambulatory surgery center or hospital setting; ASCRS (C&R) - This size of lesion removal may require anesthesia that is not available in an office setting; ASSH - Could be combined with another procedure.
11620	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	No	Yes	ASSH	Can be part of another procedure done in ASC.
11621	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm	No	Yes	ASSH	Can be part of another procedure done in ASC.
11622	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm	No	Yes	ASSH	Can be part of another procedure done in ASC.
11623	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	No	Yes	ASSH	Can be part of another procedure done in ASC.
11624	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, ASCRS (C&R), ASSH	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. Although excision of a lesion of this size is possible in an office setting, accompanying reconstruction is more involved for these anatomical regions and may require procedures, such as wide undermining, flaps, or skin grafts, that cannot be safely performed in all office settings. Patients may require regional or general anesthesia and may need post-operative monitoring to observe for circulatory compromise of the extremity. Physicians typically need access to suction, electrocautery, appropriate lighting and adequate personnel that is available in an ASC. Also, a malignant lesion of this size will usually require frozen section analysis before reconstruction. This may only be available in an ambulatory surgery center or hospital setting; ASCRS (C&R) - This size of lesion removal may require anesthesia that is not available in an office setting; Could be combined with another procedure.
11640	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list
11641	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm	No	Yes	AAO	Should be added to ASC approved procedure list
11642	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list
11643	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
11644	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, AAO, ASCRS, OOSS	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. Although excision of a lesion of this size is possible in an office setting, accompanying reconstruction is more involved for these anatomical regions and may require procedures, such as wide undermining, flaps, or skin grafts, that cannot be safely performed in all office settings. Extensive nerves in the face require particular attention to control bleeding. Patients may require regional or general anesthesia, and physicians typically need access to suction, electrocautery, appropriate lighting and adequate personnel that is available in an ASC. Also, a malignant lesion of this size will usually require frozen section analysis before reconstruction. This may only be available in an ambulatory surgery center or hospital setting; AAO - Should remain on ASC approved procedure list; ASCRS, OOSS - This procedure is more safely and effectively performed in an ASC.
11730	Avulsion of nail plate, partial or complete, simple; single	No	Yes	ASSH	This can be part of another procedure or independent.
11732	Avulsion of nail plate, partial or complete, simple; each additional nail plate (List separately in addition to code for primary procedure)	No	Yes	ASSH	This can be part of another procedure or independent.
11740	Evacuation of subungual hematoma	No	Yes	ASSH	This can be part of another procedure or independent.
11750	Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;	No	Yes	ASSH	This can be part of another procedure or independent.
11752	Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal; with amputation of tuft of distal phalanx	No	Yes	ASSH	This can be part of another procedure or independent.
11755	Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)	No	Yes	ASSH	This can be part of another procedure or independent.
11760	Repair of nail bed	No	Yes	ASSH	This can be part of another procedure or independent.
11762	Reconstruction of nail bed with graft	No	Yes	ASSH	This can be part of another procedure or independent.
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	No	Yes	ASSH	Part of rx of trauma case or performed in addition to other procedures performed during the same operative event.
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	No	Yes	ASSH	Part of rx of trauma case or performed in addition to other procedures performed during the same operative event.
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	No	Yes	ASSH	Part of rx of trauma case or performed in addition to other procedures performed during the same operative event.
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
12014	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
12015	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
12021	Treatment of superficial wound dehiscence; with packing	Proposed Deletion - 4	Yes	ACS, ASCRS (C&R), ASSH	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASCRS (C&R) - Change of packing may require anesthesia that is not available in an office setting; ASSH - Should be done in ASC.
12032	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm	No	Yes	ACS	Should be added to ASC approved procedure list.
12041	Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less	No	Yes	ASSH	Part of rx of trauma case or performed in addition to other procedures performed during the same operative event.
12042	Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm	No	Yes	ACS, ASSH	ACS - Should be added to ASC approved procedure list; ASSH - Part of rx of trauma case or performed in addition to other procedures performed during the same operative event.

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
12051	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
12052	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
12053	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
13100	Repair, complex, trunk; 1.1 cm to 2.5 cm	Proposed Deletion - 4	Yes	ACS	Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities.
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm	Proposed Deletion - 4	Yes	ACS	Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities.
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm	Proposed Deletion - 4	Yes	ACS, ASSH	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASSH - Should be done in ASC, could also be part of a complex case done in the ASC.
13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	Proposed Deletion - 4	Yes	ACS	Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities.
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm	Proposed Deletion - 4	Yes	ASPS, ASMS, AAFPRS, ASCRS (C&R)	ASPS, ASMS, AAFPRS - Not always safe in the office. Procedure can involve very wide undermining, and patients often require sedation. The size of such defects necessitating a complex repair typically would justify the equipment and monitoring environment that an ASC provides. This procedure is often done in conjunction with other procedures that are approved in ASCs; ASCRS (C&R) - Complex repairs of this size may require anesthesia that is not available in an office setting.
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm	Proposed Deletion - 4	Yes	ASPS, ASMS, AAFPRS	Not always safe in the office. Procedure can involve very wide undermining, and patients often require sedation. The size of such defects necessitating a complex repair typically would justify the equipment and monitoring environment that an ASC provides. This procedure is often done in conjunction with other procedures that are approved in ASCs.
13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	Proposed Deletion - 4	Yes	ASPS, ASMS, AAFPRS, ASCRS (C&R), ASSH	ASPS, ASMS, AAFPRS - Not always safe in the office. Procedure can involve very wide undermining, and patients often require sedation. The size of such defects necessitating a complex repair typically would justify the equipment and monitoring environment that an ASC provides. A repair of this size in this anatomical location, when performed under local anesthesia alone may cause undue hardships for many patients. Conscious sedation or general anesthesia may be needed. This procedure is often done in conjunction with other procedures that are approved in ASCs ; ASCRS (C&R) - Complex repairs of this size may require anesthesia that is not available in an office setting; ASSH - Should be done in ASC, could also be part of a complex case done in the ASC.
13122	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)	No	Yes	ASSH	Part of rx of trauma case or performed in addition to other procedures performed during the same operative event.

