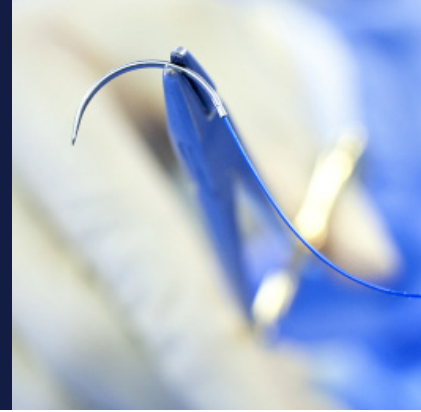


2020 WOUND CLOSURE MEDICARE REIMBURSEMENT CODING GUIDE

Effective January 1, 2020



2020 Medicare Physician, Hospital Outpatient, ASC Coding and Payment

Medicare National Average Rates and Allowables (Not Adjusted for Geography)

CPT® CODE¹/ HCPCS CODE²	CODE DESCRIPTION	PHYSICIAN³		HOSPITAL OUTPATIENT⁴		ASC⁴
		MEDICARE NAT'L AVG		APC AND APC DESCRIPTION	MEDICARE NAT'L AVG	MEDICARE NAT'L AVG
		FACILITY SETTING	NON-FACILITY SETTING			
MASTOPEXY AND MAMMAPLASTY						
19316	Mastopexy	\$807	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	\$5,237	\$2,193
19318	Reduction mammoplasty	\$1,145	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	\$5,237	\$2,193
19324	Mammoplasty, augmentation; without prosthetic implant	\$556	NA	5093, Level 3 Breast/ Lymphatic Surgery and Related Procedures	\$8,136	\$2,679
19325	Mammoplasty, augmentation; with prosthetic implant	\$675	NA	5093, Level 3 Breast/ Lymphatic Surgery and Related Procedures	\$8,136	\$2,679
EXCISION OF BREAST LESION, LUMPECTOMY AND MASTECTOMY						
19120	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, 1 or more lesions	\$433	\$524	5091, Level 1 Breast/ Lymphatic Surgery and Related Procedures	\$3,030	\$1,118
19300	Mastectomy for gynecomastia	\$438	\$571	5091, Level 1 Breast/ Lymphatic Surgery and Related Procedures	\$3,030	\$1,118

CPT® CODE¹/ HCPCS CODE²	CODE DESCRIPTION	PHYSICIAN³		HOSPITAL OUTPATIENT⁴		ASC⁴
		MEDICARE NAT'L AVG		APC AND APC DESCRIPTION	MEDICARE NAT'L AVG	MEDICARE NAT'L AVG
		FACILITY SETTING	NON-FACILITY SETTING			
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	\$688	NA	5091, Level 1 Breast/ Lymphatic Surgery and Related Procedures	\$3,030	\$1,118
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	\$946	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	\$5,237	\$2,193
19303	Mastectomy, simple, complete	\$1005	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	\$5,237	\$2,193
19305	Mastectomy, radical, including pectoral muscles, axillary lymph nodes	\$1,193	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)	\$1,266	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	\$1,262	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	\$5,237	N/A for ASC
BREAST RECONSTRUCTIVE PROCEDURES						
11970	Replacement of tissue expander with permanent prosthesis	\$636	NA	5114, Level 4 Musculoskeletal Procedures	\$5,982	\$2,803
11971	Removal of tissue expander(s) without insertion of prosthesis	\$336	\$497	5073, Level 3 Excision/ Biopsy/ Incision and Drainage	\$2,319	\$994
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	\$1,031	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	\$5,237	\$2,193
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	\$966	NA	5093, Level 3 Breast/ Lymphatic Surgery and Related Procedures	\$8,136	\$2,679
19350	Nipple/areola reconstruction	\$701	\$860	5091, Level 1 Breast/ Lymphatic Surgery and Related Procedures	\$3,030	\$1,118

CPT [®] CODE ¹ / HCPCS CODE ²	CODE DESCRIPTION	PHYSICIAN ³		HOSPITAL OUTPATIENT ⁴		ASC ⁴
		MEDICARE NAT'L AVG		APC AND APC DESCRIPTION	MEDICARE NAT'L AVG	MEDICARE NAT'L AVG
		FACILITY SETTING	NON-FACILITY SETTING			
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	\$1,565	NA	5094, Level 4 Breast/ Lymphatic Surgery and Related Procedures	\$13,853	\$4,683
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant	\$1,641	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
19364	Breast reconstruction with free flap	\$2,877	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
19366	Breast reconstruction with other technique	\$1,457	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	\$5,237	\$2,193
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;	\$1,859	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)	\$2,293	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site	\$2,130	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
19370	Open periprosthetic capsulotomy, breast	\$719	NA	5091, Level 1 Breast/ Lymphatic Surgery and Related Procedures	\$3,030	\$1,118
19371	Periprosthetic capsulectomy, breast	\$821	NA	5091, Level 1 Breast/ Lymphatic Surgery and Related Procedures	\$3,030	\$1,118
19380	Revision of reconstructed breast	\$811	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	\$5,237	\$2,193
CABG						
33510	Coronary artery bypass, vein only; single coronary venous graft	\$2,022	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33511	Coronary artery bypass, vein only; 2 coronary venous grafts	\$2,220	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33512	Coronary artery bypass, vein only; 3 coronary venous grafts	\$2,528	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33513	Coronary artery bypass, vein only; 4 coronary venous grafts	\$2,595	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33514	Coronary artery bypass, vein only; 5 coronary venous grafts	\$2,731	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33516	Coronary artery bypass, vein only; 6 or more coronary venous grafts	\$2,830	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		

