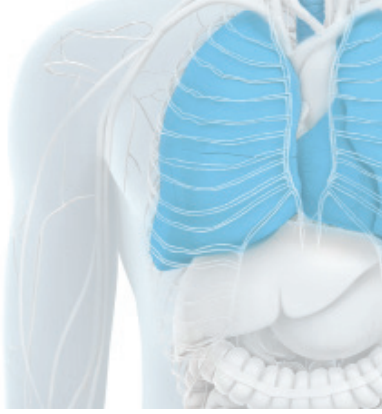
2020 THORACIC SURGERY
MEDICARE REIMBURSEMENT CODING GUIDE

EFFECTIVE JANUARY 1, 2020



Medicare National Average Rates and Allowables

(Not Adjusted for Geography)

		PHYSICIAN[3]	HOSPITAL OUTPATIENT[4]			AMBULATORY SURGICAL CENTER[4]
CPT® / HCPCS CODE[1,2]	PROCEDURE DESCRIPTION	MPFS	APC CLASSIFICATION	APC DESCRIPTOR	APC RATE	ASC
	DIAGNOSTIC					
32096	Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral	$835	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32097	Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral	$836	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32098	Thoracotomy, with biopsy(ies) of pleura	$793	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32100	Thoracotomy; with exploration	$844	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32400	Biopsy, pleura; percutaneous needle	$90 / $165	5072	Level 2 Excision/ Biopsy/ Incision and Drainage	$1,373	$576
32405	Biopsy, lung or mediastinum, percutaneous needle	$93/$409	5072	Level 2 Excision/ Biopsy/ Incision and Drainage	$1,373	$576
32505	Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial	$971	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32506	Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)	$163	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32507	Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)	$163	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32601	Thoracoscopy, diagnostic (separate procedure); lungs, pericardial sac, mediastinal or pleural space, without biopsy	$322	5361	Thoracoscopy	$4,834	Not reimbursed in ASC by Medicare
32604	Thoracoscopy, diagnostic (separate procedure); pericardial sac, with biopsy	$501	5361	Thoracoscopy	$4,834	Not reimbursed in ASC by Medicare
32606	Thoracoscopy, diagnostic (separate procedure); mediastinal space, with biopsy	$483	5361	Thoracoscopy	$4,834	Not reimbursed in ASC by Medicare

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CPT® / HCPCS CODE[1,2]	PROCEDURE DESCRIPTION	MPFS	APC CLASSIFICATION	APC DESCRIPTOR	APC RATE	ASC
32607	Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral	$322	5361	Thoracoscopy	$4,834	Not reimbursed in ASC by Medicare
32608	Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral	$396	5361	Thoracoscopy	$4,834	Not reimbursed in ASC by Medicare
32609	Thoracoscopy; with biopsy(ies) of pleura	$268	5361	Thoracoscopy	$4,834	Not reimbursed in ASC by Medicare
32666	Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral	$905	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32667	Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)	$163	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32668	Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)	$163	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
	EXCISION					
32110	Thoracotomy; with control of traumatic hemorrhage and/or repair of lung tear	$1,530	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32120	Thoracotomy; for postoperative complications	$909	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32140	Thoracotomy; with cyst(s) removal, includes pleural procedure when performed	$1,032	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32141	Thoracotomy; with resection-plication of bullae, includes any pleural procedure when performed	$1,589	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32150	Thoracotomy; with removal of intrapleural foreign body or fibrin deposit	$1,046	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32151	Thoracotomy; with removal of intrapulmonary foreign body	$1,047	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32160	Thoracotomy; with cardiac massage	$829	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32440	Removal of lung, pneumonectomy;	$1,633	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32442	Removal of lung, pneumonectomy; with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)	$3,198	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32445	Removal of lung, pneumonectomy; extrapleural	$3,691	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32480	Removal of lung, other than pneumonectomy; single lobe (lobectomy)	$1,542	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32482	Removal of lung, other than pneumonectomy; 2 lobes (bilobectomy)	$1,653	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32484	Removal of lung, other than pneumonectomy; single segment (segmentectomy)	$1,495	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32486	Removal of lung, other than pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)	$2,457	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32488	Removal of lung, other than pneumonectomy; with all remaining lung following previous removal of a portion of lung (completion pneumonectomy)	$2,497	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			