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, ASCRS (C&R), AAO, ASSH, ASCRS, OOSS	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. Procedure can involve very wide undermining, and patients often require sedation. The size of such defects necessitating a complex repair typically would justify the equipment and monitoring environment that an ASC provides. This procedure is often done in conjunction with other procedures that are approved in ASCs; ASCRS (C&R) - Complex repairs of the genitalia may require anesthesia that is not available in an office setting; AAO - Should remain on ASC approved procedure list; ASSH - Should be done in ASC, could also be part of a complex case done in the ASC; ASCR, OOSS - This procedure is more safely and effectively performed in an ASC. Many of the plastic surgery codes involve extensive tissue dissection and should not be performed in the office and their migration to the office or hospital outpatient settings will actually increase Medicare costs.
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, ASCRS (C&R), AAO, ASSH, ASCRS, OOSS	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. Procedure can involve very wide undermining, and patients often require sedation. The size of such defects necessitating a complex repair typically would justify the equipment and monitoring environment that an ASC provides. A repair of this size in this anatomical location, when performed under local anesthesia alone may cause undue hardships for many patients. Conscious sedation or general anesthesia may be needed. This procedure is often done in conjunction with other procedures that are approved in ASCs; ASCRS (C&R) - Complex repairs of the genitalia may require anesthesia that is not available in an office setting; AAO - Should remain on ASC approved procedure list; ASSH - Should be done in ASC, could also be part of a complex case done in the ASC; ASCRS, OOSS - This procedure is more safely and effectively performed in an ASC.
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)	No	Yes	ASSH	Part of rx of trauma case or performed in addition to other procedures performed during the same operative event.
13150	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, AAO, ASCRS, OOSS	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. Procedure can involve very wide undermining, and patients often require sedation. The size of such defects necessitating a complex repair typically would justify the equipment and monitoring environment that an ASC provides. This procedure is often done in conjunction with other procedures that are approved in ASCs ; AAO - Should remain on ASC approved procedure list; ASCRS, OOSS - This procedure is more safely and effectively performed in an ASC. Many of the plastic surgery codes involve extensive tissue dissection and should not be performed in the office and their migration to the office or hospital outpatient settings will actually increase Medicare costs.

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
13151	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, AAO, ASCRS, OOSS	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. Procedure can involve very wide undermining, and patients often require sedation. The size of such defects necessitating a complex repair typically would justify the equipment and monitoring environment that an ASC provides. This procedure is often done in conjunction with other procedures that are approved in ASCs; AAO - Should remain on ASC approved procedure list; ASCRS, OOSS - This procedure is more safely and effectively performed in an ASC. Many of the plastic surgery codes involve extensive tissue dissection and should not be performed in the office and their migration to the office or hospital outpatient settings will actually increase Medicare costs.
13152	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, AAO, ASCRS, OOSS	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. Procedure can involve very wide undermining, and patients often require sedation. The complex anatomy of the facial structures necessitates the specialized equipment and monitoring environment that an ASC provides. A repair of this size in this anatomical location, when performed under local anesthesia alone may cause undue hardships for many patients. Conscious sedation or general anesthesia is recommended. This procedure is often done in conjunction with other procedures that are approved in ASCs; AAO - Should remain on ASC approved procedure list; ASCRS, OOSS - This procedure is more safely and effectively performed in an ASC. Many of the plastic surgery codes involve extensive tissue dissection and should not be performed in the office and their migration to the office or hospital outpatient settings will actually increase Medicare costs.
13153	Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)	No	Yes	AAO	Should be added to the list of ASC approved procedures.
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, ASCRS (C&R), AAO, ASSH, ASCRS, OOSS	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. A repair of this nature performed under local anesthesia may cause undue hardships for many patients. Conscious sedation or general anesthesia is preferable. Physicians typically need access to suction, electrocautery, appropriate lighting and adequate personnel that is available in an ASC. This procedure is often done in conjunction with other procedures that are approved in ASCs; ASCRS (C&R) - This procedure at the higher end of the defect size (ie, 10 sq cm) may require anesthesia that is not available in an office setting; AAO - Should remain on ASC approved list; ASSH - Should be done in ASC, could also be part of a complex case done in the ASC; ASCRS, OOSS - This procedure is more safely and effectively performed in an ASC. Many of the plastic surgery codes involve extensive tissue dissection and should not be performed in the office and their migration to the office or hospital outpatient settings will actually increase Medicare costs.
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, ASSH	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. A repair of this nature performed under local anesthesia may cause undue hardships for many patients. Conscious sedation or general anesthesia is preferable, and patients may need post-operative monitoring to observe for circulatory compromise of the extremity. Physicians typically need access to suction, electrocautery, appropriate lighting and adequate personnel that is available in an ASC. This procedure is often done in conjunction with other procedures that are approved in ASCs; ASSH - Should be done in ASC, could also be part of a complex case done in the ASC.

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, ASSH	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. A repair of this nature performed under local anesthesia may cause undue hardships for many patients. Conscious sedation or general anesthesia is preferable, and patients may need post-operative monitoring to observe for circulatory compromise of the extremity. Physicians typically need access to suction, electrocautery, appropriate lighting and adequate personnel that is available in an ASC. This procedure is often done in conjunction with other procedures that are approved in ASCs; ASSH - Should be done in ASC, could also be part of a complex case done in the ASC.
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, AAO, ASSH	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. A repair of this nature performed under local anesthesia may cause undue hardships for many patients. Conscious sedation or general anesthesia is preferable. Physicians typically need access to suction, electrocautery, appropriate lighting and adequate personnel that is available in an ASC. This procedure is often done in conjunction with other procedures that are approved in ASCs; AAO - Should remain on ASC approved procedure list; ASSH - Should be done in ASC, could also be part of a complex case done in the ASC.
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, AAO, ASSH, ASCRS, OOSS	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. A repair of this nature performed under local anesthesia may cause undue hardships for many patients. Conscious sedation or general anesthesia is preferable, and patients may need post-operative monitoring to observe for circulatory compromise of the extremity. Physicians typically need access to suction, electrocautery, appropriate lighting and adequate personnel that is available in an ASC. This procedure is often done in conjunction with other procedures that are approved in ASCs; AAO - Should remain on ASC approved procedure list; ASSH - Should be done in ASC, could also be part of a complex case done in the ASC; This procedure is more safely and effectively performed in an ASC. Many of the plastic surgery codes involve extensive tissue dissection and should not be performed in the office and their migration to the office or hospital outpatient settings will actually increase Medicare costs.
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, AAO, ASCRS	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; ASPS, ASMS, AAFPRS - Not always safe in the office. The complex anatomy of the facial structures necessitates the specialized equipment and monitoring environment that an ASC provides. A repair of this nature performed under local anesthesia may cause undue hardships for many patients. Conscious sedation or general anesthesia is preferable. Physicians typically need access to suction, electrocautery, appropriate lighting and adequate personnel that is available in an ASC. This procedure is often done in conjunction with other procedures that are approved in ASCs; AAO - Should remain on ASC approved procedure list; ASCRS - This procedure is more safely and effectively performed in an ASC. Many of the plastic surgery codes involve extensive tissue dissection and should not be performed in the office and their migration to the office or hospital outpatient settings will actually increase Medicare costs.