CPT [®] CODE ¹ / HCPCS CODE ²	CODE DESCRIPTION	PHYSICIAN ³		HOSPITAL OUTPATIENT ⁴		ASC ⁴
		MEDICARE NAT'L AVG		APC AND APC DESCRIPTION	MEDICARE NAT'L AVG	MEDICARE NAT'L AVG
		FACILITY SETTING	NON-FACILITY SETTING			
33517	Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (List separately in addition to code for primary procedure)	\$196	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33518	Coronary artery bypass, using venous graft(s) and arterial graft(s); 2 venous grafts (List separately in addition to code for primary procedure)	\$431	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33519	Coronary artery bypass, using venous graft(s) and arterial graft(s); 3 venous grafts (List separately in addition to code for primary procedure)	\$570	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33521	Coronary artery bypass, using venous graft(s) and arterial graft(s); 4 venous grafts (List separately in addition to code for primary procedure)	\$685	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33522	Coronary artery bypass, using venous graft(s) and arterial graft(s); 5 venous grafts (List separately in addition to code for primary procedure)	\$767	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33523	Coronary artery bypass, using venous graft(s) and arterial graft(s); 6 or more venous grafts (List separately in addition to code for primary procedure)	\$872	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33530	Reoperation, coronary artery bypass procedure or valve procedure, more than 1 month after original operation (List separately in addition to code for primary procedure)	\$551	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33533	Coronary artery bypass, using arterial graft(s); single arterial graft	\$1,956	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33534	Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts	\$2,298	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33535	Coronary artery bypass, using arterial graft(s); 3 coronary arterial grafts	\$2,563	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33536	Coronary artery bypass, using arterial graft(s); 4 or more coronary arterial grafts	\$2,762	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
HEART VALVE REPLACEMENT AND REPAIR						
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	\$2,373	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33406	Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand)	\$3,012	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33410	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve	\$2,659	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33411	Replacement aortic valve; with aortic annulus enlargement noncoronary sinus	\$3,515	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33412	Replacement aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	\$3,301	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33413	Replacement aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)	\$3,379	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33425	Valvuloplasty, mitral valve, with cardiopulmonary bypass;	\$2,857	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	\$2,490	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		

CPT® CODE¹/ HCPCS CODE²	CODE DESCRIPTION	PHYSICIAN³		HOSPITAL OUTPATIENT⁴		ASC⁴
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		FACILITY SETTING	NON-FACILITY SETTING			
33427	Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring	\$2,554	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33430	Replacement, mitral valve, with cardiopulmonary bypass	\$2,929	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33463	Valvuloplasty, tricuspid valve; without ring insertion	\$3,229	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33464	Valvuloplasty, tricuspid valve; with ring insertion	\$2,552	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33465	Replacement, tricuspid valve, with cardiopulmonary bypass	\$2,883	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33475	Replacement, pulmonary valve	\$2,438	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
HIP AND KNEE REPLACEMENT						
27125	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)	\$1,181	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	\$1,415	NA	5115, Level 5 Musculoskeletal Procedures	\$11,901	N/A for ASC
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	\$1,749	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	\$1,999	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	\$1,536	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	\$1,597	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
27445	Arthroplasty, knee, hinge prosthesis (eg, Walldius type)	\$1,310	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	\$1,209	NA	5115, Level 5 Musculoskeletal Procedures	\$11,901	\$8,411
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	\$1,413	NA	5115, Level 5 Musculoskeletal Procedures	\$11,901	\$8,610
27486	Revision of total knee arthroplasty, with or without allograft; 1 component	\$1,468	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	\$1,836	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
ABDOMINOPLASTY						
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	\$1,226	NA	5092, Level 2 Breast/Lymphatic Surgery and Related Procedures	\$5,237	\$2,193
+15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)	contractor priced	NA	Not separately payable, packaged into payment for other procedures		

