

## Type 2 VICNISS Procedure Groups, ICD10-AM Codes, and CMBS Codes

Participating hospitals have a choice to undertake VICNISS surveillance of surgical site infections on a select number of procedure groups. This list helps to ensure sufficient numbers of procedures are available to allow calculation of valid aggregate infection rates within a shorter time frame.

CMBS codes are now included here in addition to ICD10 as these are often used in theatre databases accessed by SHIINe. While there is sometimes a correlation between codes and they may be similar, there is not a one to one correlation between them. Both groups of codes presented here are intended to include the same procedures. CMBS codes listed here are the ones the SHIINe software uses to obtain data from the theatre database for VICNISS procedure groups included in your surveillance plan.

### APPENDIX SURGERY

Procedure Group: *APPY*

Description: *Operation of appendix (not incidental to another procedure)*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3057100	Appendicectomy	30571	Appendicectomy, not being a service to which item 30574 applies
3057200	Laparoscopic appendicectomy	30572	Laparoscopic appendicectomy
3037530	Caecoappendicostomy; Malone antegrade continence enema proceure	30574	Appendicectomy
9031100	Anastomosis of appendix;Closure of appendiceal fistula	30394	Laparotomy for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess or for peritonitis from any cause, with or without appendicectomy

**GALLBLADDER SURGERY**Procedure Group: *CHOL*Description: *Cholecystectomy and cholecystotomy; includes procedures performed using the laparoscope.*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3037505	Cholecystostomy	30375	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystectomy, Gastrostomy, Gastrotomy, Reduction of intussusception, Removal of Merckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas.
3037526	Cholecystotomy		
3044300	Cholecystectomy	30443	Cholecystectomy
3044500	Laparoscopic cholecystectomy	30445	Laparoscopic cholecystectomy
3044600	Laparoscopic cholecystectomy proceeding to open cholecystectomy	30446	Laaroscopic cholecystectomy when procedure is complicated by laparotomy
3044800	Laparoscopic cholecystectomy with removal of common bile duct calculus via cystic duct	30448	Laparoscopic cholecystectomy involving removal of common duct calculi via the cystic duct
3044900	Laparoscopic cholecystectomy with removal of common bile duct calculus via laparoscopic choledochotomy	30449	Laparoscopic cholecystectomy involving removal of common duct calculi via laaparoscopic choledochotomy
3045401	Cholecystectomy with choledochotomy	30454	Choledochotomy(with or without cholocystecomy) with or without removal of calculi
3045500	Cholecystectomy with choledochotomy and biliary intestinal anastomosis	30455	Choledochotomy(with or without cholocystectomy) with removal of calculi including biliary intestinal anastomosis

**COLORECTAL SURGERY**Procedure Group: *COLO*Description: *Incision, resection, or anastomosis of the large intestine; includes large-to-small and small-to-large bowel anastomosis.*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
		30373	Laparotomy, exploratory, including associated biopsies, where no other abdominal procedure is performed
3037500	Caecostomy	30375	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystectomy, Gastrostomy, Gastrotomy, Reduction of intussusception, Removal of Merckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas.
3037502	Colotomy		
3037504	Other colostomy	30376	Laparotomy involving division of peritoneal adhesions (where no other abdominal procedure is performed)
3037514	Biopsy of large intestine	30378	Laparotomy involving division of adhesions in conjunction with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours
3037525	Suture of laceration of large intestine	30379	Laparotomy with division of extensive adhesions (duration greater than 2 hours) with or without insertion of long intestinal tube
3037528	Temporary colostomy	30382	Enterocutaneous fistula, radical repair of, involving extensive dissection and resection of bowel
3038202	Radical repair of enterocutaneous fistula of large intestine	30387	Laparotomy involving operation on abdominal viscera (including pelvic viscera)
3056202	Closure of loop colostomy	30388	Laparotomy for trauma involving 3 or more organs
3056203	Closure of colostomy with restoration of bowel continuity	30392	Radical or debulking operation for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure
3056205	Closure of other stoma of large intestine	30393	Laparoscopic division of adhesions in association with another intra-abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes
3056301	Revision of stoma of large intestine	30563	Colostomy or ileostomy, refashioning of

