2018 GENERAL SURGERY MEDICARE REIMBURSEMENT CODING GUIDE

Effective January 1, 2018

Medicare National Average Rates and Allowables

(Not Adjusted for Geography)

		PHYSICIAN[3]		HOSPITAL OUTPATIENT[4]		ASC[4]
CPT CODE[1]/ HCPCS CODE[2]	CODE DESCRIPTION	MEDICARE NAT'L AVG CF=$35.9996		APC AND APC DESCRIPTION	MEDICARE NAT'L AVG	MEDICARE NAT'L AVG
		FACILITY SETTING	NON-FACILITY SETTING			
	ADRENALECTOMY					
60540	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure)	$1,105	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
60545	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure); with excision of adjacent retroperitoneal tumor	$1,265	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
60650	Laparoscopy, surgical, with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal	$1,242	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
	APPENDECTOMY					
44950	Appendectomy	$669	NA	5341, Peritoneal and Abdominal Procedures	$2,911	N/A for ASC
44955	Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure)	$88	NA	Not separately payable, packaged into payment for other procedures		N/A for ASC
44960	Appendectomy; for ruptured appendix with abscess or generalized peritonitis	$911	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
44970	Laparoscopy, surgical, appendectomy	$626	NA	5361, Level 1 Laparoscopy	$4,488	N/A for ASC
	CHOLECYSTECTOMY					
47562	Laparoscopy, surgical; cholecystectomy	$685	NA	5361, Level 1 Laparoscopy	$4,488	$2,097
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	$744	NA	5361, Level 1 Laparoscopy	$4,488	$2,097
47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct	$1,160	NA	5361, Level 1 Laparoscopy	$4,488	$2,097
47600	Cholecystectomy	$1,112	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		

Medtronic

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		FACILITY SETTING	NON-FACILITY SETTING			
47605	Cholecystectomy; with cholangiography	$1,171	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
47610	Cholecystectomy with exploration of common duct	$1,308	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
47612	Cholecystectomy with exploration of common duct; with choledochoenterostomy	$1,327	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
47620	Cholecystectomy with exploration of common duct; with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography	$1,439	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
	ESOPHAGECTOMY					
43107	Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)	$3,109	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43108	Total or near total esophagectomy, without thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es)	$4,637	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43112	Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty	$3,643	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43113	Total or near total esophagectomy, with thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	$4,531	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43116	Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction	$5,179	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43117	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)	$3,385	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43118	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	$3,785	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43121	Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty	$2,981	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43122	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty	$2,665	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		

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		FACILITY SETTING	NON-FACILITY SETTING			
43123	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	$4,695	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43124	Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy	$3,968	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
	GASTRECTOMY					
43620	Gastrectomy, total; with esophagoenterostomy	$2,061	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43621	Gastrectomy, total; with Roux-en-Y reconstruction	$2,367	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43622	Gastrectomy, total; with formation of intestinal pouch, any type	$2,414	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43631	Gastrectomy, partial, distal; with gastroduodenostomy	$1,511	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43632	Gastrectomy, partial, distal; with gastrojejunostomy	$2,120	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	$2,004	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43634	Gastrectomy, partial, distal; with formation of intestinal pouch	$2,221	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
	REPAIR OF DIAPHRAGMATIC HERNIA (HIATAL HERNIA)					
43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)	$1,127	NA	5362, Level 2 Laparoscopy	$7,595	N/A for ASC
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	$1,610	NA	5362, Level 2 Laparoscopy	$7,595	N/A for ASC
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	$1,810	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43325	Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)	$1,417	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	$1,210	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis	$1,319	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	$1,303	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43335	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis	$1,398	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		

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43336	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis	$1,569	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43337	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis	$1,617	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
	FUNDOPLICATION (EG, FOR GERD)					
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	$469	NA	5331, Complex GI Procedures	$4,294	N/A for ASC
43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)	$1,127	NA	5362, Level 2 Laparoscopy	$7,595	N/A for ASC
43325	Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)	$1,417	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43327	Esophagogastric fundoplasty partial or complete; laparotomy	$856	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
43328	Esophagogastric fundoplasty partial or complete; thoracotomy	$1,177	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
	HEPATECTOMY (LIVER)					
47120	Hepatectomy, resection of liver; partial lobectomy	$2,428	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
47122	Hepatectomy, resection of liver; trisegmentectomy	$3,565	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
47125	Hepatectomy, resection of liver; total left lobectomy	$3,207	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
47130	Hepatectomy, resection of liver; total right lobectomy	$3,444	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
	LYMPH NODE PROCEDURES					
38500	Biopsy or excision of lymph node(s); open, superficial	$264	$342	5091, Level 1 Breast/Lymphatic Surgery and Related Procedures	$2,728	$1,030
38510	Biopsy or excision of lymph node(s); open, deep cervical node(s)	$432	$532	5091, Level 1 Breast/Lymphatic Surgery and Related Procedures	$2,728	$1,030
38520	Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad	$481	NA	5091, Level 1 Breast/Lymphatic Surgery and Related Procedures	$2,728	$1,030
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)	$454	NA	5091, Level 1 Breast/Lymphatic Surgery and Related Procedures	$2,728	$1,030