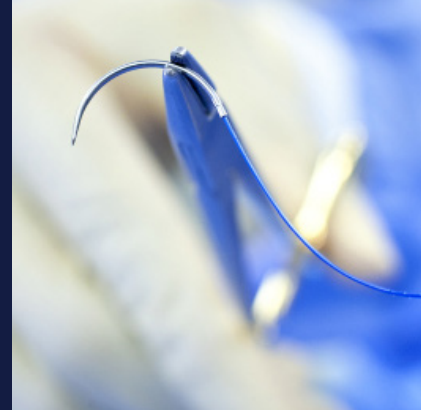
CPT® CODE¹/ HCPCS CODE²	CODE DESCRIPTION	PHYSICIAN³		HOSPITAL OUTPATIENT⁴		ASC⁴
		MEDICARE NAT'L AVG		APC AND APC DESCRIPTION	MEDICARE NAT'L AVG	MEDICARE NAT'L AVG
		FACILITY SETTING	NON-FACILITY SETTING			
STERNUM CLOSURE						
21620	Ostectomy of sternum, partial	\$527	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
21630	Radical resection of sternum;	\$1,268	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
21632	Radical resection of sternum; with mediastinal lymphadenectomy	\$1,261	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
21825	Open treatment of sternum fracture with or without skeletal fixation	\$564	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
ROBOTIC ASSISTANCE						
S2900⁵	Surgical techniques requiring use of robotic surgical system	N/A				

REFERENCES:

- 2020 CPT® Professional Edition. 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.
- Centers for Medicare and Medicaid Services. Alpha-numeric HCPCS. <https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS-Items/2020-Alpha-Numeric-HCPCS-File>
- Centers for Medicare & Medicaid Services. 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.
- 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; <https://federalregister.gov/d/2019-28364>. Published January 3, 2020. Addendum B, AA.
- 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 WOUND CLOSURE SURGERIES: BREAST PROCEDURES



Assigning ICD-10-PCS Procedure Codes¹

ICD-10-PCS procedure codes¹ 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	Root operations are assigned according to the objective of the procedure, following standard definitions. Physicians may use these terms variably, but 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. ² Also note that because the procedure’s objective is the defining factor in assigning the root operation, some procedures with different clinical names may use the same ICD-10-PCS code.
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
6: Device	The device character is not used for surgical instruments that accomplish the procedure but rather for devices that remain in the patient’s body after the procedure is completed, ie., implanted devices.
7: Qualifier	Qualifiers add further information to the code. However, for therapeutic procedures, the most common qualifier is Z-No Qualifier.

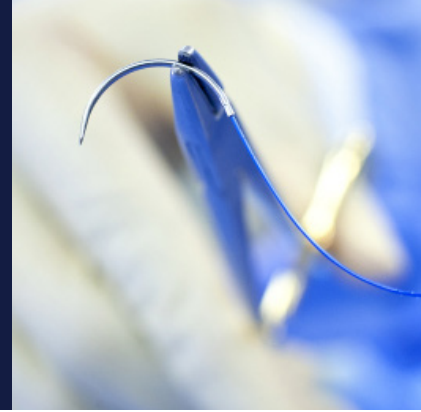
Breast Procedures

ICD-10-PCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
MASTOPEXY AND MAMMAPLASTY	
> MASTOPEXY	
Mastopexy uses root operation S-Repotion, because the objective is to restore the breast to their appropriate location.	
0HST0ZZ	Reposition right breast, open approach
0HSU0ZZ	Reposition left breast, open approach
0HSV0ZZ	Reposition bilateral breasts, open approach
> REDUCTION MAMMAPLASTY	
Reduction mammoplasty uses root operation E-Excision, which is defined for removing some of a body part's tissue but not all.	
0HBT0ZZ	Excision right breast, open approach
0HBU0ZZ	Excision left breast, open approach
0HBV0ZZ	Excision bilateral breasts, open approach
> AUGMENTATION MAMMAPLASTY (BREAST IMPLANTS, NON-RECONSTRUCTIVE)	
Breast implants placed for non-reconstructive reasons use root operation 0-Alteration which is defined as modifying the anatomic structure of a body part without affecting its function. The sixth character for device is J-Synthetic Substitute, used for silicone and saline implants.	
0H0T0JZ	Alteration of right breast with synthetic substitute, open approach
0H0U0JZ	Alteration of left breast with synthetic substitute, open approach
0H0V0JZ	Alteration of bilateral breasts with synthetic substitute, open approach
EXCISION OF BREAST LESION, LUMPECTOMY AND MASTECTOMY	
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, lumpectomy and subtotal mastectomy are both coded to B-Excision, while complete mastectomy is coded to T-Resection.	
> 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
> 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.	
BREAST RECONSTRUCTIVE PROCEDURES	
> TISSUE EXPANDERS	
Note that replacement of a tissue expander uses two codes: one for insertion of the new expander and one for removal of the prior expander.	
0HHT0NZ	Insertion of tissue expander into right breast, open approach
0HHU0NZ	Insertion of tissue expander into left breast, open approach
0HHV0NZ	Insertion of tissue expander into bilateral breasts, open approach
0HPT0NZ	Removal of tissue expander from right breast, open approach
0HPU0NZ	Removal of tissue expander from left breast, open approach