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3200000	Limited excision of large intestine with formation of stoma	32000	Large intestine, resection of , without anastomosis, including right hemicolectomy (including formation of stoma)
3200001	Right hemicolectomy with formation of stoma		
3200300	Limited excision of large intestine with anastomosis	32003	Large intestine, resection of , without anastomosis, including right hemicolectomy
3200301	Right hemicolectomy with anastomosis		
3200400	Sub-total colectomy with formation of stoma	32004	Large intestine, subtotal colectomy(resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32004 or 32006 applies.
3200401	Extended right hemicolectomy with formation of stoma		
3200500	Subtotal colectomy with anastomosis	32005	Large intestine, subtotal colectomy(resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32005 or 32006 applies.
3200501	Extended right hemicolectomy with anastomosis		
3200600	Left hemicolectomy with anastomosis	32006	Left hemicolectomy, including the descending and sigmoid colon (including formation of stoma)
3200601	Left hemicolectomy with formation of stoma		
3200900	Total colectomy with ileostomy	32009	Total colectomy and ileostomy
3201200	Total colectomy with ileorectal anastomosis	32012	Total colectomy and ileorectal anastomosis
3201500	Total proctectomy with ileostomy	32015	Total colectomy with excision of rectum and ileostomy
		32018	Total colectomy with excision of rectum and ileostomy, combined synchronous operation;abdominal resection
		32021	Total colectomy with excision of rectum and ileostomy, combined synchronous operation;perineal resection
3202400	High restorative anterior resection of rectum with intraperitoneal anastomosis	32024	Rectum, high restorative anterior resection with intraperitoneal anastomosis(of the rectum) greater than 10cm from the anal verge excluding resection of sigmoid colon alone not being a service associated with a service to which item 32013, 32014 or 32016 applies.
3202500	Low restorative anterior resection of rectum with extraperitoneal anastomosis	32025	Rectum, low restorative anterior resection with extraperitoneal anastomosis (of the rectum) less than 10 cm from the anal verge with or without covering stoma not being a service associated with a service to which item 32013, 32014 or 32016 applies.

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3202600	Low restorative anterior resection of rectum with coloanal anastomosis	32026	Rectum, ultra low restorative resection, with or without covering stoma, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge.
3202800	Ultra low restorative anterior resection of rectum with sutured coloanal anastomosis	32028	Rectum, low or ultra low restorative resection, with peranal sutured coloanal anastomosis, with or without covering stoma.
3202900	Construction of colonic reservoir		
3202901	Revision of colonic reservoir		
3203000	Rectosigmoidectomy with formation of stoma - Hartmann's procedure	32030	Rectosigmoidectomy (Hartmann's operation)
3203300	Restoration of bowel continuity after Hartmann's procedure	32033	Restoration of bowel following Hartmann's or similar operation, including dismantling of the stoma.
3203900	Abdominoperineal proctectomy	32039	Rectum and anus, abdominoperineal resection of 1 surgeon
		32042	Rectum and anus, abdominoperineal resection of, combined synchronous operation abdominal resection
		32045	Rectum and anus, abdominoperineal resection of, combined synchronous operation perineal resection
		32046	Rectum and anus, abdomino-perineal resection of, combined synchronous operation - perineal resection wheer the perineal surgeon also provides assistance to the abdominal surgeon
3204700	Perineal proctectomy	32047	Perineal proctectomy
3205100	Total proctectomy with ileo-anal anastomosis	32051	Total colectomy with excision of rectum and ieloanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy 1 surgeon
3205101	Total proctocolectomy with ileo-anal anastomosis and formation of temporary ileostomy	32054	Total colectomy with excision of rectum and ieloanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, abdominal surgeon(including aftercare)
		32057	Total colectomy with excision of rectum and ieloanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, perineal surgeon
3206000	Restorative proctectomy	32060	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy 1 surgeon
		32063	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare)