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38530	Biopsy or excision of lymph node(s); open, internal mammary node(s)	$580	NA	5091, Level 1 Breast/Lymphatic Surgery and Related Procedures	$2,728	$1,030
38542	Dissection, deep jugular node(s)	$533	NA	5361, Level 1 Laparoscopy	$4,488	$2,097
38562	Limited lymphadenectomy for staging (separate procedure); pelvic and para-aortic	$734	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
38564	Limited lymphadenectomy for staging (separate procedure); retroperitoneal (aortic and/or splenic)	$732	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
38570	Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple	$528	NA	5361, Level 1 Laparoscopy	$4,488	$2,097
38571	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy	$692	NA	5362, Level 2 Laparoscopy	$7,595	$3,368
38572	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple	$963	NA	5362, Level 2 Laparoscopy	$7,595	$3,368
38700	Suprahyoid lymphadenectomy	$825	NA	5092, Level 2 Breast/Lymphatic Surgery and Related Procedures	$4,812	$2,046
38720	Cervical lymphadenectomy (complete)	$1,382	NA	5093, Level 3 Breast/Lymphatic Surgery and Related Procedures	$7,387	N/A for ASC
38724	Cervical lymphadenectomy (modified radical neck dissection)	$1,490	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
38740	Axillary lymphadenectomy; superficial	$723	NA	5361, Level 1 Laparoscopy	$4,488	$2,097
38745	Axillary lymphadenectomy; complete	$913	NA	5361, Level 1 Laparoscopy	$4,488	$2,097
38746	Thoracic lymphadenectomy by thoracotomy, mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)	$224	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
38747	Abdominal lymphadenectomy, regional, including celiac, gastric, portal, peripancreatic, with or without para-aortic and vena caval nodes (List separately in addition to code for primary procedure)	$279	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
38760	Inguinofemoral lymphadenectomy, superficial, including Cloquets node (separate procedure)	$876	NA	5092, Level 2 Breast/Lymphatic Surgery and Related Procedures	$4,812	$2,046
38765	Inguinofemoral lymphadenectomy, superficial, in continuity with pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)	$1,348	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		

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38770	Pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)	$842	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
38780	Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure)	$1,068	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
	MASTECTOMY					
19300	Mastectomy for gynecomastia	$429	$542	5091, Level 1 Breast/Lymphatic Surgery and Related Procedures	$2,728	$1,030
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	$677	NA	5091, Level 1 Breast/Lymphatic Surgery and Related Procedures	$2,728	$1,030
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	$932	NA	5092, Level 2 Breast/Lymphatic Surgery and Related Procedures	$4,812	$2,046
19303	Mastectomy, simple, complete	$995	NA	5092, Level 2 Breast/Lymphatic Surgery and Related Procedures	$4,812	$2,046
19304	Mastectomy, subcutaneous	$598	NA	5091, Level 1 Breast/Lymphatic Surgery and Related Procedures	$2,728	$1,030
19305	Mastectomy, radical, including pectoral muscles, axillary lymph nodes	$1,171	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
19306	Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)	$1,245	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
19307	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle	$1,241	NA	5092, Level 2 Breast/Lymphatic Surgery and Related Procedures	$4,812	N/A for ASC
	PANCREATECTOMY					
48140	Pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostomy	$1,630	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
48145	Pancreatectomy, distal subtotal, with or without splenectomy; with pancreaticojejunostomy	$1,705	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
48146	Pancreatectomy, distal, near-total with preservation of duodenum (Child-type procedure)	$1,961	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
48150	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreatojejunostomy	$3,243	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		

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		FACILITY SETTING	NON-FACILITY SETTING			
48152	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); without pancreatojejunostomy	$3,012	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
48153	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy	$3,227	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
48154	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); without pancreatojejunostomy	$3,024	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
48155	Pancreatectomy, total	$1,895	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
	SPLENECTOMY					
38100	Splenectomy; total (separate procedure)	$1,202	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
38101	Splenectomy; partial (separate procedure)	$1,216	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
38102	Splenectomy; total, en bloc for extensive disease, in conjunction with other procedure (List in addition to code for primary procedure)	$275	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
38120	Laparoscopy, surgical, splenectomy	$1,096	NA	5362, Level 2 Laparoscopy	$7,595	N/A for ASC
	ROBOTIC ASSISTANCE5					
S2900	Surgical techniques requiring use of robotic surgical system	N/A				

NOTES:

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2. Centers for Medicare and Medicaid Services. Healthcare Common Procedure Coding System. http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.
3. Centers for Medicare & Medicaid Services. Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017 Final Rule; 82 Fed. Reg. 52976; 52976-53371. https://www.gpo.gov/fdsys/pkg/FR-2017-11-15/pdf/2017-23953.pdf. Published November 15, 2017. See also the January 2018. See also the January 2018 release of the PFS Relative Value File RVU18A at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html. Final payment to the physician is adjusted by the Geographic Practice Cost Indices (GPCI). Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the payment amount shown.
4. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems Final Rule: 82 Fed. Reg. 52356; 52356-52637 [CMS- 1678-FC] https://www.federalregister.gov/documents/2017/11/13/2017-23932/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment. Published November 13, 2017. Payment is adjusted by the wage index for each hospital or ASC's specific geographic locality, so payment will vary from the national average Medicare payment levels displayed. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.
5. HCPCS II S-codes cannot be reported to Medicare. They are used only by non-Medicare payers, which cover and price them according to their own requirements.

HOSPITAL INPATIENT PROCEDURE CODING FOR GENERAL SURGERY

ICD-10-PCS procedure codes[1] are used by hospitals to report surgeries and procedures performed in the inpatient setting.

All ICD-10-PCS codes have seven digits, each digit representing a specific character associated with procedures. Code assignment in ICD-10-PCS is a process of "constructing" the code by selecting values from a code table for each of the seven standard characters. Key characters are discussed below.

CHARACTER	DESCRIPTION
3: Root Operation	The two main root operations for removal of tissue are B-Excision and T-Resection. By definition, B-Excision involves removing a portion of the body part and T-Resection involves removing the entire body part.[2] For example, removal of a portion of the stomach is coded to B-Excision and removal of the entire stomach is coded to T-Resection. Note that physicians may use these terms more variably. It is the coder's responsibility to determine what the physician's documentation equates to in terms of ICD-10-PCS definitions. The physician is not expected to document using ICD-10-PCS code descriptions.[3] It should also be noted that procedural steps necessary to close an operative site, including end-to-end or side-to-side anastomosis, are not coded separately. For example, in a resection of the distal esophagus with anastomosis of the remaining esophagus to the stomach, the anastomosis is considered inherent and is not coded.[4]
5: Approach	Different codes are constructed depending on the approach: **0-**Open involves an open incision to directly expose the surgical site **4-**Percutaneous Endoscopic is used for procedures performed via laparoscopy or thoracoscopy

ICD-10-PCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
ADRENALECTOMY	
> PARTIAL ADRENALECTOMY, PARTIAL EXCISION OF ADRENAL GLAND, EXCISION OF LESION OF ADRENAL GLAND	
0GB20ZZ	Excision of left adrenal gland, open approach
0GB30ZZ	Excision of right adrenal gland, open approach
0GB40ZZ	Excision of bilateral adrenal glands, open approach
0GB24ZZ	Excision of left adrenal gland, percutaneous endoscopic approach
0GB34ZZ	Excision of right adrenal gland, percutaneous endoscopic approach
0GB44ZZ	Excision of bilateral adrenal glands, percutaneous endoscopic approach
> TOTAL ADRENALECTOMY	
0GT20ZZ	Resection of left adrenal gland, open approach
0GT30ZZ	Resection of right adrenal gland, open approach
0GT40ZZ	Resection of bilateral adrenal glands, open approach
0GT24ZZ	Resection of left adrenal gland, percutaneous endoscopic approach
0GT34ZZ	Resection of right adrenal gland, percutaneous endoscopic approach
0GT44ZZ	Resection of bilateral adrenal glands, percutaneous endoscopic approach
APPENDECTOMY	
0DTJ0ZZ	Resection of appendix, open approach
0DTJ4ZZ	Resection of appendix, percutaneous endoscopic approach
CHOLECYSTECTOMY	
0FT40ZZ	Resection of gallbladder, open approach
0FT44ZZ	Resection of gallbladder, percutaneous endoscopic approach
ESOPHAGECTOMY	
> PARTIAL ESOPHAGECTOMY, PARTIAL EXCISION OF ESOPHAGUS, EXCISION OF LESION OF ESOPHAGUS	
0DB10ZZ	Excision of upper esophagus, open approach
0DB20ZZ	Excision of middle esophagus, open approach
0DB30ZZ	Excision of lower esophagus, open approach
0DB40ZZ	Excision of esophagogastric junction, open approach
0DB50ZZ	Excision of esophagus, open approach
0DB14ZZ	Excision of upper esophagus, percutaneous endoscopic approach
0DB24ZZ	Excision of middle esophagus, percutaneous endoscopic approach
0DB34ZZ	Excision of lower esophagus, percutaneous endoscopic approach
0DB44ZZ	Excision of esophagogastric junction, percutaneous endoscopic approach
0DB54ZZ	Excision of esophagus, percutaneous endoscopic approach
> TOTAL ESOPHAGECTOMY	
0DT10ZZ	Resection of upper esophagus, open approach
0DT20ZZ	Resection of middle esophagus, open approach
0DT30ZZ	Resection of lower esophagus, open approach
0DT40ZZ	Resection of esophagogastric junction, open approach
0DT50ZZ	Resection of esophagus, open approach
0DT14ZZ	Resection of upper esophagus, percutaneous endoscopic approach
0DT24ZZ	Resection of middle esophagus, percutaneous endoscopic approach