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CPT® / HCPCS CODE[1,2]	PROCEDURE DESCRIPTION	MPFS	APC CLASSIFICATION	APC DESCRIPTOR	APC RATE	ASC
32491	Removal of lung, other than pneumonectomy; with resectionplication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes any pleural procedure, when performed	$1,533	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
+32501	Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure. Use 32501 in conjunction with 32480, 32482, 32484.)	$254	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32505	Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial	$971	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32506	Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)	$163	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32507	Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)	$163	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32650	Thoracoscopy, surgical; with pleurodesis (eg, mechanical or chemical)	$693	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32651	Thoracoscopy, surgical; with partial pulmonary decortication	$1,142	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32652	Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis	$1,732	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32653	Thoracoscopy, surgical; with removal of intrapleural foreign body or fibrin deposit	$1,107	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32654	Thoracoscopy, surgical; with control of traumatic hemorrhage	$1,211	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32655	Thoracoscopy, surgical; with resection-plication of bullae, includes any pleural procedure when performed	$996	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32656	Thoracoscopy, surgical; with parietal pleurectomy	$835	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32658	Thoracoscopy, surgical; with removal of clot or foreign body from pericardial sac	$743	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32659	Thoracoscopy, surgical; with creation of pericardial window or partial resection of pericardial sac for drainage	$762	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32661	Thoracoscopy, surgical; with excision of pericardial cyst, tumor, or mass	$831	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32662	Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass	$929	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32663	Thoracoscopy, surgical; with lobectomy (single lobe)	$1,459	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32664	Thoracoscopy, surgical; with thoracic sympathectomy	$883	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32665	Thoracoscopy, surgical; with esophagomyotomy (Heller type)	$1,284	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
32666	Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral	$905	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			

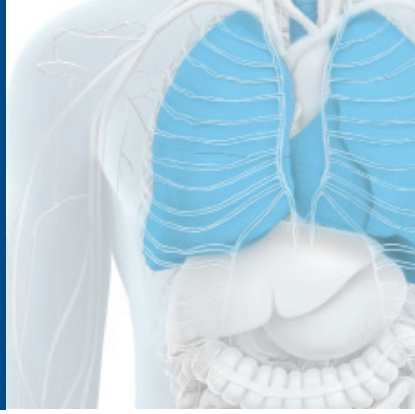
		PHYSICIAN[2]	HOSPITAL OUTPATIENT[3]			AMBULATORY SURGICAL CENTER[3]
CPT® / HCPCS CODE[1,2]	PROCEDURE DESCRIPTION	MPFS	APC CLASSIFICATION	APC DESCRIPTOR	APC RATE	ASC
+32667	Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral. (List separately in addition to code for primary procedure, Report 32667 only in conjunction with 32666.)	$163	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
+32668	Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure, Report 32668 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32663, 32669, 32670, 32671)	$163	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
	HERNIA					
32800	Repair lung hernia through chest wall	$985	Inpatient Procedures, not reimbursed in outpatient or ASC by Medicare			
	ROBOTIC ASSISTANCE					
S2900[5]	Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)	Not Valid for Medicare	Not Valid for Medicare			

REFERENCE

1. 2020 CPT® Professional Edition. American Medical Association. Copyright 2020 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.
2. Centers for Medicare and Medicaid Services. Centers for Medicare & Medicaid Services. Alpha-numeric HCPCS. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS-Items/2020-Alpha-Numeric-HCPCS-File
3. Centers for Medicare & Medicaid Services. Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations Final Rule; and Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine Interim Final Rule; Final Rule, Federal Register 84 Fed. Reg. No. 221 (62568-63563) 42 CFR Parts 403, 409, 410, 411, 414, 415, 416, 418, 424, 425, 489 and 498. https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other Published November 15, 2019.
4. Centers for Medicare & Medicaid Services. Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Revisions of Organ Procurement Organizations Conditions of Coverage; Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Changes to Grandfathered Children's Hospitals-Within-Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity To Apply for Available Slots. Final Rule, Federal Register (84 Fed. Reg. No. 218 61142 - 61492) 42 CFR Parts 405, 410, 412, 414, 416, 419, and 486. https://www.govinfo.gov/content/pkg/FR-2019-11-12/pdf/2019-24138.pdf. Published November 12, 2019. Addendum B, AA. See also correction notice CMS-1717-CN; Addendum B, AA https://federalregister.gov/d/2019-28364. Published January 3, 2020.
5. HCPCS II S-Codes cannot be reported to Medicare. They are used only by non-Medicare payers, which may cover and price them according to their own requirements

HOSPITAL INPATIENT PROCEDURE CODING

FOR THORACIC SURGERY



All ICD-10-PCS[1] 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. The first three characters identify the code table that is used to complete the remaining four characters.