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
14061	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, ASCRS, OOSS	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities; Not always safe in the office. The complex anatomy of the facial structures necessitates the specialized equipment and monitoring environment that an ASC provides. A repair of this nature performed under local anesthesia may cause undue hardships for many patients. Conscious sedation or general anesthesia is preferable. Physicians typically need access to suction, electrocautery, appropriate lighting and adequate personnel that is available in an ASC. This procedure is often done in conjunction with other procedures that are approved in ASCs; ASCRS, OOSS - This procedure is more safely and effectively performed in an ASC. Many of the plastic surgery codes involve extensive tissue dissection and should not be performed in the office and their migration to the office or hospital outpatient settings will actually increase Medicare costs.
15732	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)	Proposed Deletion - 2	No	ACS	Agree with proposed deletion.
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk	Proposed Deletion - 2	No	ACS	Agree with proposed deletion.
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk	Proposed Deletion - 2	No	ASSH	Agree with proposed deletion.
15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity	Proposed Deletion - 2	No	ACS, ASSH	Agree with proposed deletion.
15740	Flap; island pedicle	Proposed Deletion - 4	Yes	ASPS, ASMS, AAFPRS, ASSH	ASPS, ASMS, AAFPRS - Not always safe in the office. Reconstruction is more involved and may require procedures, such as wide undermining, that cannot be safely performed in an office setting. Patients may require sedation and may need post-operative monitoring to observe for circulatory compromise of the extremity. Physicians typically need access to suction, electrocautery, appropriate lighting and adequate personnel that is available in an ASC; ASSH - Should be done in ASC, could also be part of a complex case done in the ASC.
15850	Removal of sutures under anesthesia (other than local), same surgeon	No	Yes	ASSH	Can be part of another procedure done in ASC. Large wound. Need anesthesia.
15851	Removal of sutures under anesthesia (other than local), other surgeon	No	Yes	ACS, ASSH	ACS - Many of these wound debridements are under anesthesia for small children or for the elderly with other medical problems, and cannot be done in the office, and are now being done in the hospital as outpatients; ASSH - Can be part of another procedure done in ASC. Large wound. Need anesthesia.
15852	Dressing change (for other than burns) under anesthesia (other than local)	No	Yes	ACS, ASSH	ACS - Should be added to ASC approved procedures list; ASSH - Can be part of another procedure done in ASC. Large wound. Need anesthesia.
15860	Intravenous injection of agent (eg, fluorescein) to test vascular flow in flap or graft	No	Yes	ASSH	Done as part of larger procedure in ASC.
16000	Initial treatment, first degree burn, when no more than local treatment is required	No	Yes	ASSH	Can done with other procedure.
16010	Dressings and/or debridement, initial or subsequent; under anesthesia, small	No	Yes	ACS, ASSH	ACS - Should be added to ASC approved procedures list; ASSH - Can be done with other procedure.
16020	Dressings and/or debridement, initial or subsequent; without anesthesia, office or hospital, small	No	Yes	ASSH	Can done with other procedure.
16025	Dressings and/or debridement, initial or subsequent; without anesthesia, medium (eg, whole face or whole extremity)	No	Yes	ASSH	Too big for office.
16035	Escharotomy; initial incision	No	Yes	ASSH	Can be done with other procedure.
16036	Escharotomy; each additional incision (List separately in addition to code for primary procedure)	No	Yes	ASSH	Can be done with other procedure.
19100	Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)	Proposed Deletion - 4	Yes	ACS	Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities. Appropriate for ASC when done with another procedure. This is often an add-on procedure, done on one breast, when an open or 19103 biopsy is being done in the contralateral breast. Denying coverage would mean that the equipment, supplies, etc. would not be covered for the second procedure.

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
19295	Image guided placement, metallic localization clip, percutaneous, during breast biopsy (List separately in addition to code for primary procedure)	No	Yes	ACS	Appropriate in an ASC when done with other covered procedure. This is a new code, and is used as a companion to 19103 and should be covered in order to pay for the clip and equipment needed for marking the site of breast biopsy.
19296	Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy	No	Yes	ACS, ASGS	ACS - Appropriate for ASC; ASGS - Appropriate for ASC provided they have the equipment.
19297	Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary)	No	Yes	ACS, ASGS	ACS - Appropriate in an ASC when done with another procedure. This is a new code, and is used as a companion to lumpectomy, which is a covered service, and should be covered in order to pay for the balloon catheter and equipment needed for marking the site of breast biopsy; ASGS - Appropriate for ASC provided they have the equipment.
20000	Incision of soft tissue abscess (eg, secondary to osteomyelitis); superficial	No	Yes	ASSH	Can be part of another procedure.
20103	Exploration of penetrating wound (separate procedure); extremity	No	Yes	ASSH	Not done in office.
20501	Injection of sinus tract; diagnostic (sinogram)	No	Yes	ASSH	Can be part of another procedure.
20520	Removal of foreign body in muscle or tendon sheath; simple	No	Yes	ASSH	Can be part of another procedure.
20526	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel	No	Yes	ASSH	Can be part of another procedure.
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	No	Yes	ASSH	Can be part of another procedure.
20551	Injection(s); single tendon origin/insertion	No	Yes	ASSH	Can be part of another procedure.
20552	Injection(s); single or multiple trigger point(s), one or two muscle(s)	No	Yes	ASSH	Can be part of another procedure.
20553	Injection(s); single or multiple trigger point(s), three or more muscle(s)	No	Yes	ASSH	Can be part of another procedure.
20600	Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)	No	Yes	ASSH	Can be part of another procedure.
20605	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	No	Yes	ASSH	Can be part of another procedure.
20610	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)	No	Yes	ASSH	Can be part of another procedure.
20612	Aspiration and/or injection of ganglion cyst(s) any location	No	Yes	ASSH	Can be part of another procedure.
20615	Aspiration and injection for treatment of bone cyst	No	Yes	ASSH	Can be part of another procedure.
20670	Removal of implant; superficial, (eg, buried wire, pin or rod) (separate procedure)	Proposed Deletion - 4	Yes	ACS, ASPS, ASMS, AAFPRS, ASGS, ASSH	ACS - Retain on ASC list. Determined by anesthesia needs, patient age, comorbidities. This code is most often used for removal of hardware in young children, the elderly, and those patients who for other reasons need anesthesia to help with the removal. If this procedure is now denied, this will force surgeons to do these procedures as an outpatient in the hospital OR, as opposed to ASCs, which will increase the cost of the removal. Additionally, this is another example of a procedure being done at the time of another covered procedure, such as in a contralateral extremity; ASPS, ASMS, AAFPRS - Not always safe in the office. This procedure may require conscious sedation or general anesthesia. Airway compromise from swelling from surgery is a concern; ASGS - May require sedation beyond what may be safe in office setting; ASSH - Not always done in office can be too deep; could be done as part of another procedure.
20816	Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon), complete amputation	No	Yes	ASSH	Does not always need to be done hospital.
20822	Replantation, digit, excluding thumb (includes distal tip to sublimis tendon insertion), complete amputation	No	Yes	ASSH	Does not always need to be done hospital.
20824	Replantation, thumb (includes carpometacarpal joint to MP joint), complete amputation	No	Yes	ASSH	Does not always need to be done hospital.
20827	Replantation, thumb (includes distal tip to MP joint), complete amputation	No	Yes	ASSH	Does not always need to be done hospital.

