Medtronic

2022 Billing and Coding Guide

General Surgery

Rates listed in this guide are based on their respective site of care- physician office, ambulatory surgical center, or hospital outpatient department. All rates provided are for the Medicare unadjusted national average for the calendar year and do not represent adjustment specific to the provider's location or facility. Commercial rates are based on individual contracts. Providers are encouraged to review contracts to verify their specific contracted allowables. Medtronic products associated with general surgery procedures addressed within this guide do not have a dedicated HCPCS[1] level II coding assignment. Providers may choose to report *A4649 Surgical supply; miscellaneous* for purposes of cost tracking. Medicare considers the use of surgical supplies to be included in the payment for the associated CPT, and no additional payment is allowed.

CPT© Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
Adrenalectomy				
60540	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure)	Facility Only: $1,102	Inpatient only, not reimbursed for hospital outpatient or ASC	
60545	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure); with excision of adjacent retroperitoneal tumor	Facility Only: $1,278	Inpatient only, not reimbursed for hospital outpatient or ASC	
60650	Laparoscopy, surgical, with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal	Facility Only: $1,219	Inpatient only, not reimbursed for hospital outpatient or ASC	
Appendectomy				
44950	Appendectomy	Facility Only: $664	NA	$3,249
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)	Facility Only: $85	NA	Not separately payable, packaged into payment for other procedures
44960	Appendectomy; for ruptured appendix with abscess or generalized peritonitis	Facility Only: $908	Inpatient only, not reimbursed for hospital outpatient or ASC	
44970	Laparoscopy, surgical, appendectomy	Facility Only: $623	NA	$5,168
Cholecystectomy				
47562	Laparoscopy, surgical; cholecystectomy	Facility Only: $684	$2,363	$5,168

CPT© Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	Facility Only: $744	$2,363	$5,168
47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct	Facility Only: $1,154	$2,363	$5,168
47600	Cholecystectomy;	Facility Only: $1,105	Inpatient only, not reimbursed for hospital outpatient or ASC	
47605	Cholecystectomy; with cholangiography	Facility Only: $1,166	Inpatient only, not reimbursed for hospital outpatient or ASC	
47610	Cholecystectomy with exploration of common duct	Facility Only: $1,297	Inpatient only, not reimbursed for hospital outpatient or ASC	
47612	Cholecystectomy with exploration of common duct; with choledochoenterostomy	Facility Only: $1,318	Inpatient only, not reimbursed for hospital outpatient or ASC	
47620	Cholecystectomy with exploration of common duct; with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography	Facility Only: $1,423	Inpatient only, not reimbursed for hospital outpatient or ASC	
Esophagectomy				
43107	Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)	Facility Only: $3,032	Inpatient only, not reimbursed for hospital outpatient or ASC	
43108	Total or near total esophagectomy, without thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es)	Facility Only: $4,517	Inpatient only, not reimbursed for hospital outpatient or ASC	
43112	Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty	Facility Only: $3,533	Inpatient only, not reimbursed for hospital outpatient or ASC	
43113	Total or near total esophagectomy, with thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	Facility Only: $4,414	Inpatient only, not reimbursed for hospital outpatient or ASC	
43116	Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction	Facility Only: $5,050	Inpatient only, not reimbursed for hospital outpatient or ASC	
43117	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)	Facility Only: $3,314	Inpatient only, not reimbursed for hospital outpatient or ASC	

CPT© Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
Esophagectomy				
43118	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	Facility Only: $3,685	Inpatient only, not reimbursed for hospital outpatient or ASC	
43121	Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty	Facility Only: $2,905	Inpatient only, not reimbursed for hospital outpatient or ASC	
43122	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty	Facility Only: $2,613	Inpatient only, not reimbursed for hospital outpatient or ASC	
43123	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	Facility Only:$4,576	Inpatient only, not reimbursed for hospital outpatient or ASC	
43124	Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy	Facility Only: $3,870	Inpatient only, not reimbursed for hospital outpatient or ASC	
Gastrectomy				
43620	Gastrectomy, total; with esophagoenterostomy	Facility Only: $2,047	Inpatient only, not reimbursed for hospital outpatient or ASC	
43621	Gastrectomy, total; with Roux-en-Y reconstruction	Facility Only: $2,339	Inpatient only, not reimbursed for hospital outpatient or ASC	
43622	Gastrectomy, total; with formation of intestinal pouch, any type	Facility Only: $2,384	Inpatient only, not reimbursed for hospital outpatient or ASC	
43631	Gastrectomy, partial, distal; with gastroduodenostomy	Facility Only: $1,495	Inpatient only, not reimbursed for hospital outpatient or ASC	
43632	Gastrectomy, partial, distal; with gastrojejunostomy	Facility Only: $2,094	Inpatient only, not reimbursed for hospital outpatient or ASC	
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	Facility Only: $1,980	Inpatient only, not reimbursed for hospital outpatient or ASC	
43634	Gastrectomy, partial, distal; with formation of intestinal pouch	Facility Only: $2,193	Inpatient only, not reimbursed for hospital outpatient or ASC	
Repair of Diaphragmatic Hernia (Hiatal Hernia)				
43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)	Facility Only: $1,113	NA	$9,096