Lung Procedures

For the purposes of this guide, the focus of thoracic surgery is lung procedures. This specifically includes diagnostic biopsy, local and segmental excision, lobectomy, and pneumonectomy, performed primarily for lung tumors.

CHARACTER	DESCRIPTION
1: Section	For surgical procedures of the lung, including both diagnostic and therapeutic procedures, the appropriate section is 0-Medical and Surgical.
2: Body System	The body system for lung procedures is B-Respiratory System.
3: Root Operation	The two main root operations for removal of lung 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. For example, biopsy and local excision use B-Excision while lobectomy and pneumonectomy use T-Resection.[2] It is critical to be aware that physicians may use the term "resection" more broadly, for example in documenting a wedge "resection" or a segmental "resection" of lung. For coding purposes, however, wedge and segmental removal of tissue use root operation B-Excision, not root operation T-Resection. It's 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, and the coder is not required to query the physician in these circumstances. Ablation of lung tissue uses root operation 5-Destruction.[2] A few other root operations may also be used depending on the procedure, for example root operation 9-Drainage for diagnostic bronchial alveolar lavage.
4: Body Part	On their given code tables, specific body part values are available for main bronchus and bronchi in various lobes, specific lobes of the lung, and entire lungs.
5: Approach	Lung procedures performed via sternotomy and thoracotomy use 0-Open. Procedures performed by transthoracic needle use 3-Percutaneous, those performed by bronchoscopy use 8-Via Natural or Artificial Opening Endoscopic, and those performed by thoracoscopy use 4-Percutaneous Endoscopic.
6: Device	The device character refers to devices that remain in the patient's body after the procedure is completed, eg, implanted devices. For removal of tissue, there are rarely implanted devices so Z-No Device is typically used.
7: Qualifier	Qualifiers add further information to the code. Qualifier X-Diagnostic is used to identify biopsies.[2] For therapeutic procedures, the most common qualifier is Z-No Qualifier. This means that the same code can be used for both biopsy and removal of the same lung tumor, with only the different qualifier values identifying if the procedure was a diagnostic biopsy or a therapeutic excision.

SECTION	**0**	Medical And Surgical
BODY SYSTEM	**B**	Respiratory System
OPERATION	**B**	Excision: Cutting out or off, without replacement, a portion of a body part

BODY PART	APPROACH	DEVICE	QUALIFIER
1 Trachea **2** Carina **3** Main Bronchus, Right **4** Upper Lobe Bronchus, Right **5** Middle Lobe Bronchus, Right **6** Lower Lobe Bronchus, Right **7** Main Bronchus, Left **8** Upper Lobe Bronchus, Left **9** Lingula Bronchus **B** Lower Lobe Bronchus, Left **C** Upper Lung Lobe, Right **D** Middle Lung Lobe, Right **F** Lower Lung Lobe, Right **G** Upper Lung Lobe, Left **H** Lung Lingula **J** Lower Lung Lobe, Left **K** Lung, Right **L** Lung, Left **M** Lungs, Bilateral	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic	**Z** No Device	**X** Diagnostic **Z** No Qualifier
N Pleura, Right **P** Pleura, Left **R** Diaphragm, Right **S** Diaphragm, Left	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**Z** No Device	**X** Diagnostic **Z** No Qualifier

Examples

- **Excision of endobronchial tumor, left upper lobe, performed by bronchoscopy**

0BB88ZZ Excision of left upper lobe bronchus, via natural or artificial opening endoscopic

- **Endoscopic transbronchial needle aspiration biopsy of right lung**

0BBK8ZX Excision of right lung, via natural or artificial opening endoscopic, diagnostic

- **Transthoracic needle aspiration biopsy of right lung**

0BBK3ZX Excision of right lung, percutaneous approach, diagnostic

SECTION	**0**	Medical And Surgical
BODY SYSTEM	**B**	Respiratory System
OPERATION	**T**	Resection: Cutting out or off, without replacement, all of a body part

