Medtronic

Engineering the extraordinary

2026 Reimbursement Guide

General surgery

Overview

This guide is intended to aid providers in appropriate procedure code selection for general surgery procedures. The document reflects applicable and commonly billed procedure codes as well as the unadjusted national Medicare average rates assigned to the CPT®[1] code. For details on hernia or bariatric procedures, please refer to the specific guides dedicated to those topics. HPB (Hepatectomy) procedures are included.

Instructions for use:

- New tools and updates can be found in the New for 2026 section.
- Code descriptions and details of code reporting requirements and/or guidance, as well as Physician, Hospital Outpatient, and/or Ambulatory Surgery Center (ASC) rates, can be found in the Coding & Reimbursement section.
- Details surrounding specialized coding and reimbursement information can be found in the resources section.
- This document is not all-inclusive, nor does it replace advice from your coding and compliance departments and/or CPT®[1] coding manuals.

Click here To access important disclaimer information

New for 2026

Key updates in CMS Policy & Reimbursement

Changes to Physician Payment

Beginning in calendar year (CY) 2026 and beyond, CMS will pay APM and non-APM participants at distinct rates across all settings of care.Δ

CMS has also finalized a –2.5% "efficiency adjustment" to physician work RVUs and time inputs used to value most non–time-based services under the Medicare Physician Fee Schedule. Time-based services, such as evaluation and management (E/M) codes and new codes effective in 2026, are excluded from this adjustment according to the final rule.[3]

Changes to Facility Payment

CMS is phasing out the Inpatient Only (IPO) list over the next three years. Selected procedures have been removed for 2026, and additional procedures will be removed annually until the IPO list is fully sunset in calendar year (CY) 2029.

Additionally, CMS is expanding the Ambulatory Surgical Center Covered Procedures List (ASC-CPL) by modifying inclusion criteria, which will allow approximately ~500 more procedures to be performed in this setting beginning in CY 2026. Additional procedures may be added in the future. Physicians will continue to have the discretion to choose the most appropriate care setting for each patient and procedure.[5]

Δ Advanced Alternative Payment Models (APMs) are one track of the Quality Payment Program that offer incentives for meeting participation thresholds based on levels of payments or patients through Advanced APMs. Achievement of these thresholds results in qualification as an APM Participant (QP).

Coding & reimbursement

This section provides Medicare unadjusted national average allowable rates for physician, hospital outpatient, ambulatory surgery, and hospital inpatient settings. The coding information in this section does not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. All diagnosis and procedure codes must be supported by clear documentation within the medical record.

Providers may choose to perform multiple procedures during the same encounter. When this occurs, providers must report all procedures and the payment may be subject to packaging rules, multiple procedure reduction, complexity adjustments, or multiple endoscopy reductions.

- HCPCS[2] II codes
- CPT®[1] procedure codes and Physician,[3] Hospital outpatient[4] and Ambulatory surgery center[5] reimbursement rates
- ICD-10 PCS[6] codes and Inpatient[7] national unadjusted reimbursement rates

HCPCS[2] II codes

C-code Finder

Level II HCPCS[2] codes are primarily used to report supplies, drugs and implants that are not reported by a CPT®[1] code. HCPCS codes are reported by the physician, hospital or DME provider that purchased the item, device, or supply. Different payers have different payment methods for these items.

C-codes are a series of HCPCS codes that facilities reimbursed under the Medicare Outpatient Prospective Payment System (OPPS) are required to report for eligible items and services. Medicare assigns C-codes to specific devices eligible for pass-through payment. Every year, in the OPPS rule, Medicare publishes a list of CPT®[1] and HCPCS codes that are designated as device-intensive procedures. When reporting procedures on this list, facilities should capture both the CPT®[1] code representing the procedure performed and the C-code representing the device used. Although C-codes only affect Medicare outpatient reimbursement, facilities may also want to report C-codes on inpatient claims if the device is not used exclusively for inpatient procedures. Medicare tracks this information and uses it in its rate-setting process. Non-OPPS facilities may report C-codes at their discretion.