ICD-10-PCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
0DT34ZZ	Resection of lower esophagus, percutaneous endoscopic approach
0DT44ZZ	Resection of esophagogastric junction, percutaneous endoscopic approach
0DT54ZZ	Resection of esophagus, percutaneous endoscopic approach
GASTRECTOMY	
> PARTIAL GASTRECTOMY, PARTIAL EXCISION OF STOMACH, EXCISION OF LESION OF STOMACH	
0DB60ZZ	Excision of stomach, open approach
0DB64ZZ	Excision of stomach, percutaneous endoscopic approach
> TOTAL GASTRECTOMY	
0DT60ZZ	Resection of stomach, open approach
0DT64ZZ	Resection of stomach, percutaneous endoscopic approach
REPAIR OF DIAPHRAGMATIC HERNIA (HIATAL HERNIA)	
Note that fundoplication for associated GERD is coded separately as below.[5]	
> WITH IMPLANTATION OF MESH	
Character 3 is the root operation. When mesh is used to effect the repair, the root operation is U-Supplement because U-Supplement is defined as putting on or in material, such as mesh, that physically reinforces a body part.[6] The codes are then further differentiated by the type of mesh, shown in character [6].	
0BUR07Z	Supplement right diaphragm with autologous tissue substitute, open approach
0BUR0JZ	Supplement right diaphragm with synthetic substitute, open approach
0BUR0KZ	Supplement right diaphragm with nonautologous tissue substitute, open approach
0BUS07Z	Supplement left diaphragm with autologous tissue substitute, open approach
0BUS0JZ	Supplement left diaphragm with synthetic substitute, open approach
0BUS0KZ	Supplement left diaphragm with nonautologous tissue substitute, open approach
0BUR47Z	Supplement right diaphragm with autologous tissue substitute, percutaneous endoscopic approach
0BUR4JZ	Supplement right diaphragm with synthetic substitute, percutaneous endoscopic approach
0BUR4KZ	Supplement right diaphragm with nonautologous tissue substitute, percutaneous endoscopic approach
0BUS47Z	Supplement left diaphragm with autologous tissue substitute, percutaneous endoscopic approach
0BUS4JZ	Supplement left diaphragm with synthetic substitute, percutaneous endoscopic approach
0BUS4KZ	Supplement left diaphragm with nonautologous tissue substitute, percutaneous endoscopic approach
> WITHOUT IMPLANTATION OF MESH	
Character 3 is the root operation. When mesh is not used to effect the repair, the root operation is Q-Repair.[5] This root operation is a default.	
0BQR0ZZ	Repair right diaphragm, open approach
0BQRS0ZZ	Repair left diaphragm, open approach
0BQR4ZZ	Repair right diaphragm, percutaneous endoscopic approach
0BQRS4ZZ	Repair left diaphragm, percutaneous endoscopic approach
FUNDOPLICATION (EG, FOR GERD)	
Character 3 is the root operation. For fundoplication, the root operation is V-Restriction because V-Restriction is defined as partially closing a lumen.[7]	
0DV40ZZ	Restriction of esophagogastric junction, open approach
0DV44ZZ	Restriction of esophagogastric junction, percutaneous endoscopic approach
0DV48ZZ	Restriction of esophagogastric junction, via natural or artificial opening endoscopic