BODY PART	APPROACH	DEVICE	QUALIFIER
1 Trachea **2** Carina **3** Main Bronchus, Right **4** Upper Lobe Bronchus, Right **5** Middle Lobe Bronchus, Right **6** Lower Lobe Bronchus, Right **7** Main Bronchus, Left **8** Upper Lobe Bronchus, Left **9** Lingula Bronchus **B** Lower Lobe Bronchus, Left **C** Upper Lung Lobe, Right **D** Middle Lung Lobe, Right **F** Lower Lung Lobe, Right **G** Upper Lung Lobe, Left **H** Lung Lingula **J** Lower Lung Lobe, Left **K** Lung, Right **L** Lung, Left **M** Lungs, Bilateral **R** Diaphragm, Right **S** Diaphragm, Left	**0** Open **4** Percutaneous Endoscopic	**Z** No Device	**Z** No Qualifier

Example

- **Right lower lobectomy by thoracoscopy**

0BTF4ZZ Excision of left upper lobe bronchus, via natural or artificial opening endoscopic

SECTION	**0**	Medical And Surgical
BODY SYSTEM	**B**	Respiratory System
OPERATION	**5**	Resection: Cutting out or off, without replacement, all of a body part

BODY PART	APPROACH	DEVICE	QUALIFIER
1 Trachea **2** Carina **3** Main Bronchus, Right **4** Upper Lobe Bronchus, Right **5** Middle Lobe Bronchus, Right **6** Lower Lobe Bronchus, Right **7** Main Bronchus, Left **8** Upper Lobe Bronchus, Left **9** Lingula Bronchus **B** Lower Lobe Bronchus, Left **C** Upper Lung Lobe, Right **D** Middle Lung Lobe, Right **F** Lower Lung Lobe, Right **G** Upper Lung Lobe, Left **H** Lung Lingula **J** Lower Lung Lobe, Left **K** Lung, Right **L** Lung, Left **M** Lungs, Bilateral **R** Diaphragm, Right **S** Diaphragm, Left	**0** Open **4** Percutaneous Endoscopic	**Z** No Device	**Z** No Qualifier

Example

- **Thoracoscopic ablation of left lower lobe lung tumor**

0B5J4ZZ Destruction of left lower lung lobe, percutaneous endoscopic approach

REFERENCES

1. Centers for Medicare & Medicaid Services. 2020 ICD-10 PCS Code Tables and Index. https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-PCS
2. Centers for Medicare & Medicaid Services. ICD-10-PCS Official Guidelines for Coding and Reporting (Procedure), B3.1b. https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2020-ICD-10-PCS-Guidelines.pdf

HOSPITAL INPATIENT DRGS FOR THORACIC SURGERY

DRG Assignment FY2020—effective October 1, 2019

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.

W MCC in MS-DRG titles refer to the secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs have at least one major secondary complication or comorbidity. Similarly, W CC in MS-DRG titles refer to secondary diagnosis codes designated as other (non-major) complications or comorbidities. 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 during the stay.

In addition, 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.

MS-DRG[1]	MS-DRG TITLE[1]	FY 2020 Relative Weight[1]	FY 2020 Geometric Mean Length of Stay[1]	FY 2020 Subject to PACT[1]	FY 2020 Medicare National Average[1]
Wedge and Segmental Excision, Lobectomy, Pneumonectomy, Lung Ablation, Open Biopsy and Local Excision of Lung and Bronchus					
163	Major Chest Procedures W MCC	4.8737	9.3	Yes	$30,504
164	Major Chest Procedures W CC	2.5316	4.5	Yes	$15,845
165	Major Chest Procedures W/O CC/MCC	1.8492	2.7	Yes	$11,574
Other Lung Biopsy[1]					
166	Other Respiratory System O.R. Procedures W MCC	3.7307	7.9	Yes	$23,350
167	Other Respiratory System O.R. Procedures W CC	1.9144	3.9	Yes	$11,982
168	Other Respiratory System O.R. Procedures W/O CC/MCC	1.3267	2.1	Yes	$8,304

REFERENCES

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 and Policy Changes and Fiscal Year 2020 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals; Final Rule, Federal Register (84 Fed Reg. No. 159 42044 – 42701) 42 CFR Parts 412, 413, and 495. https://www.govinfo.gov/content/pkg/FR-2019-08-16/pdf/2019-16762.pdf Published August 16, 2019. See also – Correction Notice, Federal Register (84 Fed. Reg. No. 195 53603 – 53630) 42 CFR Parts 412, 413, and 495. https://www.govinfo.gov/content/pkg/FR-2019-10-08/pdf/2019-21865.pdf. Published October 8, 2019.

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