ICD-10-PCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
> AUGMENTATION MAMMAPLASTY (BREAST IMPLANTS, RECONSTRUCTIVE)	
When the implants are reconstructive, root operation R-Replacement is used because it is defined as physically taking the place of a body part. If the reconstruction is performed concurrently with the mastectomy, mastectomy is coded separately. ²	
0HRT0JZ	Replacement of right breast with synthetic substitute, open approach
0HRU0JZ	Replacement of left breast with synthetic substitute, open approach
0HRV0JZ	Replacement of bilateral breasts with synthetic substitute, open approach
> FREE GRAFTS, FLAP GRAFTS AND PEDICLE GRAFTS²	
Free grafts use root operation R-Replacement. If the reconstruction is performed concurrently with the mastectomy, mastectomy is not coded separately. Flap grafts and pedicle grafts, which are still connected to their original site, use root operation K-Transfer. The seventh character for qualifier identifies the type of tissue used in the reconstruction.	
0KXF0Z2	Transfer right trunk muscle with skin and subcutaneous tissue, open approach
0KXG0Z2	Transfer left trunk muscle with skin and subcutaneous tissue, open approach
0KXK0Z6	Transfer right abdomen muscle, transverse rectus abdominis myocutaneous (TRAM) flap, open approach
0KXL0Z6	Transfer right abdomen muscle, transverse rectus abdominis myocutaneous (TRAM) flap, open approach
0HRT075	Replacement of right breast using latissimus dorsi myocutaneous flap, open approach
0HRT076	Replacement of right breast using transverse rectus abdominis myocutaneous (TRAM) flap, open approach
0HRT077	Replacement of right breast using deep inferior epigastric artery perforator (DIEP) flap, open approach
0HRT078	Replacement of right breast using superficial inferior epigastric artery flap, open approach
0HRT079	Replacement of right breast using gluteal artery perforator flap, open approach
0HRT07Z	Replacement of right breast with autologous tissue substitute, open approach
0HRU075	Replacement of left breast using latissimus dorsi myocutaneous flap, open approach
0HRU076	Replacement of left breast using transverse rectus abdominis myocutaneous (TRAM) flap, open approach
0HRU077	Replacement of left breast using deep inferior epigastric artery perforator (DIEP) flap, open approach
0HRU078	Replacement of left breast using superficial inferior epigastric artery flap, open approach
0HRU079	Replacement of left breast using gluteal artery perforator flap, open approach
0HRU07Z	Replacement of left breast with autologous tissue substitute, open approach
0HRV075	Replacement of bilateral breasts using latissimus dorsi myocutaneous flap, open approach
0HRV076	Replacement of bilateral breasts using transverse rectus abdominis myocutaneous (TRAM) flap, open approach
0HRV077	Replacement of bilateral breasts using deep inferior epigastric artery perforator (DIEP) flap, open approach
0HRV078	Replacement of bilateral breasts using superficial inferior epigastric artery flap, open approach
0HRV079	Replacement of bilateral breasts using gluteal artery perforator flap, open approach
0HRV07Z	Replacement of bilateral breasts with autologous tissue substitute, open approach

HOSPITAL INPATIENT PROCEDURE CODING

FOR WOUND CLOSURE SURGERIES: CARDIAC PROCEDURES



CABG

ICD-10-PCS has over 230 codes for CABG, often used in combination with each other to capture the entire procedure. Codes for CABG are constructed from code table 021.

CHARACTER	DESCRIPTION
4: Body Part	The fourth character shows the number of coronary artery sites that are being bypassed.
6: Device	The device character refers to a free graft between the vessels and specifies the type of tissue or other material used: 9 -Autologous Venous Tissue, eg, saphenous vein graft A -Autologous Arterial Tissue, eg, radial artery graft J -Synthetic Substitute, eg, PTFE graft K -Nonautologous Tissue Substitute, eg, cadaveric vessel Z -No Device is used when the vessels are connected directly without the use of a graft
7: Qualifier	The qualifier shows the vessel bypassed from, ie. the vessel now supplying the blood.

SECTION	0	Medical And Surgical	
BODY SYSTEM	2	Heart and Great Vessels	
OPERATION	1	Bypass: Altering the route of passage of the contents of a tubular body part	
BODY PART	APPROACH	DEVICE	QUALIFIER
0 Coronary Artery, One Site 1 Coronary Artery, Two Sites 2 Coronary Artery, Three Sites 3 Coronary Artery, Four or More Sites	0 Open	9 Autologous Venous Tissue A Autologous Arterial Tissue J Synthetic Substitute K Nonautologous Tissue Substitute	3 Coronary Artery 8 Internal Mammary, Right 9 Internal Mammary, Left C Thoracic Artery F Abdominal Artery W Aorta
0 Coronary Artery, One Site 1 Coronary Artery, Two Sites 2 Coronary Artery, Three Sites 3 Coronary Artery, Four or More Sites	0 Open	Z No Device	3 Coronary Artery 8 Internal Mammary, Right 9 Internal Mammary, Left C Thoracic Artery F Abdominal Artery

Examples

- **CABG, aortocoronary bypass to obtuse marginal branch of the left circumflex coronary artery and the right coronary artery via saphenous vein graft, and left internal mammary artery to the left anterior descending coronary artery**

021109W Bypass coronary artery, two sites from aorta with autologous venous tissue, open approach

02100Z9 Bypass coronary artery, one site from left internal mammary artery, open approach

Heart Valve Replacement

Codes for heart valve replacement are constructed from code table 02R. Removal of the native valve is not coded separately.