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.

HCPCS[2] code	Description
A4649	Surgical supply; miscellaneous
S2900◊	Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)

◊ S2900 is not recognized by Medicare and should not be used for Medicare claims.

Coding & reimbursement

		Physician[3]				Hospital Outpatient[4]			Ambulatory Surgery[5]	
CPT®[1] code	Description	Global days	Work RVU	Non-APM Office rate#	Non-APM Facility rate#	APC	Status indicator	Rate	Payment indicator	Rate
Adrenalectomy										
60540	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure)	090	17.57	NA	$1,011			Inpatient only		
60545	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure); with excision of adjacent retroperitoneal tumor	090	20.41	NA	$1,174			Inpatient only		
60650	Laparoscopy, surgical, with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal	090	20.21	NA	$1,104			Inpatient only		
Appendectomy										
44950	Appendectomy	090	10.34	NA	$606	5342†	J1	$6,614	G2	$3,365
44955	Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure)	ZZZ	1.49	NA	$75	NA	N	NA§	N1	NA§

Rates shown reflect the CY 2026 Medicare Physician Fee Schedule for clinicians who did not qualify as participants in Advanced Alternative Payment Model (APM). Physicians and other eligible clinicians who qualify as participants in an Advanced APM under the Quality Payment Program may receive higher payment rates.

† Comprehensive APC

§ Packaged payment.

Coding & reimbursement

		Physician[3]				Hospital Outpatient[4]			Ambulatory Surgery[5]	
CPT®[1] code	Description	Global days	Work RVU	Non-APM Office rate[#]	Non-APM Facility rate[#]	APC	Status indicator	Rate	Payment indicator	Rate
Appendectomy, continued										
44960	Appendectomy; for ruptured appendix with abscess or generalized peritonitis	090	14.14	NA	$825			Inpatient only		
44970	Laparoscopy, surgical, appendectomy	090	9.21	NA	$578	5361†	J1	$6,176	G2	$3,031
Cholecystectomy										
47562	Laparoscopy, surgical; cholecystectomy	090	10.21	NA	$632	5361†	J1	$6,176	G2	$3,031
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	090	11.18	NA	$684	5361†	J1	$6,176	G2	$3,031
47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct	090	17.55	NA	$1,061	5362†	J1	$10,860	G2	$5,120
47600	Cholecystectomy;	090	17.04	NA	$1,010			Inpatient only		
47605	Cholecystectomy; with cholangiography	090	18.02	NA	$1,061			Inpatient only		
47610	Cholecystectomy with exploration of common duct	090	20.40	NA	$1,173			Inpatient only		

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† Comprehensive APC.

Coding & reimbursement

		Physician[3]				Hospital Outpatient[4]			Ambulatory Surgery[5]	
CPT®[1] code	Description	Global days	Work RVU	Non-APM Office rate#	Non-APM Facility rate#	APC	Status indicator	Rate	Payment indicator	Rate
Gastrectomy										
43620	Gastrectomy, total; with esophagoenterostomy	090	33.19	NA	$1,834			Inpatient only		
43621	Gastrectomy, total; with Roux-en-Y reconstruction	090	38.54	NA	$2,091			Inpatient only		
43631	Gastrectomy, partial, distal; with gastroduodenostomy	090	23.90	NA	$1,355			Inpatient only		
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	090	32.31	NA	$1,776			Inpatient only		
Fundoplication										
43130	Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach	090	12.22	NA	$714	5165†	J1	$6,048	G2	$3,026
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	000	7.56	NA	$379	5362†	J1	$10,860	J8¶	$7,481
43279	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed	090	21.55	NA	$1,200			Inpatient only		
43327	Esophagogastric fundoplasty partial or complete; laparotomy	090	13.02	NA	$791			Inpatient only		

Rates shown reflect the CY 2026 Medicare Physician Fee Schedule for clinicians who did not qualify as participants in Advanced Alternative Payment Model (APM). Physicians and other eligible clinicians who qualify as participants in an Advanced APM under the Quality Payment Program may receive higher payment rates.
† Comprehensive APC. ¶ Device intensive[5].