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
20950	Monitoring of interstitial fluid pressure (includes insertion of device, eg, wick catheter technique, needle manometer technique) in detection of muscle compartment syndrome	No	Yes	ASSH	Part of rx of trauma case or performed in addition to other procedures performed during the same operative event.
20982	Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance	No	Yes	ACS, ASGS, ASSH	ACS - Determined by anesthesia needs, patient age, comorbidities, site and size of lesion; ASGS - Can be performed in ASC provided they have the equipment/Anesthesia may be required; ASSH - Can be done in an ASC, not in office.
21040	Excision of benign tumor or cyst of mandible, by enucleation and/or curettage	Proposed Deletion - 1	Yes	ASPS, ASMS, AAFPRS	Not always safe in the office. This procedure may require conscious sedation or general anesthesia. Airway compromise from swelling from surgery is a concern.
21048	Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))	No	Yes	ACS	Determined by anesthesia needs, patient age and comorbidities, site and size of lesion.
21049	Excision of benign tumor or cyst of maxilla; requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion(s))	No	Yes	ACS	Determined by anesthesia needs, patient age and comorbidities, site and size of lesion.
21050	Condylectomy, temporomandibular joint (separate procedure)	Proposed Deletion - 2	Yes	ASPS, ASMS, AAFPRS	Not always safe in the office. This procedure may require conscious sedation or general anesthesia. Airway compromise from swelling from surgery is a concern.
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	Proposed Deletion - 1	Yes	ASPS, ASMS, AAFPRS	Rarely safe in the office. This procedure may require conscious sedation or general anesthesia. Airway compromise from swelling from surgery is a concern.
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	Proposed Deletion - 1	Yes	ASPS, ASMS, AAFPRS	Rarely safe in the office. This procedure may require conscious sedation or general anesthesia. Airway compromise from swelling from surgery is a concern.
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	Proposed Deletion - 1	Yes	ASPS, ASMS, AAFPRS	Not always safe in the office. This procedure may require conscious sedation or general anesthesia. Airway compromise from swelling from surgery is a concern.
21325	Open treatment of nasal fracture; uncomplicated	Proposed Deletion - 1	Yes	ASPS, ASMS, AAFPRS	Not always safe in the office. This procedure may require conscious sedation or general anesthesia. Airway compromise from swelling from surgery is a concern.
21355	Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation	Proposed Deletion - 1	Yes	ASPS, ASMS, AAFPRS	Not always safe in the office. This procedure may require conscious sedation or general anesthesia. Airway compromise from swelling from surgery is a concern.
21386	Open treatment of orbital floor blowout fracture; periorbital approach	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
21390	Open treatment of orbital floor blowout fracture; periorbital approach, with alloplastic or other implant	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list. No different than other orbital surgery coded in the the eye section of CPT.
21406	Open treatment of fracture of orbit, except blowout; without implant	No	Yes	AAO	Should be added to ASC approved procedure list. No different than other orbital surgery coded in the the eye section of CPT.
21407	Open treatment of fracture of orbit, except blowout; with implant	No	Yes	AAO	Should be added to ASC approved procedure list. No different than other orbital surgery coded in the the eye section of CPT.
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)	Proposed Deletion - 1	Yes	ASPS, ASMS, AAFPRS	Not always safe in the office. This procedure may require conscious sedation or general anesthesia. Airway compromise from swelling from surgery is a concern.
21485	Closed treatment of temporomandibular dislocation; complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent	Proposed Deletion - 1	Yes	ASPS, ASMS, AAFPRS	Not always safe in the office. This procedure may require conscious sedation or general anesthesia. Airway compromise from swelling from surgery is a concern.
21550	Biopsy, soft tissue of neck or thorax	No	Yes	ACS, ASGS	ACS - Determined by anesthesia needs, patient age and comorbidities, site and size of lesion; ASGS - May require General Anesthesia.
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy	No	Yes	ACS	Determined by anesthesia needs, patient age and comorbidities.
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy	No	Yes	ACS	Determined by anesthesia needs, patient age and comorbidities.
24065	Biopsy, soft tissue of upper arm or elbow area; superficial	No	Yes	ASSH	Can be done in ASC not in office.
24200	Removal of foreign body, upper arm or elbow area; subcutaneous	No	Yes	ASSH	Can be done in ASC not in office.
24220	Injection procedure for elbow arthrography	No	Yes	ASSH	Can be part of more extensive procedure.
24300	Manipulation, elbow, under anesthesia	No	Yes	ASSH	Requires anesthesia. Not done in office.

