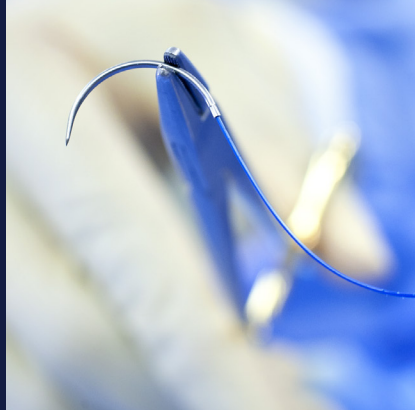
2017 WOUND CLOSURE MEDICARE REIMBURSEMENT CODING GUIDE

Effective January 1, 2017



2017 Medicare Physician, Hospital Outpatient, ASC Coding and Payment

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=$35.887		APC AND APC DESCRIPTION	MEDICARE NAT'L AVG	MEDICARE NAT'L AVG
		FACILITY SETTING	NON-FACILITY SETTING			
	MASTOPEXY AND MAMMAPLASTY					
19316	Mastopexy	$795	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	$4,419	$1,937
19318	Reduction mammaplasty	$1,139	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	$4,419	$1,937
19324	Mammaplasty, augmentation; without prosthetic implant	$510	NA	5093, Level 3 Breast/ Lymphatic Surgery and Related Procedures	$6,486	$2,277
19325	Mammaplasty, augmentation; with prosthetic implant	$662	NA	5093, Level 3 Breast/ Lymphatic Surgery and Related Procedures	$6,486	$2,277
	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	$426	$506	5091, Level 1 Breast/ Lymphatic Surgery and Related Procedures	$2,499	$1,007
19300	Mastectomy for gynecomastia	$425	$535	5091, Level 1 Breast/ Lymphatic Surgery and Related Procedures	$2,499	$1,007

Medtronic

		PHYSICIAN[3]		HOSPITAL OUTPATIENT[4]		ASC[4]
CPT CODE[1]/ HCPCS CODE[2]	CODE DESCRIPTION	MEDICARE NAT'L AVG CF=$35.887		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);	$674	NA	5091, Level 1 Breast/ Lymphatic Surgery and Related Procedures	$2,499	$1,007
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	$930	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	$4,419	$1,937
19303	Mastectomy, simple, complete	$1,044	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	$4,419	$1,937
19304	Mastectomy, subcutaneous	$595	NA	5091, Level 1 Breast/ Lymphatic Surgery and Related Procedures	$2,499	$1,007
19305	Mastectomy, radical, including pectoral muscles, axillary lymph nodes	$1,167	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)	$1,225	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	$1,236	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	$4,419	N/A for ASC
	BREAST RECONSTRUCTIVE PROCEDURES					
11970	Replacement of tissue expander with permanent prosthesis	$628	NA	5114, Level 4 Musculoskeletal Procedures	$5,222	$2,651
11971	Removal of tissue expander(s) without insertion of prosthesis	$327	$478	5073, Level 3 Excision/ Biopsy/ Incision and Drainage	$2,149	$1,032
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	$1,036	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	$4,419	$1,937
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	$952	NA	5093, Level 3 Breast/ Lymphatic Surgery and Related Procedures	$6,486	$2,277
19350	Nipple/areola reconstruction	$695	$844	5091, Level 1 Breast/ Lymphatic Surgery and Related Procedures	$2,499	$1,007

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		FACILITY SETTING	NON-FACILITY SETTING			
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	$1,553	NA	5094, Level 4 Breast/ Lymphatic Surgery and Related Procedures	$10,037	$2,863
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant	$1,629	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
19364	Breast reconstruction with free flap	$2,852	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
19366	Breast reconstruction with other technique	$1,459	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	$4,419	$1,937
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;	$1,849	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)	$2,279	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	$2,097	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
19370	Open periprosthetic capsulotomy, breast	$708	NA	5091, Level 1 Breast/ Lymphatic Surgery and Related Procedures	$2,499	$1,007
19371	Periprosthetic capsulectomy, breast	$809	NA	5091, Level 1 Breast/ Lymphatic Surgery and Related Procedures	$2,499	$1,007
19380	Revision of reconstructed breast	$798	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	$4,419	$1,937
	CABG					
33510	Coronary artery bypass, vein only; single coronary venous graft	$2,012	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33511	Coronary artery bypass, vein only; 2 coronary venous grafts	$2,212	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33512	Coronary artery bypass, vein only; 3 coronary venous grafts	$2,514	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33513	Coronary artery bypass, vein only; 4 coronary venous grafts	$2,588	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33514	Coronary artery bypass, vein only; 5 coronary venous grafts	$2,733	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33516	Coronary artery bypass, vein only; 6 or more coronary venous grafts	$2,861	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		