Coding & reimbursement

		Physician[3]				Hospital Outpatient[4]			Ambulatory Surgery[5]	
CPT®[1] code	Description	Global days	Work RVU	Non-APM Office rate[#]	Non-APM Facility rate[#]	APC	Status indicator	Rate	Payment indicator	Rate
Small bowel resection										
44120	Enterectomy, resection of small intestine; single resection and anastomosis	090	20.30	NA	$1,136		Inpatient only			
+44121	Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)	ZZZ	4.33	NA	$216		Inpatient only			
44125	Enterectomy, resection of small intestine; with enterostomy	090	19.53	NA	$1,097		Inpatient only			
Enterectomy										
44202	Laparoscopy, surgical; enterectomy, resection of small intestine, single resection and anastomosis	090	22.81	NA	$1,289		Inpatient only			
Liver biopsy										
47100	Biopsy of liver, wedge	090	12.59	NA	$815		Inpatient only			
Liver allotransplantation										
47135	Liver allotransplantation, orthotopic, partial or whole, from cadaver or living donor, any age	090	87.75	NA	$5,039		Inpatient only			

Rates shown reflect the CY 2026 Medicare Physician Fee Schedule for clinicians who did not qualify as participants in Advanced Alternative Payment Model (APM). Physicians and other eligible clinicians who qualify as participants in an Advanced APM under the Quality Payment Program may receive higher payment rates.

Coding & reimbursement

		Physician[3]				Hospital Outpatient[4]			Ambulatory Surgery[5]	
CPT®[1] code	Description	Global days	Work RVU	Non-APM Office rate[#]	Non-APM Facility rate[#]	APC	Status indicator	Rate	Payment indicator	Rate
Hepatectomy										
47120	Hepatectomy, resection of liver; partial lobectomy	090	38.03	NA	$2,166			Inpatient only		
47122	Hepatectomy, resection of liver; trisegmentectomy	090	57.99	NA	$3,147			Inpatient only		
47125	Hepatectomy, resection of liver; total left lobectomy	090	51.71	NA	$2,826			Inpatient only		
47130	Hepatectomy, resection of liver; total right lobectomy	090	55.76	NA	$3,022			Inpatient only		
47142	Donor hepatectomy (including cold preservation), from living donor; total right lobectomy (segments V, VI, VII and VIII)	090	77.45	NA	$4,375			Inpatient only		
Management liver hemorrhage										
47350	Management of liver hemorrhage; simple suture of liver wound or injury	090	21.93	NA	$1,285			Inpatient only		
47360	Management of liver hemorrhage; complex suture of liver wound or injury, with or without hepatic artery ligation	090	30.53	NA	$1,745			Inpatient only		

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Coding & reimbursement

		Physician[3]				Hospital Outpatient[4]			Ambulatory Surgery[5]	
CPT®[1] code	Description	Global days	Work RVU	Non-APM Office rate[#]	Non-APM Facility rate[#]	APC	Status indicator	Rate	Payment indicator	Rate
Management liver hemorrhage, continued										
47361	Management of liver hemorrhage; exploration of hepatic wound, extensive debridement, coagulation and/or suture, with or without packing of liver	090	51.29	NA	$2,769		Inpatient only			
47362	Management of liver hemorrhage; re-exploration of hepatic wound for removal of packing	090	22.95	NA	$1,338		Inpatient only			
Pancreatectomy										
48140	Pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostomy	090	25.66	NA	$1,456		Inpatient only			
48146	Pancreatectomy, distal, near-total with preservation of duodenum (Child-type procedure)	090	29.84	NA	$1,768		Inpatient only			
48150	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreatojejunostomy	090	51.52	NA	$2,870		Inpatient only			
48152	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); without pancreatojejunostomy	090	47.43	NA	$2,673		Inpatient only			