ICD-10-PCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
HEPATECTOMY	
> PARTIAL HEPATECTOMY, PARTIAL EXCISION OF LIVER, EXCISION OF LESION OF LIVER	
0FB00ZZ	Excision of liver, open approach
0FB10ZZ	Excision of right lobe liver, open approach
0FB20ZZ	Excision of left lobe liver, open approach
0FB04ZZ	Excision of liver, percutaneous endoscopic approach
0FB14ZZ	Excision of right lobe liver, percutaneous endoscopic approach
0FB24ZZ	Excision of left lobe liver, percutaneous endoscopic approach
> TOTAL LOBECTOMY OF LIVER	
0FT10ZZ	Resection of right lobe liver, open approach
0FT20ZZ	Resection of left lobe liver, open approach
0FT14ZZ	Resection of right lobe liver, percutaneous endoscopic approach
0FT24ZZ	Resection of left lobe liver, percutaneous endoscopic approach
> TOTAL HEPATECTOMY	
0FT00ZZ	Resection of liver, open approach
0FT04ZZ	Resection of liver, percutaneous endoscopic approach
LYMPH NODE PROCEDURES	
Character 3 is the root operation. For lymph nodes, root operation B-Excision is used for partial removal of a lymph chain, including removal of a single node or sampling selected nodes within a chain. When an entire chain of lymph nodes is removed, including radical resection, root operation T-Resection is used.[8]	
Character 7 is the qualifier, which adds further information to the code. Qualifier X-Diagnostic is used when the intent is to biopsy the lymph nodes, as is typically the case for biopsy, sampling and other partial removal. Qualifier Z-No Qualifier is used when the intent is therapeutic, as is typically the case when the entire lymph chain is removed.[8]	
> BIOPSY, SAMPLING, AND SELECTIVE REMOVAL OF LYMPH NODES, AND PARTIAL REMOVAL OF LYMPH NODE CHAIN	
07B00ZX	Excision of head lymphatic, open approach, diagnostic
07B10ZX	Excision of right neck lymphatic, open approach, diagnostic
07B20ZX	Excision of left neck lymphatic, open approach, diagnostic
07B30ZX	Excision of right upper extremity lymphatic, open approach, diagnostic
07B40ZX	Excision of left upper extremity lymphatic, open approach, diagnostic
07B50ZX	Excision of right axillary lymphatic, open approach, diagnostic
07B60ZX	Excision of left axillary lymphatic, open approach, diagnostic
07B70ZX	Excision of thorax lymphatic, open approach, diagnostic
07B80ZX	Excision of right internal mammary lymphatic, open approach, diagnostic
07B90ZX	Excision of left internal mammary lymphatic, open approach, diagnostic
07BB0ZX	Excision of mesenteric lymphatic, open approach, diagnostic
07BC0ZX	Excision of pelvis lymphatic, open approach, diagnostic
07BD0ZX	Excision of aortic lymphatic, open approach, diagnostic
07BF0ZX	Excision of right lower extremity lymphatic, open approach, diagnostic
07BG0ZX	Excision of left lower extremity lymphatic, open approach, diagnostic
07BH0ZX	Excision of right inguinal lymphatic, open approach, diagnostic
07BJ0ZX	Excision of left inguinal lymphatic, open approach, diagnostic
07B74ZX	Excision of thorax lymphatic, percutaneous endoscopic approach, diagnostic
07B84ZX	Excision of right internal mammary lymphatic, percutaneous endoscopic approach, diagnostic

ICD-10-PCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
07B94ZX	Excision of left internal mammary lymphatic, percutaneous endoscopic approach, diagnostic
07BB4ZX	Excision of mesenteric lymphatic, percutaneous endoscopic approach, diagnostic
07BC4ZX	Excision of pelvis lymphatic, percutaneous endoscopic approach, diagnostic
07BD4ZX	Excision of aortic lymphatic, percutaneous endoscopic approach, diagnostic
07BH4ZX	Excision of right inguinal lymphatic, percutaneous endoscopic approach, diagnostic
07BJ4ZX	Excision of left inguinal lymphatic, percutaneous endoscopic approach, diagnostic
> TOTAL REMOVAL OF LYMPH NODE CHAIN	
07T00ZZ	Resection of head lymphatic, open approach
07T10ZZ	Resection of right neck lymphatic, open approach
07T20ZZ	Resection of left neck lymphatic, open approach
07T30ZZ	Resection of right upper extremity lymphatic, open approach
07T40ZZ	Resection of left upper extremity lymphatic, open approach
07T50ZZ	Resection of right axillary lymphatic, open approach
07T60ZZ	Resection of left axillary lymphatic, open approach
07T70ZZ	Resection of thorax lymphatic, open approach
07T80ZZ	Resection of right internal mammary lymphatic, open approach
07T90ZZ	Resection of left internal mammary lymphatic, open approach
07TB0ZZ	Resection of mesenteric lymphatic, open approach
07TC0ZZ	Resection of pelvis lymphatic, open approach
07TD0ZZ	Resection of aortic lymphatic, open approach
07TF0ZZ	Resection of right lower extremity lymphatic, open approach
07TG0ZZ	Resection of left lower extremity lymphatic, open approach
07TH0ZZ	Resection of right inguinal lymphatic, open approach
07TJ0ZZ	Resection of left inguinal lymphatic, open approach
07T74ZZ	Resection of thorax lymphatic, percutaneous endoscopic approach
07T84ZZ	Resection of right internal mammary lymphatic, percutaneous endoscopic approach
07T94ZZ	Resection of left internal mammary lymphatic, percutaneous endoscopic approach
07TB4ZZ	Resection of mesenteric lymphatic, percutaneous endoscopic approach
07TC4ZZ	Resection of pelvis lymphatic, percutaneous endoscopic approach
07TD4ZZ	Resection of aortic lymphatic, percutaneous endoscopic approach
07TH4ZZ	Resection of right inguinal lymphatic, percutaneous endoscopic approach
07TJ4ZZ	Resection of left inguinal lymphatic, percutaneous endoscopic approach
MASTECTOMY	
> LUMPECTOMY, SEGMENTECTOMY, PARTIAL OR SUBTOTAL MASTECTOMY, EXCISION OF LESION OF BREAST	
0HBT0ZZ	Excision of right breast, open approach
0HBU0ZZ	Excision of left breast, open approach
0HBV0ZZ	Excision of bilateral breast, open approach
> TOTAL MASTECTOMY	
0HTT0ZZ	Resection of right breast, percutaneous endoscopic approach
0HTU0ZZ	Resection of left breast, percutaneous endoscopic approach
0HTV0ZZ	Resection of bilateral breast, percutaneous endoscopic approach