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		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)	$430	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)	$568	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)	$681	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)	$765	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)	$867	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)	$549	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33533	Coronary artery bypass, using arterial graft(s); single arterial graft	$1,946	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33534	Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts	$2,290	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33535	Coronary artery bypass, using arterial graft(s); 3 coronary arterial grafts	$2,556	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33536	Coronary artery bypass, using arterial graft(s); 4 or more coronary arterial grafts	$2,755	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	$2,363	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33406	Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand)	$2,998	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33410	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve	$2,649	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33411	Replacement aortic valve; with aortic annulus enlargement noncoronary sinus	$3,497	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33412	Replacement aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	$3,306	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)	$3,384	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33425	Valvuloplasty, mitral valve, with cardiopulmonary bypass;	$2,845	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	$2,481	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		

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		FACILITY SETTING	NON-FACILITY SETTING			
33427	Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring	$2,548	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33430	Replacement, mitral valve, with cardiopulmonary bypass	$2,914	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33463	Valvuloplasty, tricuspid valve; without ring insertion	$3,220	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33464	Valvuloplasty, tricuspid valve; with ring insertion	$2,544	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33465	Replacement, tricuspid valve, with cardiopulmonary bypass	$2,874	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
33475	Replacement, pulmonary valve	$2,429	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
	HIP AND KNEE REPLACEMENT					
27125	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)	$1,172	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	$1,404	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	$1,734	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	$1,986	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	$1,526	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	$1,585	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
27445	Arthroplasty, knee, hinge prosthesis (eg, Walldius type)	$1,296	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	$1,199	NA	5125, Level 5 Musculoskeletal Procedures	$9,561	$7,157
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	$1,403	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
27486	Revision of total knee arthroplasty, with or without allograft; 1 component	$1,456	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	$1,821	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
	ABDOMINOPLASTY					
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	$1,212	NA	5092, Level 2 Breast/ Lymphatic Surgery and Related Procedures	$4,419	$1,937
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		

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		FACILITY SETTING	NON-FACILITY SETTING			
	STERNUM CLOSURE					
21620	Ostectomy of sternum, partial	$521	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
21630	Radical resection of sternum;	$1,256	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
21632	Radical resection of sternum; with mediastinal lymphadenectomy	$1,238	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
21825	Open treatment of sternum fracture with or without skeletal fixation	$558	NA	Inpatient only, not reimbursed for hospital outpatient or ASC		
	ROBOTIC ASSISTANCE					
S2900	Surgical techniques requiring use of robotic surgical system	N/A				

NOTES:

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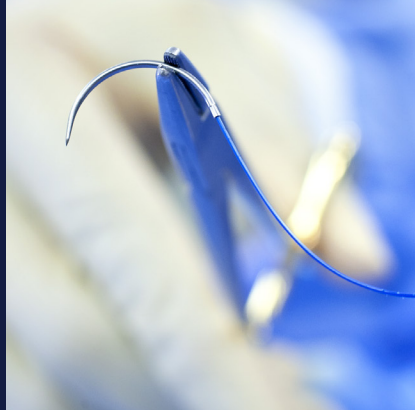
2. Centers for Medicare and Medicaid Services. Healthcare Common Procedure Coding System. http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.
3. Centers for Medicare & Medicaid Services. Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017 Final Rule; 81 Fed. Reg.80170-80562 : https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-26668.pdf Published November 15, 2016. See also the January 2017 release of the PFS Relative Value File RVU16A 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. 24; 24-37 [CMS- 1656-CN] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1656-CN.html. Published January 3, 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 WOUND CLOSURE SURGERIES: BREAST PROCEDURES



ICD-10 went into effect on October 1, 2015. 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	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[3], 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

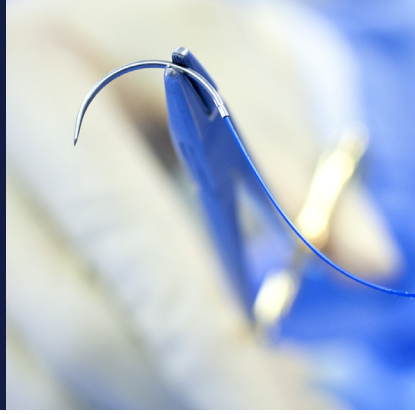
ICD-10-PCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
MASTOPEXY AND MAMMAPLASTY	
> MASTOPEXY	
Mastopexy uses root operation S-Reposition, because the objective is to restore the breast to their appropriate location.	
0HST0ZZ	Reposition right breast, open approach
0HSU0ZZ	Reposition left breast, open approach
0HSV0ZZ	Reposition bilateral breasts, open approach
> REDUCTION MAMMAPLASTY	
Reduction mammaplasty 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.[4]	
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.[5] 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.[6]	
BREAST RECONSTRUCTIVE PROCEDURES	
> TISSUE EXPANDERS[7]	
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