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
		32066	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, perineal surgeon
3209600	Full thickness biopsy of rectum'	32096	Rectal biopsy, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital or approved day hospital facility
3209900	Per anal sub mucosal excision of lesion or tissue of rectum		
3210800	Trans-sphincteric excision of lesion or tissue of rectum	32108	Ileostomy reservoir, continent type, creation of, including conversion of existing ileostomy where appropriate
3211200	Perineal rectosigmoidectomy		
4399301	Definitive intestinal resection and pull-through anastomosis		
9034100	Other excision of lesion of rectum		
9095900	Excision of other lesion of large intestine		

**CAESAREAN SECTION**

Procedure Group: CSEC

Description: *Obstetrical delivery by Caesarean section*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
1652000	Elective classical caesarean section	16520	Caeserean section and postoperative care for 7 days where the patients care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care
1652001	Emergency classical caesarean section		
1652002	Elective lower segment caesarean section		
1652003	Emergency lower segment caesarean section	16522	Management of labour and delivery or delivery alone, (including caesarean section) where in the course of antenatal supervision or intrapartum management 1 or more of the following conditions is present including postnatal care for 7 days - multiple pregnancy etc etc
3564900	Hysterotomy	35649	Hysterotomy or uterine myectomy, abdominal
		16519	MANAGEMENT OF LABOUR and delivery by any means (including Caesarean section) including post-partum care for 5 days

**GASTRIC SURGERY**

Procedure Group: GAST

Description: *Incision or excision of stomach; includes subtotal or total gastrectomy, does not include vagotomy and fundoplication*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3037506	Gastrotomy	30375	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystectomy, Gastrotomy, Gastrostomy, Reduction of intussusception, Removal of Merckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas.
3037510	Suture of perforated ulcer	30388	Laparotomy for trauma involving 3 or more organs

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3037512	Reduction of gastric volvulus		
3037513	Pyloroplasty		
3037515	Gastrotomy with removal of foreign body		
3049601	Selective vagotomy with pyloroplasty	30496	Vagotomy, truncal or selective, with or without pyloroplasty or gastroenterostomy
3049602	Selective vagotomy with gastro-enterostomy		
3049700	Selective vagotomy with partial gastrectomy and gastroduodenal anastomosis	30497	Vagotomy and antrectomy
3049701	Selective vagotomy with partial gastrectomy and gastrojejunal anastomosis		
3049702	Selective vagotomy with partial gastrectomy and Roux-en-Y reconstruction		
3050000	Highly selective vagotomy with duodenoplasty	30500	Vagotomy, highly selective with duodenoplasty for peptic stricture
3050200	Highly selective vagotomy with dilation of pylorus	30502	Vagotomy, highly selective with dilatation of pylorus
3050300	Partial gastrectomy with gastroduodenal anastomosis following previous procedure for peptic ulcer disease	30503	Vagotomy or antrectomy, or both, for peptic ulcer, following previous operation for peptic ulcer
3050301	Partial gastrectomy with gastrojejunal anastomosis following previous procedure for peptic ulcer disease		
3050302	Partial gastrectomy with Roux-en-Y reconstruction following previous procedure for peptic ulcer disease		
3050303	Selective vagotomy with partial gastrectomy and gastroduodenal anastomosis following previous procedure for peptic ulcer disease		
3050304	Selective vagotomy with partial gastrectomy and gastrojejunal anastomosis following previous procedure for peptic ulcer disease		
3050305	Selective vagotomy with partial gastrectomy and Roux-en-Y reconstruction following previous procedure for peptic ulcer disease		
3050500	Control of bleeding peptic ulcer	30505	Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision
		30506	Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy
		30508	Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3050900	Control of bleeding peptic ulcer by gastric resection	30509	Bleeding peptic ulcer, control of, involving gastric resection (other than wedge resection)
3051100	Gastric reduction	30511	Morbid obesity, gastric reduction of gastroplasty for, by any method
3051101	Laparoscopic adjustable gastric banding (LAGB)		
3051200	Gastric bypass	30512	Morbid obesity, gastric reduction of gastroplasty for, by any method including anastomosis
3051201			
3051202			
3051400	Surgical reversal of procedure for morbid obesity	30514	Morbid obesity, surgical reversal, by any method, of procedure to which item 30511 or 30512 applies
3051500	Gastro-enterostomy	30515	Gastroenterostomy (including gastroduodenostomy) or enterocolostomy or enteroenterostomy
3051700	Reconstruction of pyloroplasty	30517	Gastroenterostomy, pyloroplasty or gastroduodenostomy, reconstruction of
3051701	Reconstruction of gastroenterostomy		
3051800	Partial distal gastrectomy with gastroduodenal anastomosis	30518	Partial gastrectomy
3051801	Partial distal gastrectomy with gastrojejunal anastomosis		
3051802	Partial proximal gastrectomy with oesophagogastric anastomosis		
3052000	Local excision of gastric lesion	30520	Gastric tumour, removal of, by local excision, not being a service to which item 30518 applies
3052100	Total gastrectomy	30521	Gastrectomy, total, for benign disease
3052300	Subtotal gastrectomy	30523	Gastrectomy, subtotal radical, for carcinoma (including splenectomy when performed)
3052400	Radical gastrectomy	30524	Gastrectomy, total radical, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed)
		30526	Gastrectomy, total, and including lower oesophagus, performed by left thoraco-abdominal incision or opening of diaphragmatic hiatus (including splenectomy when performed)
9030400	Other repair of stomach		
9033900	Closure of gastrostomy		
9034202	Suture of laceration of stomach		