ICD-10-PCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
	> RADICAL MASTECTOMY, MODIFIED RADICAL MASTECTOMY
Radical and modified radical mastectomy involve removal of the breast as well as removal of underlying muscles and/or extensive removal of lymph nodes. Mastectomy is coded as above. Additional codes are then assigned to capture removal of underlying muscles and lymph nodes performed.[9]	
	PANCREATECTOMY
	> PARTIAL OR SUBTOTAL PANCREATECTOMY, EXCISION OF LESION OF PANCREAS
0FBG0ZZ	Excision of pancreas, open approach
0FBG4ZZ	Excision of pancreas, percutaneous endoscopic approach
	> TOTAL PANCREATECTOMY
0FTG0ZZ	Resection of pancreas, open approach
0FTG4ZZ	Resection of pancreas, percutaneous endoscopic approach
	> WHIPPLE PROCEDURE
A conventional Whipple involves removing the head of the pancreas, duodenum, a portion of the stomach, gallbladder and a portion of the bile duct. In a pylorus-sparing Whipple, the stomach is not removed. The subtotal pancreatectomy is coded as above with additional codes for removal of the stomach and duodenum as performed. Removal of the gallbladder and bile duct is considered inherent and not coded separately. Likewise, the anastomoses are not coded separately.[10]	
	SPLENECTOMY
	> PARTIAL OR SUBTOTAL SPLENECTOMY, EXCISION OF LESION OF SPLEEN
07BP0ZZ	Excision of spleen, open approach
07BP4ZZ	Excision of spleen, percutaneous endoscopic approach
	> TOTAL SPLENECTOMY
07TP0ZZ	Resection of spleen, open approach
07TP4ZZ	Resection of spleen, percutaneous endoscopic approach
	ROBOTIC ASSISTANCE[11]
8E0W0CZ	Robotic assisted procedure of trunk region, open approach
8E0W4CZ	Robotic assisted procedure of trunk region, percutaneous endoscopic approach
8E0X0CZ	Robotic assisted procedure of upper extremity, open approach
8E0X4CZ	Robotic assisted procedure of upper extremity, percutaneous endoscopic approach
8E0Y0CZ	Robotic assisted procedure of lower extremity, open approach
8E0Y4CZ	Robotic assisted procedure of lower extremity, percutaneous endoscopic approach

Notes:

1. ICD-10-CM: Department of Health and Human Services, Centers for Medicare & Medicaid Services. International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS). https://www.cms.gov/Medicare/Coding/ICD10/2018-ICD-10-PCS-and-GEMs.html
2. CMS ICD-10-PCS Reference Manual 2016, p.64. See also ICD-10-PCS Procedure Coding System (ICD-10-PCS) 2016 Tables and Index, ICD-10-PCS Definitions appendix (0 3: Medical and Surgical - Operation), root operations Excision and Resection
3. 2016 ICD-10-PCS Official Guidelines for Coding and Reporting (Procedure), A11
4. 2016 ICD-10-PCS Official Guidelines for Coding and Reporting (Procedure), B3.1b
5. Coding Clinic, 3rd Q 2014, p.28
6. AHIIMA ICD-10-PCS: An Allied Approach 2015, p.606, case study 50.
7. CMS ICD-10-PCS Reference Manual 2016, p.60-61. See also ICD-10-PCS Procedure Coding System (ICD-10-PCS) 2016 Tables and Index, ICD-10-PCS Definitions appendix (0 3: Medical and Surgical - Operation), root operation Restriction
8. Coding Clinic, 3rd Q 2014, p.9-11
9. AHA ICD-10-CM and ICD-10-PCS Coding Handbook with Answers 2016, p.468, exercise 29.8:4
10. Coding Clinic, 3rd Q 2014, p.32-33

11. Codes for robotic assistance are assigned separately in addition to the primary procedure code.

HOSPITAL INPATIENT DRGS FOR GENERAL SURGERY

DRG Assignment FY2018—effective January 1, 2018

Under Medicare's MS-DRG methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 750 diagnosis-related groups, based on the ICD-10 codes assigned to the diagnoses and procedures. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Implanted devices are typically included in the flat payment and are not paid separately. Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed. MS-DRGs shown are those typically assigned to the following scenarios when the patient is admitted specifically for the procedure.