CPT© Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
Repair of Diaphragmatic Hernia (Hiatal Hernia)				
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	Facility Only: $1,586	NA	$9,096
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	Facility Only: $1,783	NA	$9,096
43325	Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)	Facility Only: $1,405	Inpatient only, not reimbursed for hospital outpatient or ASC	
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	Facility Only: $1,185	Inpatient only, not reimbursed for hospital outpatient or ASC	
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis	Facility Only: $1,294	Inpatient only, not reimbursed for hospital outpatient or ASC	
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	Facility Only: $1,270	Inpatient only, not reimbursed for hospital outpatient or ASC	
43335	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis	Facility Only: $1,359	Inpatient only, not reimbursed for hospital outpatient or ASC	
43336	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis	Facility Only: $1,477	Inpatient only, not reimbursed for hospital outpatient or ASC	
43337	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis	Facility: $1,574	Inpatient only, not reimbursed for hospital outpatient or ASC	
Fundoplication				
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	Facility Only: $439	$5,042	$9,096
43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)	Facility Only: $1,113	NA	$9,096
43325	Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)	Facility Only: $1,405	Inpatient only, not reimbursed for hospital outpatient or ASC	
43327	Esophagogastric fundoplasty partial or complete; laparotomy	Facility Only: $846	Inpatient only, not reimbursed for hospital outpatient or ASC	
43328	Esophagogastric fundoplasty partial or complete; thoracotomy	Facility Only: $1,146	Inpatient only, not reimbursed for hospital outpatient or ASC	

CPT© Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
Hepatectomy				
47120	Hepatectomy, resection of liver; partial lobectomy	Facility Only: $2,404	Inpatient only, not reimbursed for hospital outpatient or ASC	
47122	Hepatectomy, resection of liver; trisegmentectomy	Facility Only: $3,533	Inpatient only, not reimbursed for hospital outpatient or ASC	
47125	Hepatectomy, resection of liver; total left lobectomy	Facility Only: $3,166	Inpatient only, not reimbursed for hospital outpatient or ASC	
47130	Hepatectomy, resection of liver; total right lobectomy	Facility Only: $3,396	Inpatient only, not reimbursed for hospital outpatient or ASC	
Lymph Node Procedures				
38500	Biopsy or excision of lymph node(s); open, superficial	Facility: $263 Non-Facility: $351	$1,206	$3,225
38510	Biopsy or excision of lymph node(s); open, deep cervical node(s)	Facility: $430 Non-Facility: $548	$1,206	$3,225
38520	Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad	Facility Only: $480	$1,206	$3,225
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)	Facility Only: $455	$1,206	$3,225
38530	Biopsy or excision of lymph node(s); open, internal mammary node(s)	Facility Only: $578	$1,206	$3,225
38542	Dissection, deep jugular node(s)	Facility Only: $537	$2,363	$5,168
38562	Limited lymphadenectomy for staging (separate procedure); pelvic and para-aortic	Facility Only: $724	Inpatient only, not reimbursed for hospital outpatient or ASC	
38564	Limited lymphadenectomy for staging (separate procedure); retroperitoneal (aortic and/or splenic)	Facility Only: $726	Inpatient only, not reimbursed for hospital outpatient or ASC	
38570	Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple	Facility Only: $527	$2,363	$5,168
38571	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy	Facility Only: $672	$3,890	$9,096
38572	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple	Facility Only: $927	$3,890	$9,096
38700	Suprahyoid lymphadenectomy	Facility Only: $827	$2,308	$5,652
38720	Cervical lymphadenectomy (complete)	Facility Only: $1,373	NA	$9,106
38724	Cervical lymphadenectomy (modified radical neck dissection)	Facility Only: $1,484	Inpatient only, not reimbursed for hospital outpatient or ASC	
38740	Axillary lymphadenectomy; superficial	Facility Only: $724	$2,363	$5,168
38745	Axillary lymphadenectomy; complete	Facility Only: $909	$2,363	$5,168