**HERNIORRHAPHY**Procedure Group: *HERN*Description: *Repair of inguinal, femoral, umbilical, or anterior abdominal wall hernia; does not include repair of diaphragmatic or hiatal hernia or hernias at other body sites*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3040300	Repair of incisional hernia	30403	Ventral, incisional, or recurrent hernia or burst abdomen, repair of with or without mesh
3040301	Repair of other abdominal wall hernia		
3040500	Repair of incisional hernia with muscle transposition	30405	Ventral or incisional hernia,(excluding recurrent inguinal or femoral hernia), repair of, requiring muscle transposition, mesh hernioplasty or resection of strangulated bowel
3040501	Repair incisional hernia with prosthesis		
3040502	Repair of incisional hernia with resection of strangulated intestine		
3040503	Repair of other abdominal wall hernia with muscle transposition		
3040504	Repair of other abdominal wall hernia with prosthesis		
3040505	Repair of other abdominal wall hernia with resection of strangulated intestine		
3060900	Laparoscopic repair of femoral hernia, unilateral	30609	Femoral or inguinal hernia, laparoscopic repair of, not being a service associate with a service to which item 30612 or 30614 applies
3060901	Laparoscopic repair of femoral hernia, bilateral		
3060902	Laparoscopic repair of inguinal hernia, unilateral		
3060903	Laparoscopic repair of inguinal hernia, bilateral	30612	Femoral or inguinal hernia or infantile hydrocele, repair of, not being a service to which item 30403 or 30615 applies
3061400	Repair of femoral hernia, unilateral	30614	Femoral or inguinal hernia or infantile hydrocele, repair of, not being a service to which item 30403 or 30615 applies
3061401	Repair of femoral hernia, bilateral		
3061402	Repair of inguinal hernia, unilateral		
3061403	Repair of inguinal hernia, bilateral	30616	Umbilical, epigastric or linea alba hernia, repair of, in a person under 10 years of age
3061700	Repair of umbilical hernia	30617	Umbilical, epigastric or linea alba hernia, repair of, in a person under 10 years of age

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3061701	Repair of epigastric hernia	30620	Umbilical, epigastric or linea alba hernia, repair of, in a person 10 years of age or over
3061702	Repair of linea alba hernia	30621	Umbilical, epigastric or linea alba hernia, repair of, in a person 10 years of age or over
		44108	Inguinal hernia repair at age less than 3 months
		44114	Inguinal hernia repair at age less than 3 months, including orchidopexy when performed