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Coding & reimbursement

		Physician[3]				Hospital Outpatient[4]			Ambulatory Surgery[5]	
CPT®[1] code	Description	Global days	Work RVU	Non-APM Office rate#	Non-APM Facility rate#	APC	Status indicator	Rate	Payment indicator	Rate
Pancreatectomy, continued										
48153	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple- type procedure); with pancreatojejunostomy	090	51.47	NA	$2,862			Inpatient only		
48155	Pancreatectomy, total	090	28.71	NA	$1,711			Inpatient only		
Splenectomy										
38100	Splenectomy; total (separate procedure)	090	19.06	NA	$1,074			Inpatient only		
38101	Splenectomy; partial (separate procedure)	090	19.06	NA	$1,087			Inpatient only		
38102	Splenectomy; total, en bloc for extensive disease, in conjunction with other procedure (List in addition to code for primary procedure)	ZZZ	4.67	NA	$236			Inpatient only		
38120	Laparoscopy, surgical, splenectomy	090	16.64	NA	$999	5362†	J1	$10,860	G2	$5,120

Rates shown reflect the CY 2026 Medicare Physician Fee Schedule for clinicians who did not qualify as participants in Advanced Alternative Payment Model (APM). Physicians and other eligible clinicians who qualify as participants in an Advanced APM under the Quality Payment Program may receive higher payment rates.
† Comprehensive APC.

Coding & reimbursement

ICD-10-PCS[6] codes are used by hospitals to report surgeries and procedures performed in the inpatient setting. Below are commonly assigned ICD-10-PCS codes. However, the codes listed below are not exhaustive, as other codes may apply.

ICD-10-PCS[6] code	Description
Adrenalectomy	
0GB20ZZ	Excision of left adrenal gland, open approach
0GB30ZZ	Excision of right adrenal gland, open approach
0GB40ZZ	Excision of bilateral adrenal glands, open approach
0GB24ZZ	Excision of left adrenal gland, percutaneous endoscopic approach
0GB34ZZ	Excision of right adrenal gland, percutaneous endoscopic approach
0GB44ZZ	Excision of bilateral adrenal glands, percutaneous endoscopic approach
0GT20ZZ	Resection of left adrenal gland, open approach
0GT30ZZ	Resection of right adrenal gland, open approach
0GT40ZZ	Resection of bilateral adrenal glands, open approach
0GT24ZZ	Resection of left adrenal gland, percutaneous endoscopic approach
0GT34ZZ	Resection of right adrenal gland, percutaneous endoscopic approach
0GT44ZZ	Resection of bilateral adrenal glands, percutaneous endoscopic approach
Appendectomy	
0DTJ0ZZ	Resection of appendix, open approach
0DTJ4ZZ	Resection of appendix, percutaneous endoscopic approach

Coding & reimbursement

ICD-10-PCS[6] codes are used by hospitals to report surgeries and procedures performed in the inpatient setting. Below are commonly assigned ICD-10-PCS codes. However, the codes listed below are not exhaustive, as other codes may apply.

ICD-10-PCS[6] code	Description
Cholecystectomy	
0FT40ZZ	Resection of gallbladder, open approach
0FT44ZZ	Resection of gallbladder, percutaneous endoscopic approach
Gastrectomy	
0DB60ZZ	Excision of stomach, open approach
0DB64ZZ	Excision of stomach, percutaneous endoscopic approach
0DT60ZZ	Resection of stomach, open approach
0DT64ZZ	Resection of stomach, percutaneous endoscopic approach
Fundoplication	
0DV40ZZ	Restriction of esophagogastric junction, open approach
0DV44ZZ	Restriction of esophagogastric junction, percutaneous endoscopic approach
0DV48ZZ	Restriction of esophagogastric junction, via natural or artificial opening endoscopic

Coding & reimbursement

ICD-10-PCS[6] codes are used by hospitals to report surgeries and procedures performed in the inpatient setting. Below are commonly assigned ICD-10-PCS codes. However, the codes listed below are not exhaustive, as other codes may apply.