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
24332	Tenolysis, triceps	No	Yes	ASSH	Can be done in ASC not in office.
24343	Repair lateral collateral ligament, elbow, with local tissue	No	Yes	ASSH	Can be done in ASC not in office.
24344	Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)	No	Yes	ASSH	Can be done in ASC not in office.
24346	Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)	No	Yes	ASSH	Can be done in ASC not in office.
24576	Closed treatment of humeral condylar fracture, medial or lateral; without manipulation	Proposed Deletion - 1	Yes	ASSH	Can be part of more extensive procedure.
24640	Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation	No	Yes	ASSH	Can be part of more extensive procedure.
24650	Closed treatment of radial head or neck fracture; without manipulation	No	Yes	ASSH	Can be part of more extensive procedure.
24670	Closed treatment of ulnar fracture, proximal end (olecranon process); without manipulation	Proposed Deletion - 4	Yes	ASSH	Can anesthesia is needed or can part of another porceddure done in ASC.
24900	Amputation, arm through humerus; with primary closure	No	Yes	ASSH	Can be done in ASC not in office.
24920	Amputation, arm through humerus; open, circular (guillotine)	No	Yes	ASSH	Can be done in ASC not in office.
24930	Amputation, arm through humerus; re-amputation	No	Yes	ASSH	Can be done in ASC not in office.
24931	Amputation, arm through humerus; with implant	No	Yes	ASSH	Can be done in ASC not in office.
24935	Stump elongation, upper extremity	No	Yes	ASSH	Can be done in ASC not in office.
24940	Cineplasty, upper extremity, complete procedure	No	Yes	ASSH	Can be done in ASC not in office.
25001	Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)	No	Yes	ASSH	Can be done in ASC not in office.
25065	Biopsy, soft tissue of forearm and/or wrist; superficial	No	Yes	ASSH	Can be done in ASC not in office.
25170	Radical resection for tumor, radius or ulna	No	Yes	ASSH	Can be done in ASC not in office.
25246	Injection procedure for wrist arthrography	No	Yes	ASSH	Can be part of more extensive procedure.
25259	Manipulation, wrist, under anesthesia	No	Yes	ASSH	Requires anesthesia. Not done in office.
25394	Osteoplasty, carpal bone, shortening	No	Yes	ASSH	Can be done in ASC not in office.
25430	Insertion of vascular pedicle into carpal bone (eg, Hori procedure)	No	Yes	ASSH	Can be done in ASC not in office.
25431	Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone	No	Yes	ASSH	Can be done in ASC not in office.
25500	Closed treatment of radial shaft fracture; without manipulation	No	Yes	ASSH	Can be part of more extensive procedure.
25505	Closed treatment of radial shaft fracture; with manipulation	Proposed Deletion - 1	Yes	ASSH	Can be part of more extensive procedure.
25530	Closed treatment of ulnar shaft fracture; without manipulation	No	Yes	ASSH	Can be part of more extensive procedure.
25560	Closed treatment of radial and ulnar shaft fractures; without manipulation	No	Yes	ASSH	Can be part of more extensive procedure.
25600	Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation	No	Yes	ASSH	Can be part of more extensive procedure.
25622	Closed treatment of carpal scaphoid (navicular) fracture; without manipulation	No	Yes	ASSH	Can be part of more extensive procedure.
25630	Closed treatment of carpal bone fracture (excluding carpal scaphoid (navicular)); without manipulation, each bone	No	Yes	ASSH	Can be part of more extensive procedure.
25650	Closed treatment of ulnar styloid fracture	No	Yes	ASSH	Can be part of more extensive procedure.
25651	Percutaneous skeletal fixation of ulnar styloid fracture	No	Yes	ASSH	Can be done in ASC not in office.
25652	Open treatment of ulnar styloid fracture	No	Yes	ASSH	Can be done in ASC not in office.
25900	Amputation, forearm, through radius and ulna;	No	Yes	ASSH	Can be done in ASC not in office.
25905	Amputation, forearm, through radius and ulna; open, circular (guillotine)	No	Yes	ASSH	Can be done in ASC not in office.
25909	Amputation, forearm, through radius and ulna; re-amputation	No	Yes	ASSH	Can be done in ASC not in office.
25915	Krukenberg procedure	No	Yes	ASSH	Can be done in ASC not in office.
25920	Disarticulation through wrist;	No	Yes	ASSH	Can be done in ASC not in office.
25924	Disarticulation through wrist; re-amputation	No	Yes	ASSH	Can be done in ASC not in office.
25927	Transmetacarpal amputation;	No	Yes	ASSH	Can be done in ASC not in office.
25931	Transmetacarpal amputation; re-amputation	No	Yes	ASSH	Can be done in ASC not in office.
26010	Drainage of finger abscess; simple	No	Yes	ASSH	Can be part of more extensive procedure.
26037	Decompressive fasciotomy, hand (excludes 26035)	No	Yes	ASSH	Can be done prophylactically not requiring admission. Not done in office.
26340	Manipulation, finger joint, under anesthesia, each joint	No	Yes	ASSH	Can be part of more extensive procedure.
26600	Closed treatment of metacarpal fracture, single; without manipulation, each bone	No	Yes	ASSH	Can be part of more extensive procedure.

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
26605	Closed treatment of metacarpal fracture, single; with manipulation, each bone	Proposed Deletion - 4	Yes	ASSH	Can be part of another procedure done in ASC.
26641	Closed treatment of carpometacarpal dislocation, thumb, with manipulation	No	Yes	ASSH	Can be part of more extensive procedure.
26670	Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; without anesthesia	No	Yes	ASSH	Can be part of more extensive procedure.
26700	Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia	No	Yes	ASSH	Can be part of more extensive procedure.
26720	Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each	No	Yes	ASSH	Can be part of more extensive procedure.
26725	Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; with manipulation, with or without skin or skeletal traction, each	No	Yes	ASSH	Can be part of more extensive procedure.
26740	Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; without manipulation, each	No	Yes	ASSH	Can be part of more extensive procedure.
26750	Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each	No	Yes	ASSH	Can be part of more extensive procedure.
26755	Closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, each	No	Yes	ASSH	Can be part of more extensive procedure.
26770	Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia	No	Yes	ASSH	Can be part of more extensive procedure.
26775	Closed treatment of interphalangeal joint dislocation, single, with manipulation; requiring anesthesia	No	Yes	ASSH	Can be part of more extensive procedure.
28800	Amputation, foot; midtarsal (eg, Chopart type procedure)	No	Yes	ACS, SVS	Similar to 28810, 28820, 28825, which are on the ASC list. Many of these patients can go home that same day, given that most have peripheral neuropathy and have reduced pain in the feet.
28805	Amputation, foot; transmetatarsal	No	Yes	ACS, SVS	Similar to 28810, 28820, 28825, which are on the ASC list. Many of these patients can go home that same day, given that most have peripheral neuropathy and have reduced pain in the feet.
29055	Application, cast; shoulder spica	No	Yes	ASSH	Can be part of more extensive procedure.
29065	Application, cast; shoulder to hand (long arm)	No	Yes	ASSH	Can be part of more extensive procedure.
29075	Application, cast; elbow to finger (short arm)	No	Yes	ASSH	Can be part of more extensive procedure.
29085	Application, cast; hand and lower forearm (gauntlet)	No	Yes	ASSH	Can be part of more extensive procedure.
29086	Application, cast; finger (eg, contracture)	No	Yes	ASSH	Can be part of more extensive procedure.
29105	Application of long arm splint (shoulder to hand)	No	Yes	ASSH	Can be part of more extensive procedure.
29125	Application of short arm splint (forearm to hand); static	No	Yes	ASSH	Can be part of more extensive procedure.
29126	Application of short arm splint (forearm to hand); dynamic	No	Yes	ASSH	Can be part of more extensive procedure.
29130	Application of finger splint; static	No	Yes	ASSH	Can be part of more extensive procedure.
29131	Application of finger splint; dynamic	No	Yes	ASSH	Can be part of more extensive procedure.
29240	Strapping; shoulder (eg, Velpeau)	No	Yes	ASSH	Can be part of more extensive procedure.
29260	Strapping; elbow or wrist	No	Yes	ASSH	Can be part of more extensive procedure.
29280	Strapping; hand or finger	No	Yes	ASSH	Can be part of more extensive procedure.
29700	Removal or bivalving; gauntlet, boot or body cast	No	Yes	ASSH	Can be part of more extensive procedure.
29705	Removal or bivalving; full arm or full leg cast	No	Yes	ASSH	Can be part of more extensive procedure.
29720	Repair of spica, body cast or jacket	No	Yes	ASSH	Can be part of more extensive procedure.
29730	Windowing of cast	No	Yes	ASSH	Can be part of more extensive procedure.
29740	Wedging of cast (except clubfoot casts)	No	Yes	ASSH	Can be part of more extensive procedure.
32002	Thoracentesis with insertion of tube with or without water seal (eg, for pneumothorax) (separate procedure)	No	Yes	ACS	May be necessary after image guided lung biopsy in ASC.
32019	Insertion of indwelling tunneled pleural catheter with cuff	No	Yes	ACS	Determined by anesthesia needs, patient age and comorbidities.
35474	Transluminal balloon angioplasty, percutaneous; femoral-popliteal	No	Yes	SVS	Safely performed in an ASC.
36215	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	No	Yes	SVS	Safely performed in an ASC.
36216	Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family	No	Yes	SVS	Safely performed in an ASC.