ICD-10-PCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
0HPU0NZ	Removal of tissue expander from left breast, open approach
> 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 not coded separately.[8,9]	
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 GRAFTS[9,10]	
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

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). http://www.cms.hhs.gov/Medicare/Coding/ICD10/2016-ICD-10-PCS-and-GEMs.html
2. 2016 ICD-10-PCS Official Guidelines for Coding and Reporting (Procedure), A11
3. 2016 ICD-10-PCS Official Guidelines for Coding and Reporting (Procedure), B6.1a
4. AHIIMA ICD-10-PCS: An Allied Approach 2015, p.321, exercise 6
5. 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
6. AHA ICD-10-CM and ICD-10-PCS Coding Handbook with Answers 2016, p.468, exercise 29.8:4
7. Coding Clinic, 2nd Q 2014, p.12 and 4th Q 2013, p.107
8. AHIIMA ICD-10-PCS: An Allied Approach 2015, p.322-323, case study 2
9. CMS ICD-10-PCS Reference Manual 2016, p.69, exercises 4 and 7
10. Coding Clinic, 2nd Q 2014, p.10-12

HOSPITAL INPATIENT PROCEDURE CODING FOR WOUND CLOSURE SURGERIES: CARDIAC PROCEDURES



CABG[1]

ICD-10-PCS has 232 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.[2]

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.[3]

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.[4]
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	**R**	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

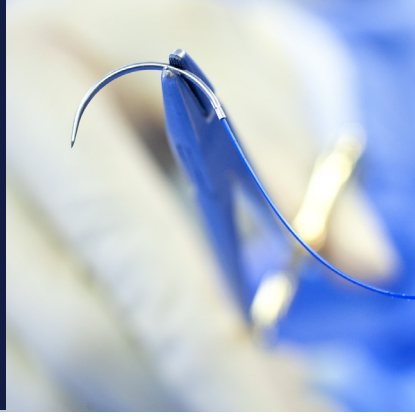
- **Open replacement of aortic valve with Open Pivot mechanical valve**

02UG0JZ Supplement mitral valve with synthetic substitute, open approach

Notes:

1. AHA ICD-10-CM and ICD-10-PCS Coding Handbook with Answers 2016, p.423-427
2. 2016 ICD-10-PCS Official Guidelines for Coding and Reporting (Procedure), B3.6b
3. 2016 ICD-10-PCS Official Guidelines for Coding and Reporting (Procedure), B3.1b
4. CMS ICD-10-PCS Reference Manual 2016, p.69-70

HOSPITAL INPATIENT PROCEDURE CODING
FOR WOUND CLOSURE SURGERIES: HIP AND KNEE REPLACEMENT



Hip Replacement[1]

Codes for hip replacement are constructed from code table 0SR.

CHARACTER	DESCRIPTION
4: Body Part	These body parts are used for total hip replacement: **9-**Hip Joint, Right and B-Hip Joint, Left 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 Note that two codes must be assigned for bilateral hip replacement, one for the right hip and one for the left hip.
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	**2**	Lower Joints
OPERATION	**1**	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**

0SRB03A 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**

0SRR019 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 0SR.

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**

0SRD0J9 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	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.[2] 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.[3,4] The code for removing the previously placed prosthesis is assigning from code table 0SP, below. The code for implanting the new prosthesis is assigned from code table 0SR, above.

SECTION	**0**	Medical And Surgical
BODY SYSTEM	**2**	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

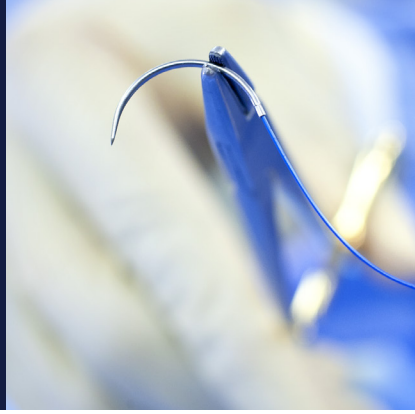
0SPC0JZ Removal of synthetic substitute from right knee joint, open approach

Notes:

1. CMS ICD-10-PCS Reference Manual 2016, p.68-69
2. CMS ICD-10-PCS Reference Manual 2016, p.73-74
3. CMS ICD-10-PCS Reference Manual 2016, p.68
4. AHA ICD-10-CM and ICD-10-PCS Coding Handbook with Answers 2016, p.302

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:[1,2] **0-**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.[3] 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.[4]	
> 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 ASSISTANCE[5]	
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

Notes:

1. CMS ICD-10-PCS Reference Manual 2016, p.81
2. Coding Clinic, 2nd Q 2014, p.38-39
3. 2016 ICD-10-PCS Official Guidelines for Coding and Reporting (Procedure), B3.1b
4. 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
5. Codes for robotic assistance are assigned separately in addition to the primary procedure code.