ICD-10-PCS[6] code	Description
Hepatectomy	
0FB00ZZ	Excision of liver, open approach
0FB10ZZ	Excision of right lobe liver, open approach
0FB20ZZ	Excision of left lobe liver, open approach
0FB04ZZ	Excision of liver, percutaneous endoscopic approach
0FB14ZZ	Excision of right lobe liver, percutaneous endoscopic approach
0FB24ZZ	Excision of left lobe liver, percutaneous endoscopic approach
0FT00ZZ	Resection of liver, open approach
0FT04ZZ	Resection of liver, percutaneous endoscopic approach
Lobectomy	
0FT10ZZ	Resection of right lobe liver, open approach
0FT20ZZ	Resection of left lobe liver, open approach
0FT14ZZ	Resection of right lobe liver, percutaneous endoscopic approach
0FT24ZZ	Resection of left lobe liver, percutaneous endoscopic approach

Coding & reimbursement

ICD-10-PCS[6] codes are used by hospitals to report surgeries and procedures performed in the inpatient setting. Below are commonly assigned ICD-10-PCS codes. However, the codes listed below are not exhaustive, as other codes may apply.

ICD-10-PCS[6] code	Description
Pancreatectomy	
0FBG0ZZ	Excision of pancreas, open approach
0FBG4ZZ	Excision of pancreas, percutaneous endoscopic approach
0FTG0ZZ	Resection of pancreas, open approach
0FTG4ZZ	Resection of pancreas, percutaneous endoscopic approach
Splenectomy	
07BP0ZZ	Excision of spleen, open approach
07BP4ZZ	Excision of spleen, percutaneous endoscopic approach
07TP0ZZ	Resection of spleen, open approach
07TP4ZZ	Resection of spleen, percutaneous endoscopic approach
Robotic Assistance	
8E0W0CZ	Robotic assisted procedure of trunk region, open approach
8E0W4CZ	Robotic assisted procedure of trunk region, percutaneous endoscopic approach
8E0X0CZ	Robotic assisted procedure of upper extremity, open approach
8E0X4CZ	Robotic assisted procedure of upper extremity, percutaneous endoscopic approach

Coding & reimbursement

Inpatient[7] national unadjusted reimbursement rates

Under Medicare's MS-DRG[7] 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. 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.

Below are commonly used DRGs, however codes listed below are not exhaustive as other codes may apply.

MS-DRG[7]	Description	Rate
Adrenalectomy		
614	Adrenal and Pituitary Procedures W CC/MCC	$15,949
615	Adrenal and Pituitary Procedures W/O CC/MCC	$10,182
Appendectomy		
397	Appendectomy W Complicated Principal Diagnosis W MCC	$17,427
398	Appendectomy W Complicated Principal Diagnosis W CC	$11,014
399	Appendectomy W Complicated Principal Diagnosis W/O CC/MCC	$8,330

MCC: Major Complications and/or Comorbidities **CC: Complications and/or Comorbidities**