## HIP PROSTHESIS

Procedure Group: *HPRO*

Description: *Arthroplasty of hip; includes total, partial and revision arthroplasties; does not include Birmingham hip resurfacing*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
4752200	Hemiarthroplasty of femur - Austin Moore arthroplasty	47522	FEMUR, treatment of subcapital fracture of, by hemi-arthroplasty (Anaes.) (Assist.)
4931500	Partial arthroplasty of hip	49315	HIP, arthroplasty of, unipolar or bipolar (Anaes.) (Assist)
4931800	Total arthroplasty of hip, unilateral, total joint replacement of hip	49318	HIP, total replacement arthroplasty of, including minor bone grafting (Anaes.)(Assist.)
4931900	Total arthroplasty of hip, bilateral	49319	HIP, total replacement arthroplasty of, including minor bone grafting, if performed - bilateral (Anaes.)(Assist.)
		49321	HIP, total replacement arthroplasty of, including major bone grafting, including obtaining a graft (Anaes.) (Assist.)
4932400	Revision of total arthroplasty of hip	49324	HIP, total replacement arthroplasty of, revision procedure including removal of prosthesis (Anaes.) (Assist.)
4932700	Revision of total arthroplasty of hip with bone graft to acetabulum	49327	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (Anaes.) (Assist.)
4933000	Revision of total arthroplasty of hip with bone graft to femur	49330	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Anaes.) (Assist.)

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
4933300	Revision of total arthroplasty of hip with bone graft to acetabulum and femur	49333	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Anaes.) (Assist.)
		49336	HIP, treatment of a fracture of the femur where revision total hip replacement is required as part of the treatment of the fracture (not including intra-operative fracture), being a service associated with a service to which items 49324 to 49333 apply (Anaes.) (Assist.)
4933900	Revision of total arthroplasty of hip with anatomic specific allograft to acetabulum	49339	HIP, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cm in length (Anaes. ) (Assist.)
4934200	Revision of total arthroplasty of hip with anatomic specific allograft to femur	49342	HIP, revision total replacement of, requiring anatomic specific allograft of acetabulum (Anaes.) (Assist.)
4934500	Revision of total arthroplasty of hip with anatomic specific allograft to acetabulum and femur	49345	HIP, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (Anaes.) (Assist.)
4934600	Revision of partial arthroplasty of hip	49346	HIP, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (Anaes.) (Assist.)
5021700	Arthroplasty of joint, not elsewhere classified	50127	Joint or joints, arthroplasty of, by any technique and not being a service to which another time applies
5021503	En bloc resection of lesion of soft tissue affecting the long bones of lower limb, with intercalary reconstruction using prosthesis	50215	Malignant or aggressive soft tissue tumour affecting the long bones of leg or arm, en bloc resection of, with intercalary reconstruction (prosthesis, allograft or autograft)
5021803	En bloc resection of lesion of long bone of lower limb with replacement of adjacent joint	50218	Malignant tumour of long bone, en bloc resection of, with replacement or arthrodesis of adjacent joint
		50227	Malignant bone tumour, en bloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement

**ABDOMINAL HYSTERECTOMY**Procedure Group: *HYST*Description: *Removal of uterus through an abdominal incision*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3565300	Subtotal abdominal hysterectomy	35653	Hysterectomy, abdominal, subtotal or total, with or without removal of uterine adnexae
3565301	Total abdominal hysterectomy		
3565302	Abdominal hysterectomy with unilateral salpingo-oophorectomy		
3565303	Abdominal hysterectomy with bilateral salpingo-oophorectomy		
3565304	Total abdominal hysterectomy and removal of adnexa		
3566100	Abdominal hysterectomy with extensive retroperitoneal dissection	35661	Hysterectomy, abdominal, requiring extensive retroperitoneal dissection, with or without exposure of 1 or both ureters, for the management of severe endometriosis, pelvic inflammatory disease or benign pelvic tumours, with or without conservation of the ovaries
3566400	Radical abdominal hysterectomy with radical excision of pelvic lymph nodes	35664	Radical hysterectomy with radical excision of pelvic lymph glands (with or without removal of uterine adnexae) for proven malignancy including excision of any 1 or more parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving uterolysis where performed
3566700	Radical abdominal hysterectomy	35667	Radical hysterectomy without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving uterolysis where performed
3567000	Abdominal hysterectomy with radical excision of pelvic lymph nodes	35670	Hysterectomy, abdominal, with radical excision of pelvic lymph glands, with or without removal of uterine adnexae
		35750	Laparoscopically assisted hysterectomy, including any associated laparoscopy
		35753	Laparoscopically assisted hysterectomy with one or more of the following procedures: sapinegectomy, oophrectomy, excision of ovarian cyst or treatment of moderate endometriosis, one or both sides, including any associated laparoscopy