HOSPITAL INPATIENT DRGS FOR WOUND CLOSURE SURGERIES

DRG Assignment FY2017—effective January 1, 2017

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 2017 RELATIVE WEIGHT[1]	FY 2017 GEOMETRIC MEAN LENGTH OF STAY[1]	FY 2017 SUBJECT TO PACT?[1,3]	FY 2017 MEDICARE NATIONAL AVERAGE[4]
	MASTOPEXY AND MAMMAPLASTY				
584	Breast Biopsy, Local Excision and Other Breast Procedures W CC/MCC	1.7952	3.6	No	$10,706
585	Breast Biopsy, Local Excision and Other Breast Procedures W/O CC/MCC	1.5874	2.1	No	$9,466
	EXCISION OF BREAST LESION, LUMPECTOMY AND MASTECTOMY				
582	Mastectomy for Malignancy W CC/MCC	1.4996	2.3	No	$8,943
583	Mastectomy for Malignancy W/O CC/MCC	1.3161	1.7	No	$7,848
584	Breast Biopsy, Local Excision and Other Breast Procedures W CC/MCC	1.7952	3.6	No	$10,706
585	Breast Biopsy, Local Excision and Other Breast Procedures W/O CC/MCC	1.5874	2.1	No	$9,466
	BREAST RECONSTRUCTIVE PROCEDURES				
582	Mastectomy for Malignancy W CC/MCC	1.4996	2.3	No	$8,943
583	Mastectomy for Malignancy W/O CC/MCC	1.3161	1.7	No	$7,848
584	Breast Biopsy, Local Excision and Other Breast Procedures W CC/MCC	1.7952	3.6	No	$10,706
585	Breast Biopsy, Local Excision and Other Breast Procedures W/O CC/MCC	1.5874	2.1	No	$9,466
	CABG				
231	Coronary Bypass W PTCA W MCC	8.0662	10.6	No	$48,102
232	Coronary Bypass W PTCA W/O MCC	5.8874	8.1	No	$35,109
233	Coronary Bypass W Cardiac Cath W MCC	7.4876	11.7	Yes	$44,652
234	Coronary Bypass W Cardiac Cath W/O MCC	4.9523	8.0	Yes	$29,533
235	Coronary Bypass W/O Cardiac Cath W MCC	5.7644	9.0	Yes	$34,376
236	Coronary Bypass W/O Cardiac Cath W/O MCC	3.8520	6.1	Yes	$22,971
	HEART VALVE REPLACEMENT				
216	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W MCC	9.6440	12.1	Yes	$57,511
217	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W CC	6.3198	8.1	Yes	$37,688
218	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W/O CC/MCC	5.6679	5.4	Yes	$33,800