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
36217	Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	No	Yes	SVS	Safely performed in an ASC.
36218	Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	No	Yes	SVS	Safely performed in an ASC.
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	No	Yes	SVS	Safely performed in an ASC.
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	No	Yes	SVS	Safely performed in an ASC.
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	No	Yes	SVS	Safely performed in an ASC.
36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	No	Yes	SVS	Safely performed in an ASC.
36468	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk	No	Yes	SVS	Safely performed in an ASC.
36469	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face	No	Yes	SVS	Safely performed in an ASC.
36470	Injection of sclerosing solution; single vein	No	Yes	SVS	Safely performed in an ASC.
36471	Injection of sclerosing solution; multiple veins, same leg	No	Yes	SVS	Safely performed in an ASC.
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	No	Yes	ACS, SVS, ASGS	ACS - Determined by anesthesia needs, patient age and comorbidities; ASGS: May require general anesthesia.
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in a	No	Yes	ACS, SVS, ASGS	ACS - Determined by anesthesia needs, patient age and comorbidities; ASGS: May require general anesthesia.
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	No	Yes	ACS, SVS, ASGS	ACS - Determined by anesthesia needs, patient age and comorbidities; ASGS: May require general anesthesia.
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition t	No	Yes	ACS, SVS, ASGS	ACS - Determined by anesthesia needs, patient age and comorbidities; ASGS: May require general anesthesia.
36595	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access	No	Yes	ACS	Determined by anesthesia needs, patient age and comorbidities.
36596	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen	No	Yes	ACS	Determined by anesthesia needs, patient age and comorbidities.
36597	Repositioning of previously placed central venous catheter under fluoroscopic guidance	No	Yes	ACS	Determined by anesthesia needs, patient age and comorbidities.
36818	Arteriovenous anastomosis, open; by upper arm cephalic vein transposition	No	Yes	ACS, SVS, ASGS	ACS - This operation is similar to others in this family which are on the approved ASC list; ASGS: Essentially the same as 36819.
36838	Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)	No	Yes	ACS	This operation is similar to others in this family which are on the approved ASC list.
37250	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)	No	Yes	SVS	Safely performed in an ASC.
37251	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel (List separately in addition to code for primary procedure)	No	Yes	SVS	Safely performed in an ASC.
37620	Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)	No	Yes	SVS	Safely performed in an ASC.

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
37765	Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions	No	Yes	ACS, SVS	ACS - Determined by anesthesia needs, patient age and comorbidities; SVS - Can safely be performed in an ASC.
37766	Stab phlebectomy of varicose veins, one extremity; more than 20 incisions	No	Yes	ACS, SVS	ACS - Determined by anesthesia needs, patient age and comorbidities; SVS - Can safely be performed in an ASC.
38505	Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)	Proposed Deletion - 4	Yes	ACS	Retain on ASC list. Determined by anesthesia needs, patient age and comorbidities.
41520	Frenoplasty (surgical revision of frenum, eg, with Z-plasty)	Proposed Deletion - 1	Yes	ASPS, ASMS, AAFPRS	Not always safe in the office. This procedure may require conscious sedation or general anesthesia. Airway compromise from swelling or excess bleeding is a possibility in a patient who is not alert or not able to cooperate.
43237	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus	No	Yes	ACS, ASGS	ACS - Might need to be done in ASC depending on level sedation required; ASGS - May be performed in ASC provided appropriate equipment is available.
43238	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound)	No	Yes	ACS, ASGS	ACS - Determined by anesthesia needs, patient age and comorbidities; ASGS - May be performed in ASC provided appropriate equipment is available.
43257	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal refl	No	Yes	ACS, ASGS	ACS - Determined by anesthesia needs, patient age and comorbidities; ASGS - May be performed in ASC provided appropriate equipment is available.
45303	Proctosigmoidoscopy, rigid; with dilation (eg, balloon, guide wire, bougie)	No	Yes	ASCRS (C&R)	Initial bougie or balloon dilation is often better done under IV sedation which may not be feasible in the office setting
45391	Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examination	No	Yes	ACS, ASCRS (C&R)	ACS - Determined by anesthesia needs, patient age and comorbidities; ASCRS (C&R) - Any endoscopy proximal to the splenic flexure will likely require IV sedation which may not be available in an office setting.
45392	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)	No	Yes	ACS, ASCRS (C&R)	ACS - Determined by anesthesia needs, patient age and comorbidities; ASCRS (C&R) - Any endoscopy proximal to the splenic flexure will likely require IV sedation which may not be available in an office setting.
46221	Hemorrhoidectomy, by simple ligature (eg, rubber band)	No	Yes	ASCRS (C&R)	This procedure is often performed at the same time with other ASC-approved procedures (eg, colonoscopy with biopsy), while patient is sedated.
46230	Excision of external hemorrhoid tags and/or multiple papillae	No	Yes	ASCRS (C&R)	This procedure may be performed at the same time with other ASC-approved procedures (eg, colonoscopy with biopsy), while patient is sedated. Additionally, many patients cannot tolerate the pain under local anesthesia and require IV sedation that may not be available in an office setting.
46706	Repair of anal fistula with fibrin glue	No	Yes	ASCRS (C&R)	With placement of a stitch at the internal opening and saucerizing of the external opening IV sedation is required.
46910	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation	No	Yes	ASCRS (C&R)	Many patients cannot tolerate fulguration under local anesthesia, even for mild to moderate disease. It does not make sense to approve laser fulguration (46917) in an ASC, but not electrodesiccation.
46947	Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling	No	Yes	ACS, ASCRS (C&R), ASGS	ACS - This procedure is similar to hemorrhoidectomy which is on the ASC approved list; ASCRS (C&R) - PPH requires IV sedation that may not be available in the office setting; ASGS - May be performed in an ASC provided appropriate equipment is available.
47562	Laparoscopy, surgical; cholecystectomy	No	Yes	ACS, ASGS	ACS - Laparoscopic cholecystectomy is certainly no more complex than 38570-38572, and can safely be performed an outpatient in an ASC with proper patient selection. CMS can use their data to see how many laparoscopic cholecystectomies are performed and then discharged on the same day, and this will show that this is done on a frequent basis; ASGS - Very appropriate for ASC.