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
		35754	Laparoscopically assisted hysterectomy which requires dissection of endometriosis, or other pathology, from the ureter, one or both sides, including any associated laparoscopy, including when performed with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst, or treatment of endometriosis, not being a service to which item 35641 applies
3575600	Laparoscopically assisted vaginal hysterectomy proceeding to abdominal hysterectomy	35756	Laparoscopically assisted hysterectomy, when procedure is completed by open hysterectomy, including any associated laparoscopy
3575601	Laparoscopically assisted vaginal hysterectomy proceeding to abdominal hysterectomy with unilateral salpingo-oophorectomy		
3575602	Laparoscopically assisted vaginal hysterectomy proceeding to abdominal hysterectomy with bilateral salpingo-oophorectomy		
9044800	Subtotal laparoscopic abdominal hysterectomy		
9044801	Total laparoscopic abdominal hysterectomy		
9044802	Total laparoscopic abdominal hysterectomy with removal of adnexa		

## KNEE PROSTHESIS

Procedure Group: *KPRO*

Description: *Arthroplasty of knee*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
4951700	Hemiarthroplasty of knee	49517	Knee, hemiarthroplasty of
4951800	Total arthroplasty of knee, unilateral	49518	Knee, total replacement arthroplasty of
4951900	Total arthroplasty of knee, bilateral	49519	Knee, total replacement arthroplasty of, including associated minor grafting, if performed- bilateral
4952100	Total arthroplasty of knee with bone graft to femur, unilateral	49521	Knee, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft
4952101	Total arthroplasty to knee with bone graft to femur, bilateral		
4952102	Total arthroplasty to knee with bone graft to tibia, unilateral		

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
4952103	Total arthroplasty to knee with bone graft to tibia, bilateral		
4952400	Total arthroplasty of knee with bone graft to femur and tibia, unilateral	49524	Knee, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including obtaining of graft
4952401	Total arthroplasty of knee with bone graft to femur and tibia, bilateral		
4952700	Revision of total arthroplasty of knee	49527	Knee, total replacement arthroplasty of, revision procedure, including removal of prosthesis
4953000	Revision of total arthroplasty of knee with bone graft to femur	49530	Knee, total replacement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, including obtaining of graft and including removal of prosthesis
4953001	Revision of total arthroplasty of knee with bone graft to tibia		
4953300	Revision of total arthroplasty of knee with bone graft to femur and tibia	49533	Knee, total replacement arthroplasty of, revision procedure, requiring bone grafting to both femur and tibia, including obtaining of graft and including removal of prosthesis
4953400	Total replacement arthroplasty of patellofemoral joint of knee	49534	Knee, patello-femoral joint of, total replacement arthroplasty as a primary procedure
4955400	Revision of total arthroplasty of knee with anatomic specific allograft	49554	Knee, revision of total replacement of, by anatomic specific allograft of tibia or femur
		49554	Knee, revision of total replacement of, by anatomic specific allograft of tibia or femur
5021700	Arthroplasty of joint, not elsewhere classified	50127	Joint or joints, arthroplasty of, by any technique and not being a service to which another time applies
5021503	En bloc resection of lesion of soft tissue affecting the long bones of lower limb, with intercalary reconstruction using prosthesis	50215	Malignant or aggressive soft tissue tumour affecting the long bones of leg or arm, enbloc resection of, with intercalary reconstruction (prosthesis, allograft or autograft)
5021803	En boc resection of lesion of long bone of lower limb with replacement of adjacent joint	50218	Malignant tumour of long bone, enbloc resection of, with replacement or arthrodesis of adjacent joint
		50227	Malignant bone tumour, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement

**SMALL BOWEL SURGERY**

Procedure Group: SB

Description: *Incision or resection of the small intestine; does not include small-to-large bowel anastomosis*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3007513	Biopsy of small intestine		
3037501	Other enterostomy	30375	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystectomy, Gastrostomy, Gastrotomy, Reduction of intussusception, Removal of Merckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas.
3037503	Enterotomy of small intestine		
3037509	Excision of Meckel's diverticulum		
3037519	Other repair of small intestine		
3037524	Suture of small intestine		
3037529	Temporary ileostomy		
3038200	Radicla repair of enterocutaneous fistula of small intestine		
3047805	Percutaneous endoscopic jejunostomy (PEJ)		
3051501	Enterocolostomy - ileocolonic anastomosis		
3051502	Enteroenterostomy - Roux-en-Y reconstruction		
3056200	Closure of loop ileostomy	30562	Enterostomy or colostomy, closure of not involving resection of bowel
3056201	Closure of ileostomy with restoration of bowel continuity, without resection	30563	Colostomy or ileostomy, refashioning of
3056204	Closure of other stoma of small intestine		
3056300	Revision of stoma of small intestine		
3056400	Strictureplasty of small intestine	30564	Small bowel strictureplasty for chronic inflammatory bowel disease
3056500	Resection of small intestine with formation of stoma	30565	Small intestine, resection of, without anastomosis (including formation of stoma)
3056600	Resection of small intestine with anastomosis	30566	Small intestine, resection of, with anastomosis
3056800	Endoscopic examination of small intestine via interoperative enterotomy		

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3058000	Excision of lesion of duodenum		
3058101	Exploration of duodenum		
3146200	Insertion of feeding jejunostomy tube	31462	Operative feeding jejunostomy performed in conjunction with major upper gastro-intestinal resection
		32060	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy
		32063	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare)
		32066	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, perineal surgeon (including aftercare)
3206900	Formation of ileostomy reservoir	32069	Ileostomy reservoir, continent type, creation of, including conversion of existing ileostomy where appropriate
3206901	Revision of ileostomy reservoir		
4380700	Duodenoduodenostomy		
4381000	Repair of small intestine with anastomosis		
4381001	Repair of small intestine with multiple anastomoses		
9030600	Laparoscopic insertion of feeding jejunostomy tube		
9030700	Other procedures on small intestine		
9034000	Closure of fistula of small intestine		

**VAGINAL HYSTERECTOMY**Procedure Group: *VHYS*Description: *Vaginal approach with uterine removal*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3565700	Vaginal hysterectomy	35657	Hysterectomy, vaginal, with or without uterine curettage, not being a service to which item 35673 applies
3566401	Radical vaginal hysterectomy with radical excision of pelvic lymph nodes	35664	Radical hysterectomy with radical excision of pelvic lymph glands (with or without removal of uterine adnexae) for proven malignancy including excision of any 1 or more parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving uterolysis where performed
3566701	Radical vaginal hysterectomy	35667	Radical hysterectomy without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving uterolysis where performed
3567300	Vaginal hysterectomy with unilateral salpingo-oophorectomy	35673	Hysterectomy, vaginal, (with or without uterine curettage), with salpingectomy, oophrectomy or excision of ovarian cyst, 1 or more, or both sides
3567301	Vaginal hysterectomy with bilateral salpingo-oophorectomy		
3575000	Laparoscopically assisted vaginal hysterectomy	35750	Laparoscopically assisted hysterectomy, including any associate laparoscopy
3575300	Laparoscopically assisted vaginal hysterectomy with unilateral salpingo-oophorectomy	35753	Laparoscopically assisted hysterectomy with one or more of the following procedures: salpingectomy, oophrectomy, excision of ovarian cyst or treatment of moderate endometriosis, one or both sides, including any associated laparoscopy
3575301	Laparoscopically assisted vaginal hysterectomy with bilateral salpingo-oophorectomy	35754	Laparoscopically assisted hysterectomy which requires dissection of endometriosis, or other pathology, from the ureter, one or both sides, including any associated laparoscopy, including when performed with one or more of the following procedures: salpingectomy, oophrectomy, excision of ovarian cyst, or treatment of endometriosis, not being a service to which item 35641 applies