CHARACTER	DESCRIPTION
5: Approach	0 -Open includes various less invasive techniques such as mini-sternotomy or right anterior thoracotomy, because there is still an incision that directly exposes the surgical site 4 -Percutaneous Endoscopic refers to procedures performed via thoracoscopy
6: Device	The device character specifies the type of tissue or material used for the new valve: 7 -Autologous Tissue Substitute, eg, as in the Ross procedure 8 -Zooplastic Tissue, eg, bioprosthetic valves such as Mosaic J -Synthetic Substitute, eg, mechanical, metallic valves such as Open Pivot K -Nonautologous Tissue Substitute, eg, cadaveric valve

SECTION	0	Medical And Surgical	
BODY SYSTEM	2	Heart and Great Vessels	
OPERATION	R	Replacement: Putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a body part	
BODY PART	APPROACH	DEVICE	QUALIFIER
5 Atrial Septum 6 Atrium, Right 7 Atrium, Left 9 Choradae Tendineae D Papillary Muscle J Tricuspid Valve	0 Open 4 Percutaneous Endoscopic	7 Autologous Tissue Substitute 8 Zooplastic Tissue J Synthetic Substitute K Nonautologous Tissue Substitute	Z No Qualifier
F Aortic Valve G Mitral Valve H Pulmonary Valve	0 Open 4 Percutaneous Endoscopic	7 Autologous Tissue Substitute 8 Zooplastic Tissue J Synthetic Substitute K Nonautologous Tissue Substitute	Z No Qualifier

Examples

- **Open replacement of aortic valve with Open Pivot mechanical valve**
02RF0JZ Replacement of aortic valve with synthetic substitute, open approach
- **Open replacement of aortic valve with Open Pivot mechanical valve**
02RG08Z Replacement of mitral valve with zooplastic tissue, open approach

Heart Valve Repair via Annuloplasty

Codes for heart valve annuloplasty using a ring are constructed from code table 02U.

CHARACTER	DESCRIPTION
3: Root Operation	The root operation for annuloplasty is U-Supplement because the ring or band reinforces the valve.
6: Device	The device character specifies the type of tissue or material used for the new ring. Most commonly, annuloplasty rings are composed of synthetic materials and use J-Synthetic Substitute.

SECTION	0	Medical And Surgical
BODY SYSTEM	2	Heart and Great Vessels
OPERATION	U	Supplement: Putting in or on biological or synthetic material that physically reinforces and/or augments the function of a portion of a body part

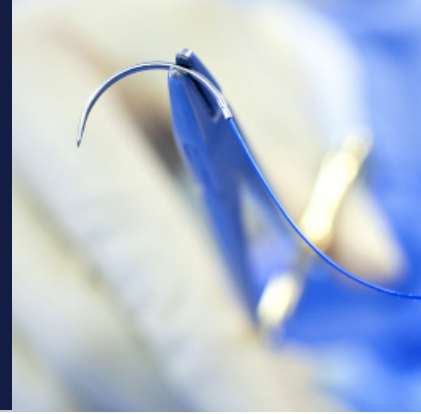
BODY PART	APPROACH	DEVICE	QUALIFIER
5 Atrial Septum 6 Atrium, Right 7 Atrium, Left 9 Choradae Tendineae A Heart D Papillary Muscle F Aortic Valve D Mitral Valve H Pulmonary Valve J Tricuspid Valve	0 Open 3 Percutaneous 4 Percutaneous Endoscopic	7 Autologous Tissue Substitute 8 Zooplastic Tissue J Synthetic Substitute K Nonautologous Tissue Substitute	Z No Qualifier

Examples

- **Open annuloplasty of the tricuspid valve using a Contour 3D ring**
02UJ0JZ Supplement tricuspid valve with synthetic substitute, open approach
- **Open replacement of aortic valve with Open Pivot mechanical valve**
02UG0JZ Supplement mitral valve with synthetic substitute, open approach

HOSPITAL INPATIENT PROCEDURE CODING

FOR WOUND CLOSURE SURGERIES: HIP AND KNEE REPLACEMENT



Hip Replacement

Codes for hip replacement are constructed from code table OSR.

CHARACTER	DESCRIPTION
4: Body Part	<p>These body parts are used for total hip replacement: 9-Hip Joint, Right and B-Hip Joint, Left</p> <p>These body parts are used for partial hip replacement: A-Hip Joint, Acetabular Surface, Right and E-Hip Joint, Acetabular Surface, Left R-Hip Joint, Femoral Surface, Right and S-Hip Joint, Femoral Surface, Left</p> <p>Note that two codes must be assigned for bilateral hip replacement, one for the right hip and one for the left hip.</p>
6: Device	The device character specifies the type of materials used for the bearing surface of the new joint prosthesis.
7: Qualifier	The qualifier shows whether synthetic substitutes are cemented or uncemented.