MS-DRG[1]	MS-DRG TITLE[1,2]	FY 2018 RELATIVE WEIGHT[1]	FY 2018 GEOMETRIC MEAN LENGTH OF STAY[1]	FY 2018 SUBJECT TO PACT[1,3]	FY 2018 MEDICARE NATIONAL AVERAGE[4]
	ADRENALECTOMY				
614	Adrenal and Pituitary Procedures W CC/MCC	2.349	3.7	No	$14,156
615	Adrenal and Pituitary Procedures W/O CC/MCC	1.4749	2.0	No	$8,888
	APPENDECTOMY				
338	Appendectomy W Complicated Principal Diagnosis W MCC	2.7639	6.5	No	$16,657
339	Appendectomy W Complicated Principal Diagnosis W CC	1.7051	4.3	No	$10,276
340	Appendectomy W Complicated Principal Diagnosis W/O CC/MCC	1.1998	2.5	No	$7,231
341	Appendectomy W/O Complicated Principal Diagnosis W MCC	2.4880	4.6	No	$14,994
342	Appendectomy W/O Complicated Principal Diagnosis W CC	1.4882	2.8	No	$8,969
343	Appendectomy W/O Complicated Principal Diagnosis W/O CC/MCC	1.0557	1.7	No	$6,362
	CHOLECYSTECTOMY				
411	Cholecystectomy W C.D.E. W MCC	3.2984	7.8	No	$19,878
412	Cholecystectomy W C.D.E. W CC	2.3743	5.5	No	$14,309
413	Cholecystectomy W C.D.E. W/O CC/MCC	1.6865	3.6	No	$10,164
414	Cholecystectomy Except by Laparoscope W/O C.D.E. W MCC	3.5468	8.1	Yes	$21,375
415	Cholecystectomy Except by Laparoscope W/O C.D.E. W CC	2.0210	5.3	Yes	$12,180
416	Cholecystectomy Except by Laparoscope W/O C.D.E. W/O CC/MCC	1.4023	3.4	Yes	$8,451
417	Laparoscopic Cholecystectomy W/O C.D.E. W MCC	2.3912	5.4	No	$14,411
418	Laparoscopic Cholecystectomy W/O C.D.E. W CC	1.6662	3.8	No	$10,041
419	Laparoscopic Cholecystectomy W/O C.D.E. W/O CC/MCC	1.3052	2.5	No	$7,866
	ESOPHAGECTOMY[5]				
133	Other Ear, Nose, Mouth and Throat O.R. Procedures W CC/MCC	1.9857	3.8	No	$11,967
134	Other Ear, Nose, Mouth and Throat O.R. Procedures W/O CC/MCC	1.1607	2.0	No	$6,995