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	No	Yes	ACS, ASGS	ACS - Laparoscopic cholecystectomy is certainly no more complex than 38570-38572, and can safely be performed as an outpatient in an ASC with proper patient selection. CMS can use their data to see how many laparoscopic cholecystectomies are performed and then discharged on the same day, and this will show that this is done on a frequent basis; ASGS - Very appropriate for ASC.
49419	Insertion of intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent (ie, totally implantable)	No	Yes	ACS, ASCRS (C&R), ASGS	ACS - This procedure is similar to other codes in this group (49421) which are on the ASC approved list. Determined by anesthesia needs, patient age and comorbidities; ASCRS (C&R)- Does not make sense to approve 49420-49422, but not 49419; ASGS - Very appropriate for ASC.
51741	Complex uroflowmetry (eg, calibrated electronic equipment)	No	Yes	ACOG	More complex than 51736, similar to 51772.
51784	Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique	No	Yes	ACOG	Similar to ASC procedure 51785.
51795	Voiding pressure studies (VP); bladder voiding pressure, any technique	No	Yes	ACOG	Though low percentage, many are still done in ASCs.
51797	Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal)	No	Yes	ACOG	Though low percentage, many are still done in ASCs.
52000	Cystourethroscopy (separate procedure)	Proposed Deletion - 4	Yes	AUA	Should be retained on the ASC list for health and safety reasons. A significant percentage of diagnostic cystoscopies result in the discovery of a condition that will require a subsequent therapeutic procedure. When the diagnostic procedure is performed in the facility setting the therapeutic procedure is most often performed in the same operative session. If the diagnostic procedure is furnished in the office and a problem requiring therapeutic intervention is discovered, the patient must undergo the second therapeutic procedure at a later date in a facility setting. In such circumstances, the patient needs to undergo the discomfort and risk of two invasive procedures.
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female	Proposed Deletion - 4	Yes	AUA	Should be retained on the ASC list for health and safety reasons. Dilation of a urethral stricture that requires cystoscopic guidance is a painful and complex procedure requiring specialized equipment, sedation and often general anesthesia. There are obvious sexual anatomic differences and individual patient characteristics that determine site of service decisions. Patient-care factors include the need for anesthesia, sterility and monitoring for high-risk patients.
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	Proposed Deletion - 1	No	AUA	Support deletion based on the fact that the ASC facility fee of \$1,339 does not cover the cost of the supplies and equipment required for this procedure. In this case, leaving the procedure off the ASC list and allowing physicians to bill for the in-office payment rate when performed in an ASC (which is the policy for procedures that aren't on the list) is the only way to ensure that Medicare beneficiaries will have access to this procedure in the ASC setting if necessary. Once the ASC payment system is reformed to include more payment groups, TUMT should be placed into a payment group that would more closely match the expenses involved in performing the procedure in an ASC.

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
55700	Biopsy, prostate; needle or punch, single or multiple, any approach	Proposed Deletion - 4	Yes	AUA	Should be retained on the ASC list for health and safety reasons. The clinical standard of care for prostate biopsy has shifted over time, and the procedure is more intensive and uncomfortable than it was in the past and patients are increasingly being anesthetized for prostate biopsy. The standard of care has moved from taking four to six biopsies of the prostate to taking 12 or more cores and urologists need to administer intravenous sedation with appropriate safeguards sometimes available only in an ASC or Hospital setting. Patients needing either a trans-perineal or trans-urethral approach require anesthesia, and cannot be comfortably and safely performed in the office setting. Also, saturation prostate biopsy is now frequently performed prior to specific curative therapies for prostate cancer. Limiting treatment fields with either localized cryotherapy or brachytherapy has become popular to minimize treatment morbidity. These therapeutic options require much more intensive prostate biopsy protocols to delineate the extent of disease, and all of these patients require anesthesia.
57288	Sling operation for stress incontinence (eg, fascia or synthetic)	Yes	Yes	AUA	Agree with addition to ASC list. However, should be added to payment category 9. Need clarification from CMS in final rule as to whether the sling material can be reimbursed separately, as the group 9 payment will not cover the cost of this supply item, which ranges from \$700 to over \$850 depending on the manufacturer and type of kit purchased.
58260	Vaginal hysterectomy, for uterus 250 grams or less;	No	Yes	ACOG	Vaginal hysterectomies are not commonly done in ASCs, but should be permitted if the physician believes that it the best setting, just as laproscopic hysterectomies (58550) are permitted in ASCs.
58262	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s), and/or ovary(s)	No	Yes	ACOG	Vaginal hysterectomies are not commonly done in ASCs, but should be permitted if the physician believes that it the best setting, just as laproscopic hysterectomies (58550) are permitted in ASCs.
58263	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s), and/or ovary(s), with repair of enterocele	No	Yes	ACOG	Vaginal hysterectomies are not commonly done in ASCs, but should be permitted if the physician believes that it the best setting, just as laproscopic hysterectomies (58550) are permitted in ASCs.
58267	Vaginal hysterectomy, for uterus 250 grams or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	No	Yes	ACOG	Vaginal hysterectomies are not commonly done in ASCs, but should be permitted if the physician believes that it the best setting, just as laproscopic hysterectomies (58550) are permitted in ASCs.
58270	Vaginal hysterectomy, for uterus 250 grams or less; with repair of enterocele	No	Yes	ACOG	Vaginal hysterectomies are not commonly done in ASCs, but should be permitted if the physician believes that it the best setting, just as laproscopic hysterectomies (58550) are permitted in ASCs.
58275	Vaginal hysterectomy, with total or partial vaginectomy;	No	Yes	ACOG	Vaginal hysterectomies are not commonly done in ASCs, but should be permitted if the physician believes that it the best setting, just as laproscopic hysterectomies (58550) are permitted in ASCs.
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele	No	Yes	ACOG	Vaginal hysterectomies are not commonly done in ASCs, but should be permitted if the physician believes that it the best setting, just as laproscopic hysterectomies (58550) are permitted in ASCs.
58290	Vaginal hysterectomy, for uterus greater than 250 grams;	No	Yes	ACOG	Vaginal hysterectomies are not commonly done in ASCs, but should be permitted if the physician believes that it the best setting, just as laproscopic hysterectomies (58550) are permitted in ASCs.
58291	Vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)	No	Yes	ACOG	Vaginal hysterectomies are not commonly done in ASCs, but should be permitted if the physician believes that it the best setting, just as laproscopic hysterectomies (58550) are permitted in ASCs.
58292	Vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s), with repair of enterocele	No	Yes	ACOG	Vaginal hysterectomies are not commonly done in ASCs, but should be permitted if the physician believes that it the best setting, just as laproscopic hysterectomies (58550) are permitted in ASCs.
58293	Vaginal hysterectomy, for uterus greater than 250 grams; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	No	Yes	ACOG	Vaginal hysterectomies are not commonly done in ASCs, but should be permitted if the physician believes that it the best setting, just as laproscopic hysterectomies (58550) are permitted in ASCs.
58294	Vaginal hysterectomy, for uterus greater than 250 grams; with repair of enterocele	No	Yes	ACOG	Vaginal hysterectomies are not commonly done in ASCs, but should be permitted if the physician believes that it the best setting, just as laproscopic hysterectomies (58550) are permitted in ASCs.