SECTION	0	Medical And Surgical	
BODY SYSTEM	S	Lower Joints	
OPERATION	R	Replacement: Putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a body part.	
BODY PART	APPROACH	DEVICE	QUALIFIER
9 Hip Joint, Right B Hip Joint, Left	0 Open	1 Synthetic Substitute, Metal 2 Synthetic Substitute, Metal on Polyethylene 3 Synthetic Substitute, Ceramic 4 Synthetic Substitute, Ceramic on Polyethylene J Synthetic Substitute	9 Cemented A Uncemented Z No Qualifier
A Hip Joint, Acetabular Surface, Right E Hip Joint, Acetabular Surface, Left	0 Open	0 Synthetic Substitute, Polyethylene 1 Synthetic Substitute, Metal 3 Synthetic Substitute, Ceramic J Synthetic Substitute	9 Cemented A Uncemented Z No Qualifier
C Knee Joint, Right D Knee Joint, Left F Ankle Joint, Right G Ankle Joint, Left	0 Open	J Synthetic Substitute	9 Cemented A Uncemented Z No Qualifier
R Hip Joint, Femoral Surface, Right S Hip Joint, Femoral Surface, Left	0 Open	1 Synthetic Substitute, Metal 3 Synthetic Substitute, Ceramic J Synthetic Substitute	9 Cemented A Uncemented Z No Qualifier

Examples

- **Total hip replacement, left hip, ceramic bearing surface of femoral head, uncemented**

OSRB03A Replacement of left hip joint with ceramic synthetic substitute, uncemented, open approach

- **Hemiarthroplasty (partial hip replacement), right femoral ball and stem, metallic components, cemented stem**

OSRR019 Replacement of right hip joint, femoral surface with metal synthetic substitute, cemented, open approach

Knee Replacement

Like hip replacement, codes for knee replacement are also constructed from code table OSR.

CHARACTER	DESCRIPTION
4: Body Part	Body parts C-Knee Joint, Right and D-Knee Joint, Left are currently used for both total and partial knee replacement.

Example

▪ **Total knee replacement, left knee, cemented**

OSRDOJ9 Replacement of left knee joint with synthetic substitute, cemented, open approach

“Revision” of Hip Replacement - Replacement of Previously Implanted Prosthesis

“Revision” of a joint replacement in this scenario refers to replacing the prior joint replacement. In other words, the patient previously underwent joint replacement and that prosthesis has now worn out or developed a complication. In the revision, the previously placed prosthesis is removed and new prosthesis is implanted.

CHARACTER	DESCRIPTION
3: Root Operation	<p>Do not use root operation W-Revision for this scenario. W-Revision is used when an implanted device is corrected without being replaced, such as repositioning a displaced prosthesis or recementing a loose prosthesis.¹</p> <p>When a previously implanted joint replacement device is removed and a new joint replacement device is placed, the procedure requires two codes: one for removing the previously implanted joint replacement prosthesis using root operation P-Removal, and one for placing the new joint prosthesis device using root operation R-Replacement.^{1,2}</p> <p>The code for removing the previously placed prosthesis is assigned from code table OSP, below. The code for implanting the new prosthesis is assigned from code table OSR.</p>

SECTION	0 Medical And Surgical		
BODY SYSTEM	S Lower Joints		
OPERATION	R Removal: Taking out or off a device from a body part		
BODY PART	APPROACH	DEVICE	QUALIFIER
9 Hip Joint, Right B Hip Joint, Left	0 Open	0 Drainage Device 3 Infusion Device 4 Internal Fixation Device 5 External Fixation Device 7 Autologous Tissue Substitute 8 Spacer 9 Liner B Resurfacing Device J Synthetic Substitute K Nonautologous Tissue Substitute	Z No Qualifier
C Knee Joint, Right D Knee Joint, Left	0 Open	0 Drainage Device 3 Infusion Device 4 Internal Fixation Device 5 External Fixation Device 7 Autologous Tissue Substitute 8 Spacer 9 Liner J Synthetic Substitute K Nonautologous Tissue Substitute	Z No Qualifier

Examples

- **Revision of hip replacement, with removal of worn-out left hip prosthesis and implantation of new prosthesis**

0SRB0JZ Replacement of left hip joint with synthetic substitute, open approach

PLUS

0SPB0JZ Removal of synthetic substitute from left hip joint, open approach

- **Conversion of previous right hip hemiarthroplasty to a total hip arthroplasty metal-on-polyethylene bearing surface**

0SR902Z Replacement of right hip joint with metal on polyethylene synthetic substitute, open approach

PLUS

0SP90JZ Removal of synthetic substitute from right hip joint, open approach

“Revision” of Knee Replacement - Replacement of Previously Implanted Prosthesis

Coding for revision of knee replacement, in which the previously placed joint prosthesis is removed and a new one is implanted, follows the same conventions as coding for revision of hip replacement and uses the same code tables.