Coding & reimbursement

Inpatient[7] national unadjusted reimbursement rates

MS-DRG[7]	Description	Rate
Cholecystectomy		
411	Cholecystectomy W C.D.E. W MCC	$24,037
412	Cholecystectomy W C.D.E. W CC	$15,299
413	Cholecystectomy W C.D.E. W/O CC/MCC	$12,083
414	Cholecystectomy Except by Laparoscope W/O C.D.E. W MCC	$25,924
415	Cholecystectomy Except by Laparoscope W/O C.D.E. W CC	$15,039
416	Cholecystectomy Except by Laparoscope W/O C.D.E. W/O CC/MCC	$9,920
417	Laparoscopic Cholecystectomy W/O C.D.E. W MCC	$17,365
418	Laparoscopic Cholecystectomy W/O C.D.E. W CC	$12,309
419	Laparoscopic Cholecystectomy W/O C.D.E. W/O CC/MCC	$9,939
Gastrectomy		
326	Stomach, Esophageal and Duodenal Procedures W MCC	$36,292
327	Stomach, Esophageal and Duodenal Procedures W CC	$17,786
328	Stomach, Esophageal and Duodenal Procedures W/O CC/MCC	$11,660

MCC: Major Complications and/or Comorbidities **CC: Complications and/or Comorbidities**

Coding & reimbursement

Inpatient[7] national unadjusted reimbursement rates

MS-DRG[7]	Description	Rate
Fundoplication		
326	Stomach, Esophageal and Duodenal Procedures W MCC	$36,292
327	Stomach, Esophageal and Duodenal Procedures W CC	$17,786
328	Stomach, Esophageal and Duodenal Procedures W/O CC/MCC	$11,660
Hepatectomy		
405	Pancreas, Liver and Shunt Procedures W MCC	$39,808
406	Pancreas, Liver and Shunt Procedures W CC	$21,104
407	Pancreas, Liver and Shunt Procedures W/O CC/MCC	$16,151
Pancreatectomy		
405	Pancreas, Liver and Shunt Procedures W MCC	$39,808
406	Pancreas, Liver and Shunt Procedures W CC	$21,104
407	Pancreas, Liver and Shunt Procedures W/O CC/MCC	$16,151

MCC: Major Complications and/or Comorbidities **CC: Complications and/or Comorbidities**

Coding & reimbursement

Inpatient[7] national unadjusted reimbursement rates

MS-DRG[7]	Description	Rate
Splenectomy		
799	Splenic Procedures W MCC	$32,956
800	Splenic Procedures W CC	$20,443
801	Splenic Procedures W/O CC/MCC	$13,891

Overview

New for 2026

Coding & Reimbursement

Resources

Disclaimer

MCC: Major Complications and/or Comorbidities **CC: Complications and/or Comorbidities**