MS-DRG[1]	MS-DRG TITLE[1,2]	FY 2018 RELATIVE WEIGHT[1]	FY 2018 GEOMETRIC MEAN LENGTH OF STAY[1]	FY 2018 SUBJECT TO PACT[1,3]	FY 2018 MEDICARE NATIONAL AVERAGE[4]
326	Stomach, Esophageal and Duodenal Procedures W MCC	4.5478	8.8	Yes	$27,407
327	Stomach, Esophageal and Duodenal Procedures W CC	2.1162	4.6	Yes	$12,753
328	Stomach, Esophageal and Duodenal Procedures W/O CC/MCC	1.5044	2.4	Yes	$9,066
	GASTRECTOMY				
326	Stomach, Esophageal and Duodenal Procedures W MCC	4.5478	8.8	Yes	$27,407
327	Stomach, Esophageal and Duodenal Procedures W CC	2.1162	4.6	Yes	$12,753
328	Stomach, Esophageal and Duodenal Procedures W/O CC/MCC	1.5044	2.4	Yes	$9,066
	REPAIR OF DIAPHRAGMATIC HERNIA (HIATAL HERNIA)				
326	Stomach, Esophageal and Duodenal Procedures W MCC	4.5478	8.8	Yes	$27,407
327	Stomach, Esophageal and Duodenal Procedures W CC	2.1162	4.6	Yes	$12,753
328	Stomach, Esophageal and Duodenal Procedures W/O CC/MCC	1.5044	2.4	Yes	$9,066
	FUNDOPLICATION (EG, FOR GERD)				
326	Stomach, Esophageal and Duodenal Procedures W MCC	4.5478	8.8	Yes	$27,407
327	Stomach, Esophageal and Duodenal Procedures W CC	2.1162	4.6	Yes	$12,753
328	Stomach, Esophageal and Duodenal Procedures W/O CC/MCC	1.5044	2.4	Yes	$9,066
	HEPATECTOMY				
405	Pancreas, Liver and Shunt Procedures W MCC	5.2874	9.9	Yes	$31,864
406	Pancreas, Liver and Shunt Procedures W CC	2.7958	5.7	Yes	$16,848
407	Pancreas, Liver and Shunt Procedures W/O CC/MCC	2.0185	4.1	Yes	$12,164
	LYMPH NODE PROCEDURES				
On an inpatient basis, many lymph node procedures are performed in association with another primary procedure, eg. mastectomy with lymphadenectomy, and the DRG is assigned on the basis of the primary procedure. When the lymph node procedure is itself the primary procedure or is the only procedure, numerous different DRGs can be assigned depending on the principal diagnosis.					
	MASTECTOMY				
582	Mastectomy for Malignancy W CC/MCC	1.4821	2.3	No	$8,932
583	Mastectomy for Malignancy W/O CC/MCC	1.3551	1.8	No	$8,166
584	Breast Biopsy, Local Excision and Other Breast Procedures W CC/MCC	1.8558	3.7	No	$11,184
585	Breast Biopsy, Local Excision and Other Breast Procedures W/O CC/MCC	1.5922	2.2	No	$9,595
	PANCREATECTOMY[6]				
405	Pancreas, Liver and Shunt Procedures W MCC	5.2874	9.9	Yes	$31,864
406	Pancreas, Liver and Shunt Procedures W CC	2.7958	5.7	Yes	$16,848
407	Pancreas, Liver and Shunt Procedures W/O CC/MCC	2.0185	4.1	Yes	$12,164

MS-DRG[1]	MS-DRG TITLE[1,2]	FY 2018 RELATIVE WEIGHT[1]	FY 2018 GEOMETRIC MEAN LENGTH OF STAY[1]	FY 2018 SUBJECT TO PACT[1,3]	FY 2018 MEDICARE NATIONAL AVERAGE[4]
628	Other Endocrine, Nutritional and Metabolic O.R. Procedures W MCC	3.5763	7.0	Yes	$21,552
629	Other Endocrine, Nutritional and Metabolic O.R. Procedures W CC	2.3157	6.1	Yes	$13,955
630	Other Endocrine, Nutritional and Metabolic O.R. Procedures W/O CC/MCC	1.5969	2.7	Yes	$9,623
	SPLENECTOMY				
799	Splenectomy W MCC	4.8769	8.0	No	$29,390
800	Splenectomy W CC	2.6869	5.1	No	$16,192
801	Splenectomy W/O CC/MCC	1.7028	2.6	No	$10,261

Notes:

1. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Changes and FY2018 Rates Final Rule, Final Rule; 82 Fed. Reg. 37990-38589: https://www.gpo.gov/fdsys/pkg/FR-2017-08-14/pdf/2017-16434.pdf. Published August 14, 2017
2. W MCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs W MCC have at least one major secondary complication or comorbidity. Similarly, W CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities, and MS-DRGs W CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs WO CC/MCCs have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise. Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were present on admission, and do not count as CCs or MCCs when the conditions are acquired in the hospital during the stay.
3. Post-Acute Care Transfer (PACT) status refers to selected DRGs in which payment to the hospital may be reduced when the patient is discharged by being transferred out. The DRGs impacted are those marked "Yes" and the patient must be transferred out before the geometric mean length of stay to certain post-acute care providers, including rehabilitation hospitals, long term care hospitals, skilled nursing facilities, or to home under the care of a home health agency. When these conditions are met, the DRG payment is converted to a per diem and payment is made as double the per diem rate for the first day plus the per diem rate for each remaining day up to the full DRG payment.
4. Payment is based on the average standardized operating amount ($5,461.19) plus the capital standard amount ($453.95). Centers for Medicare & Medicaid Services. Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Changes and FY2018 Rates; Correction, 82 Fed. Reg. 46138-46163. Tables 1A-1E. https://www.gpo.gov/fdsys/pkg/FR-2017-10-04/pdf/2017-21325.pdf Published October 4, 2017 The payment rate shown is the standardized amounts for facilities with a wage index greater than one. The average standard amounts shown also assume facilities receive the full quality update. The payment will also be adjusted by the Wage Index for specific geographic locality. Therefore, payment for a specific hospital will vary from the stated Medicare national average payment levels shown. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.
5. The DRG clusters vary depending on whether the principal diagnosis is related to ENT (DRGs 133-134) or the digestive system (DRGs 326-328).
6. The DRG clusters vary depending on whether the principal diagnosis is related to the hepatobiliary system and the pancreas (DRGs 405-407) or the endocrine system (DRGs 628-630).

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