Example

- **Revision of knee replacement, with removal of worn-out right knee prosthesis and implantation of new prosthesis**

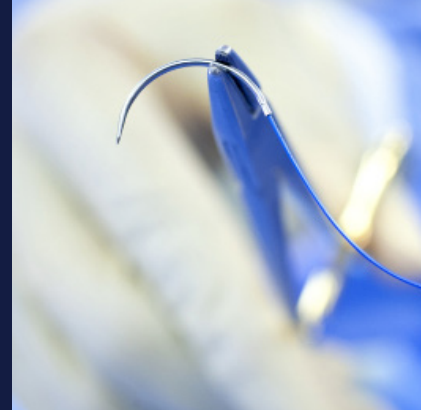
0SRC0JZ Replacement of right knee joint with synthetic substitute, open approach

PLUS

0SPC0JZ Removal of synthetic substitute from right knee joint, open approach

HOSPITAL INPATIENT PROCEDURE CODING

FOR WOUND CLOSURE SURGERIES: ABDOMINOPLASTY, STERNUM CLOSURE



ICD-10-PCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
ABDOMINOPLASTY	
The root operation varies depending on the precise nature of the abdominoplasty: O -Alteration, eg. cosmetic abdominoplasty of any kind B -Excision, eg. therapeutic removal of excess skin and subcutaneous tissue Q -Repair, eg. therapeutic suture plication	
0W0F0ZZ	Alteration of abdominal wall, open approach
0JB80ZZ	Excision of abdomen subcutaneous tissue and fascia, open approach
0WQF0ZZ	Repair abdominal wall, open approach
STERNAL CLOSURE	
Sternal closure is not coded separately when sternotomy was performed to reach another operative site. For example, sternal closure following CABG or valve replacement is considered inherent to the primary procedure. It is inherent to primary sternal procedures as well.	
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.	
> EXCISION OF LESION OF STERNUM, PARTIAL OSTECTOMY OF STERNUM	
0PB00ZZ	Excision of sternum, open approach
> TOTAL REMOVAL OF STERNUM	
0PT00ZZ	Resection of sternum, open approach
> RADICAL RESECTION OF STERNUM	
Radical sternal resection involves complete removal of the sternum as well as extensive removal of lymph nodes. Total removal of the sternum is coded as above. Additional codes are then assigned to capture the lymphadenectomy.	
ROBOTIC ASSISTANCE³	
8E0W0CZ	Robotic assisted procedure of trunk region, open approach
8E0W4CZ	Robotic assisted procedure of trunk region, percutaneous endoscopic approach
8E0Y0CZ	Robotic assisted procedure of lower extremity, open approach
8E0Y4CZ	Robotic assisted procedure of lower extremity, percutaneous endoscopic approach

References:

1. ICD-10-PCS: 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/ICD10/2020-ICD-10-PCS>
2. 2020 ICD-10-PCS Official Guidelines for Coding and Reporting. <https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2020-ICD-10-PCS-Guidelines.pdf>
3. Codes for robotic assistance are assigned separately in addition to the primary procedure code.

HOSPITAL INPATIENT DRGS FOR WOUND CLOSURE SURGERIES

DRG Assignment FY2020—effective October 1, 2020

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
MASTOPEXY AND MAMMAPLASTY					
584	Breast Biopsy, Local Excision and Other Breast Procedures W CC/MCC	1.8284	3.7	No	\$11,444
585	Breast Biopsy, Local Excision and Other Breast Procedures W/O CC/MCC	1.6973	2.2	No	\$10,623
EXCISION OF BREAST LESION, LUMPECTOMY AND MASTECTOMY					
582	Mastectomy for Malignancy W CC/MCC	1.5787	2.5	No	\$9,881
583	Mastectomy for Malignancy W/O CC/MCC	1.4614	1.7	No	\$9,147
584	Breast Biopsy, Local Excision and Other Breast Procedures W CC/MCC	1.8284	3.7	No	\$11,444
585	Breast Biopsy, Local Excision and Other Breast Procedures W/O CC/MCC	1.6973	2.2	No	\$10,623
BREAST RECONSTRUCTIVE PROCEDURES					
582	Mastectomy for Malignancy W CC/MCC	1.5787	2.5	No	\$9,881
583	Mastectomy for Malignancy W/O CC/MCC	1.4614	1.7	No	\$9,147
584	Breast Biopsy, Local Excision and Other Breast Procedures W CC/MCC	1.8284	3.7	No	\$11,444
585	Breast Biopsy, Local Excision and Other Breast Procedures W/O CC/MCC	1.6973	2.2	No	\$10,623
CABG					
231	Coronary Bypass W PTCA W MCC	8.2115	10.4	No	\$51,395
232	Coronary Bypass W PTCA W/O MCC	5.9865	8.0	No	\$37,469
233	Coronary Bypass W Cardiac Cath W MCC	7.7689	11.5	Yes	\$48,625
234	Coronary Bypass W Cardiac Cath W/O MCC	5.2063	8.1	Yes	\$32,586
235	Coronary Bypass W/O Cardiac Cath W MCC	5.8846	8.6	Yes	\$36,831
236	Coronary Bypass W/O Cardiac Cath W/O MCC	4.0291	6.0	Yes	\$25,218