Appendix

Term	Footnote	Definition
Add-on CPT®[1] codes	+	An Add-on Code (AOC) is a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) code that describes a service that is performed in conjunction with the primary service by the same practitioner. An AOC is rarely eligible for payment if it's the only procedure reported by a practitioner.
Carrier priced		Carrier priced codes are not assigned a rate on a national level. Local contractors will determine the reimbursement amount on a case-by-case basis.
Complexity adjustment		The complexity adjustments were implemented by CMS to provide for a payment adjustment when two or more high-cost procedures are performed and paid under Medicare's Hospital Outpatient Comprehensive APC system. To qualify, claims with certain code combinations must meet specific thresholds for both cost and frequency. When these thresholds are met, the code combinations qualify for reassignment to the next highest paying APC.
Comprehensive APC	†	Under its comprehensive APC (C-APC) policy, CMS makes payment for certain costly primary services and all other items and services reported on the hospital outpatient department claim, which CMS considers integral, ancillary, supportive, dependent, and adjunctive to the primary service and representing components of a complete comprehensive service.
Device intensive[5]	¶	Definition/symbol - The "device intensive" status is assigned to surgical procedures performed in the ASC with an individual HCPCS code-level device offset of greater than 30%. Device intensive procedures are identified in Addendum AA with a payment indicator of J8.
Inpatient only (IPO) list		CMS can define procedures and services for which payment under the outpatient prospective payment system (OPPS) is inappropriate. These codes have a status indicator of "C". Services designated as "inpatient only" are not appropriate to be furnished in a hospital outpatient department. Generally, inpatient only procedures are surgical services that require inpatient care because of the nature of the procedure
Modifiers[8]	‖	Modifiers are used to supplement the information or adjust the care description to provide extra details concerning a procedure or service. Modifiers help further describe a procedure code without changing its definition. Modifiers are appended to CPT®[1] codes. List of modifiers can be found in the CPT®[1] book.
Multiple procedure payment reduction (MPPR)[9]	††	The multiple procedure payment reduction (MPPR) methodology may apply to certain services when multiple services are furnished by the same physician to the same patient in the same session on the same day. Reductions may be calculated in several ways, depending on the services/procedures involved. Most typically, the primary (highest valued) procedure will be reimbursed at 100 percent of the fee schedule value, and the second and all subsequent procedures will be reimbursed at 50 percent of the fee schedule value. When multiple endoscopic procedures within the same code family are reported, the "base" value of the endoscopy is paid only one time.
Packaged payment	§	Under OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items is included in the APC payment for the service of which they are an integral part. For example, routine supplies, anesthesia, recovery room and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure.
Payment indicator		CMS uses payment indicators to identify each covered service that is eligible for ASC payment and the payment methodology by which the payment amount is calculated. The payment indicators also indicate which services' costs are packaged into the payment for other services and which surgical procedures are excluded from Medicare payment (72 FR 67189-67190).
Status indicator		In the Hospital Outpatient, Status Indicator (SI) shows how a code is handled for payment purposes: C= Inpatient procedures, not paid under OPPS; J1 = paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; S = procedure or service not discounted when multiple procedure; Additional details can be found in Addendum D1 of the OPPS rule
Unlisted codes		Unlisted codes do not have established RVUs under Medicare's Physician Payment System and are typically priced by the contractor after review and individual consideration. Unlisted CPT®[1] codes do not carry a rate assignment from Medicare in the physician office setting. Payment may be available on a case-by-case basis with submission of medical records.
Work relative value unit (RVU)		The Work RVU is a unit of measure that describes the work associated with a physician's procedural services and is factored into the total physician payment. Work RVU is one of three total components on which physician payment is based: physician work RVU, practice expense RVU, and medical malpractice RVU.[3]
w/MCC, w/CC or w/o CC/MCC		In the inpatient setting, 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/MCC 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 were acquired in the hospital during the stay.

Resources

C-code Finder

Medtronic Reimbursement Support is available to assist you with your coding and reimbursement questions. If your coding or reimbursement questions were not answered in this guide, please check out these additional resources:

Visit our website: https://www.medtronic.com/en-us/healthcare-professionals/reimbursement.html

Find educational programs, reimbursement guides, and other resources to assist with coding, coverage, and reimbursement for our products and therapies.

C-Code Finder: www.medtronic.com/c-code

Medicare provides C-codes, a type of HCPCS II code, for hospital use in billing Medicare for some medical devices and supplies in the hospital outpatient setting. The C-code finder is a database of commonly used Medtronic products and their corresponding C-codes.

Email us : rs.MedtronicMedicalSurgicalReimbursement@medtronic.com

Contact our reimbursement specialists with questions.

Assistant at Surgery Reimbursement Reference Guide: Bedside assistance by a PA, NP, CNS, or Physician in robotic-assisted surgery is supported by Medicare Assistant at Surgery guidelines.

Bariatric Patient Selection Tool: Worksheet designed to help providers by outlining commonly required documentation guidelines for bariatric surgery from commercial payers.

Payer Contract Negotiation Best Practices: A collection of best practice guidelines designed to support individual practitioners and ASCs in contract negotiations.

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The provider has the responsibility to determine medical necessity and to submit appropriate documentation, codes and charges for care provided. Medtronic makes no guarantee that the use of this information will prevent differences of opinion or disputes with Medicare or other payers as to the correct form of billing or the amount that will be paid to providers of service. Please contact your Medicare contractor, other payers, reimbursement specialists and/or legal counsel for interpretation of coding, coverage and payment policies and any applicable laws or regulations that may apply.

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References

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