MS-DRG[1]	MS-DRG TITLE[1,2]	FY 2017 RELATIVE WEIGHT[1]	FY 2017 GEOMETRIC MEAN LENGTH OF STAY[1]	FY 2017 SUBJECT TO PACT?[1,3]	FY 2017 MEDICARE NATIONAL AVERAGE[4]
219	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W MCC	7.7112	9.5	Yes	$45,985
220	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W CC	5.1554	6.4	Yes	$30,744
221	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W/O CC/MCC	4.6105	4.7	Yes	$27,494
	HEART VALVE REPAIR VIA ANNULOPLASTY				
216	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W MCC	9.6440	12.1	Yes	$57,511
217	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W CC	6.3198	8.1	Yes	$37,688
218	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W/O CC/MCC	5.6679	5.4	Yes	$33,800
219	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W MCC	7.7112	9.5	Yes	$45,985
220	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W CC	5.1554	6.4	Yes	$30,744
221	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W/O CC/MCC	4.6105	4.7	Yes	$27,494
	HIP REPLACEMENT AND KNEE REPLACEMENT				
461	Bilateral or Multiple Major Joint Procedures of Lower Extremity W MCC	5.1340	6.7	No	$30,616
462	Bilateral or Multiple Major Joint Procedures of Lower Extremity W/O MCC	3.2798	3.1	No	$19,559
469	Major Joint Replacement or Reattachment of Lower Extremity W MCC	3.2906	5.8	Yes	$19,623
470	Major Joint Replacement or Reattachment of Lower Extremity W/O MCC	2.0671	2.6	Yes	$12,327
	REVISION OF HIP AND KNEE REPLACEMENT				
466	Revision of Hip or Knee Replacement W MCC	5.0249	6.6	Yes	$29,966
467	Revision of Hip or Knee Replacement W CC	3.4412	3.6	Yes	$20,521
468	Revision of Hip or Knee Replacement W/O CC/MCC	2.7936	2.6	Yes	$16,659
	ABDOMINOPLASTY				
	> ALTERATION (COSMETIC ABDOMINOPLASTY)				
579	Other Skin, Subcutaneous Tissue and Breast Procedures W MCC	2.7198	7.0	Yes	$16,219
580	Other Skin, Subcutaneous Tissue and Breast Procedures W CC	1.6483	4.2	Yes	$9,830
581	Other Skin, Subcutaneous Tissue and Breast Procedures W/O CC/MCC	1.2666	2.3	Yes	$7,553
	> EXCISION[5]				
570	Skin Debridement W MCC	2.3711	7.0	Yes	$14,140
571	Skin Debridement W CC	1.4391	5.0	Yes	$8,582
572	Skin Debridement W/O CC/MCC	1.0494	3.7	Yes	$6,258
622	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders W MCC	3.6812	9.0	Yes	$21,953
623	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders W CC	1.8950	5.5	Yes	$11,301

MS-DRG[1]	MS-DRG TITLE[1,2]	FY 2017 RELATIVE WEIGHT[1]	FY 2017 GEOMETRIC MEAN LENGTH OF STAY[1]	FY 2017 SUBJECT TO PACT?[1,3]	FY 2017 MEDICARE NATIONAL AVERAGE[4]
624	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders W/O CC/MCC	1.0722	3.7	Yes	$6,394
	> PLICATION[6]				
353	Hernia Procedures Except Inguinal and Femoral W MCC	2.8746	6.2	No	$17,143
354	Hernia Procedures Except Inguinal and Femoral W CC	1.6751	3.9	No	$9,989
355	Hernia Procedures Except Inguinal and Femoral W/O CC/MCC	1.2698	2.5	No	$7,572
	STERNAL CLOSURE[7]				
166	Other Respiratory System O.R. Procedures W MCC	3.5562	8.3	Yes	$21,207
167	Other Respiratory System O.R. Procedures W CC	1.9550	4.9	Yes	$11,659
168	Other Respiratory System O.R. Procedures W/O CC/MCC	1.3359	2.9	Yes	$7,967
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures W MCC	3.1355	6.8	Yes	$18,698
516	Other Musculoskeletal System and Connective Tissue O.R. Procedures W CC	2.0709	4.3	Yes	$12,350
517	Other Musculoskeletal System and Connective Tissue O.R. Procedures W/O CC/MCC	1.7951	2.6	Yes	$10,705

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 FY2017 Rates Final Rule, Final Rule; 81 Fed. Reg. 56761-57438: https://www.gpo.gov/fdsys/pkg/FR-2016-10-05/pdf/2016-24042.pdf. Published August 22, 2016.
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 W/O 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 ($5,516.14) plus the capital standard amount ($446.79). 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 FY2017 Rates; Correction, 81 Fed. Reg. 68947-68963. Tables 1A-1E. https://www.gpo.gov/fdsys/pkg/FR-2016-10-05/pdf/2016-24042.pdf. Published October 5, 2016. 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 the skin and subcutaneous tissue (570-572) or obesity eg, symptomatic pannus (DRGs 622-624).
6. These DRGs assume the diagnosis involve some sort of abdominal wall separation.
7. 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).

This information is taken from the materials published by the Centers for Medicare and Medicaid Services and the American Medical Association and may be helpful to providers in staying up to date on coding and billing of services. This information cannot guarantee coverage or reimbursement, and Medtronic makes no other representations as to selecting codes for procedures or compliance with any other billing protocols or prerequisites. As with all claims, providers are responsible for exercising their independent clinical judgment in selecting the codes that most accurately reflect the patient's condition and procedures performed for a patient. Providers should refer to current, complete, and authoritative publications such as AMA HCPCS Level II, CPT publications or insurer policies for selecting codes based on the care rendered to an individual patient, and may wish to contact individual carriers, fiscal intermediaries, or other third-party payers as needed.

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