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
HEART VALVE REPLACEMENT					
216	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W MCC	10.0424	13.7	Yes	\$62,855
217	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W CC	6.6516	8.5	Yes	\$41,632
218	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W/O CC/MCC	5.4014	5.9	Yes	\$33,807
219	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W MCC	7.8401	9.0	Yes	\$49,071
220	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W CC	5.3059	6.0	Yes	\$33,209
221	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W/O CC/MCC	4.5962	4.1	Yes	\$28,767
HEART VALVE REPAIR VIA ANNULOPLASTY					
216	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W MCC	10.0424	13.7	Yes	\$62,855
217	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W CC	6.6516	8.5	Yes	\$41,632
218	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W/O CC/MCC	5.4014	5.9	Yes	\$33,807
219	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W MCC	7.8401	9.0	Yes	\$49,071
220	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W CC	5.3059	6.0	Yes	\$33,209
221	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W/O CC/MCC	4.5962	4.1	Yes	\$28,767
HIP REPLACEMENT AND KNEE REPLACEMENT					
461	Bilateral or Multiple Major Joint Procedures of Lower Extremity W MCC	5.3788	6.1	No	\$33,666
462	Bilateral or Multiple Major Joint Procedures of Lower Extremity W/O MC	3.1364	2.7	Yes	\$19,631
469	Major Joint Replacement or Reattachment of Lower Extremity W MCC	3.1399	4.7	Yes	\$19,653
470	Major Joint Replacement or Reattachment of Lower Extremity W/O MCC	1.9684	2.1	Yes	\$12,320
REVISION OF HIP AND KNEE REPLACEMENT					
466	Revision of Hip or Knee Replacement W MCC	5.0991	6.4	Yes	\$31,915
467	Revision of Hip or Knee Replacement W CC	3.5121	3.3	Yes	\$21,982
468	Revision of Hip or Knee Replacement W/O CC/MCC	2.8121	2.0	Yes	\$17,601
ABDOMINOPLASTY					
> ALTERATION (COSMETIC ABDOMINOPLASTY)					
579	Other Skin, Subcutaneous Tissue and Breast Procedures W MCC	2.9861	6.9	Yes	\$18,690
580	Other Skin, Subcutaneous Tissue and Breast Procedures W CC	1.6087	4.1	Yes	\$10,069
581	Other Skin, Subcutaneous Tissue and Breast Procedures W/O CC/MCC	1.2548	2.4	Yes	\$7,854
> EXCISION The DRG clusters vary depending on whether the principal diagnosis is related to the skin and subcutaneous tissue (570-572) or obesity eg, symptomatic pannus (DRGs 622-624).					
570	Skin Debridement W MCC	2.8732	7.4	Yes	\$17,983
571	Skin Debridement W CC	1.6723	5.0	Yes	\$10,467
572	Skin Debridement W/O CC/MCC	1.1217	3.2	Yes	\$7,021

MS-DRG ¹	MS-DRG TITLE ^{1,2}	FY 2020 RELATIVE WEIGHT ¹	FY 2020 GEOMETRIC MEAN LENGTH OF STAY ¹	FY 2020 SUBJECT TO PACT ^{1,3}	FY 2020 MEDICARE NATIONAL AVERAGE ¹
622	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders W MCC	3.7755	8.6	Yes	\$23,631
623	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders W CC	1.9526	5.5	Yes	\$12,221
624	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders W/O CC/MCC	1.1020	3.1	Yes	\$6,897
> PLICATION These DRGs assume the diagnosis involve some sort of abdominal wall separation.					
353	Hernia Procedures Except Inguinal and Femoral W MCC	2.9669	5.8	No	\$18,570
354	Hernia Procedures Except Inguinal and Femoral W CC	1.7221	3.7	No	\$10,779
355	Hernia Procedures Except Inguinal and Femoral W/O CC/MCC	1.3724	2.5	No	\$8,590
STERNAL CLOSURE The DRG clusters vary depending on whether the principal diagnosis is related to the respiratory system (166-168) or the musculoskeletal system eg, pannus (DRGs 515-517).					
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
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures W MCC	3,1540	6.5	Yes	\$19,741
516	Other Musculoskeletal System and Connective Tissue O.R. Procedures W CC	1.9391	3.7	Yes	\$12,137
517	Other Musculoskeletal System and Connective Tissue O.R. Procedures W/O CC/MCC	1.4153	2.2	Yes	\$8,858

Reference:

- 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. 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.

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