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
58356	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed	No	Yes	ACOG	Similar to 58353, which is permitted in an ASC.
58552	Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)	No	Yes	ACOG	Should be accepted in ASC just as 58550 is.
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;	No	Yes	ACOG	Should be accepted in ASC just as 58550 is.
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)	No	Yes	ACOG	Should be accepted in ASC just as 58550 is.
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	No	Yes	ACOG	Should be included with other hysteroscopic procedures, 58555-58563
58970	Follicle puncture for oocyte retrieval, any method	No	Yes	ACOG	This in vitro fertilization procedures are commonly done in an ASC, though they are almost never done on Medicare patients. There is no reason for them to be excluded.
58974	Embryo transfer, intrauterine	No	Yes	ACOG	This in vitro fertilization procedures are commonly done in an ASC, though they are almost never done on Medicare patients. There is no reason for them to be excluded.
58976	Gamete, zygote, or embryo intrafallopian transfer, any method	No	Yes	ACOG	This in vitro fertilization procedures are commonly done in an ASC, though they are almost never done on Medicare patients. There is no reason for them to be excluded.
60000	Incision and drainage of thyroglossal duct cyst, infected	Proposed Deletion - 1	Yes	ACS	Retain on ASC list. Determined by anesthesia needs, patient age and comorbidities.
64561	Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)	No	Yes	ACOG	This procedure should be included as is 64950.
64581	Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)	No	Yes	ACOG	This procedure should be included as is 64950.
64820	Sympathectomy; digital arteries, each digit	No	Yes	ASSH	Can be done in ASC not in office.
64822	Sympathectomy; ulnar artery	No	Yes	ASSH	Can be done in ASC not in office.
64823	Sympathectomy; superficial palmar arch	No	Yes	ASSH	Can be done in ASC not in office.
65125	Modification of ocular implant with placement or replacement of pegs (eg, drilling receptacle for prosthesis appendage) (separate procedure)	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
65130	Insertion of ocular implant secondary; after evisceration, in scleral shell	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
65135	Insertion of ocular implant secondary; after enucleation, muscles not attached to implant	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
65771	Radial keratotomy	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
65780	Ocular surface reconstruction; amniotic membrane transplantation	No	Yes	AAO	Should be added to ASC approved procedure list.
65781	Ocular surface reconstruction; limbal stem cell allograft (eg, cadaveric or living donor)	No	Yes	AAO	Should be added to ASC approved procedure list.
65782	Ocular surface reconstruction; limbal conjunctival autograft (includes obtaining graft)	No	Yes	AAO	Should be added to ASC approved procedure list.
65800	Paracentesis of anterior chamber of eye (separate procedure); with diagnostic aspiration of aqueous	Proposed Deletion - 1	Yes	ASCRS, OOSS	This service is frequently furnished as add-on procedures concurrent with other ophthalmic surgical procedures.
65805	Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous	Proposed Deletion - 4	Yes	ASCRS, OOSS	This service is frequently furnished as add-on procedures concurrent with other ophthalmic surgical procedures.
65820	Goniotomy	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
66711	Ciliary body destruction; cyclophotocoagulation, endoscopic	No	Yes	AAO	Should be added to ASC approved procedure list.
66990	Use of ophthalmic endoscope (List separately in addition to code for primary procedure)	No	Yes	AAO	Should be added to ASC approved procedure list.
67101	Repair of retinal detachment, one or more sessions; cryotherapy or diathermy, with or without drainage of subretinal fluid	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
67141	Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; cryotherapy, diathermy	Proposed Deletion - 4	Yes	ASCRS, OOSS	Typically provided as add-on procedure concurrent with other ophthalmic procedures.
67228	Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; photocoagulation (laser or xenon arc)	No	Yes	AAO	Should be added to ASC approved procedure list

CPT	2005 Long Descriptor	ASC Medicare Approved List (2005 Proposed Status)	Specialty Society Recommendation	Specialty Society	Specialty Society Rationale
67445	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of bone for decompression	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list. This procedure is similar in extent and equipment to 67450 which is allowed.
67570	Optic nerve decompression (eg, incision or fenestration of optic nerve sheath)	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
67810	Biopsy of eyelid	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
67840	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
67850	Destruction of lesion of lid margin (up to 1 cm)	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)	No	Yes	AAO	Should be added to ASC approved procedure list.
68100	Biopsy of conjunctiva	No	Yes	AAO, ASCRS	Should be added to ASC approved procedure list.
68110	Excision of lesion, conjunctiva; up to 1 cm	No	Yes	AAO, ASCRS	Should be added to ASC approved procedure list.
68340	Repair of symblepharon; division of symblepharon, with or without insertion of conformer or contact lens	Proposed Deletion - 1	Yes	AAO, ASCRS, OOSS	AAO - Should remain on list of ASC approved procedures; ASCRS, OOSS - Service may involve extensive surgical dissection and is more appropriately furnished in an ASC. Deletion from the list will compel the surgeon to conduct the procedure in the more costly and less convenient hospital outpatient department setting or in the inappropriate office treatment room.
68371	Harvesting conjunctival allograft, living donor	No	Yes	AAO	Should be added to ASC approved procedure list.
68400	Incision, drainage of lacrimal gland	No	Yes	AAO, ASCRS	Should be added to ASC approved procedure list.
68420	Incision, drainage of lacrimal sac (dacryocystotomy or dacryocystostomy)	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
68530	Removal of foreign body or dacryolith, lacrimal passages	No	Yes	AAO, ASCRS, OOSS	Should be added to ASC approved procedure list.
68810	Probing of nasolacrimal duct, with or without irrigation;	Proposed Deletion - 4	Yes	AAO, ASCRS, OOSS	AAO - Probing of the NLD reaching into the nose may lead to airway problems as well as nasal bleeding. This procedure in many patients should be performed in an ASC setting; ASCRS, OOS - When furnished concurrent with nasolacrimal duct surgery, the ASC environment is appropriate.
69990	Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)	No	Yes	ASSH	This is an add on code for many microsurgery codes that can be done in an ASC.
95972	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex brain, spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour	No	Yes	ACOG	This procedure should be included as is 64950.