CPT© Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
38746	Thoracic lymphadenectomy by thoracotomy, mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)	Facility Only: $218	Inpatient only, not reimbursed for hospital outpatient or ASC	
38747	Abdominal lymphadenectomy, regional, including celiac, gastric, portal, peripancreatic, with or without para-aortic and vena caval nodes (List separately in addition to code for primary procedure)	Facility Only: $273	Inpatient only, not reimbursed for hospital outpatient or ASC	
38760	Inguinofemoral lymphadenectomy, superficial, including Cloquets node (separate procedure)	Facility Only: $859	$2,308	$5,652
38765	Inguinofemoral lymphadenectomy, superficial, in continuity with pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)	Facility Only: $1,343	Inpatient only, not reimbursed for hospital outpatient or ASC	
38770	Pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)	Facility Only: $819	Inpatient only, not reimbursed for hospital outpatient or ASC	
38780	Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure)	Facility Only: $1,062	Inpatient only, not reimbursed for hospital outpatient or ASC	
Mastectomy				
19300	Mastectomy for gynecomastia	Facility: $447 Non-Facility: $608	$1,205	$3,225
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	Facility Only: $683	$1,205	$3,225
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	Facility Only: $938	$2,308	$5,652
19303	Mastectomy, simple, complete	Facility Only: $990	$2,308	$5,652
19305	Mastectomy, radical, including pectoral muscles, axillary lymph nodes	Facility Only: $1,187	Inpatient only, not reimbursed for hospital outpatient or ASC	
19306	Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)	Facility Only: $1,266	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	Facility Only: $1,221	NA	$5,652
Pancreatectomy				
48140	Pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostomy	Facility Only: $1,612	Inpatient only, not reimbursed for hospital outpatient or ASC	
48145	Pancreatectomy, distal subtotal, with or without splenectomy; with pancreaticojejunostomy	Facility Only: $1,688	Inpatient only, not reimbursed for hospital outpatient or ASC	

CPT© Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
48146	Pancreatectomy, distal, near-total with preservation of duodenum (Child-type procedure)	Facility Only: $1,952	Inpatient only, not reimbursed for hospital outpatient or ASC	
48150	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreatojejunostomy	Facility Only: $3,206	Inpatient only, not reimbursed for hospital outpatient or ASC	
48152	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); without pancreatojejunostomy	Facility Only: $2,985	Inpatient only, not reimbursed for hospital outpatient or ASC	
48153	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple- type procedure); with pancreatojejunostomy	Facility Only: $3,200	Inpatient only, not reimbursed for hospital outpatient or ASC	
48154	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple- type procedure); without pancreatojejunostomy	Facility Only: $2,998	Inpatient only, not reimbursed for hospital outpatient or ASC	
48155	Pancreatectomy, total	Facility Only: $1,879	Inpatient only, not reimbursed for hospital outpatient or ASC	
Splenectomy				
38100	Splenectomy; total (separate procedure)	Facility Only: $1,185	Inpatient only, not reimbursed for hospital outpatient or ASC	
38101	Splenectomy; partial (separate procedure)	Facility Only: $1,202	Inpatient only, not reimbursed for hospital outpatient or ASC	
38102	Splenectomy; total, en bloc for extensive disease, in conjunction with other procedure (List in addition to code for primary procedure)	Facility Only: $267	Inpatient only, not reimbursed for hospital outpatient or ASC	
38120	Laparoscopy, surgical, splenectomy	Facility Only: $1,090	NA	$9,096
Robotic Assistance[5]				
S2900	Surgical techniques requiring use of robotic surgical system	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

ICD-10-PCS procedure codes[5] are used by hospitals to report surgeries and procedures performed in the inpatient setting.

ICD-10-PCS Procedure Code	Description
Partial Adrenalectomy, Partial Excision of Adrenal Gland, Excision of Lesion of Adrenal Gland	
0GB20ZZ	Excision of left adrenal gland, open approach
0GB30ZZ	Excision of right adrenal gland, open approach
0GB40ZZ	Excision of bilateral adrenal glands, open approach
0GB24ZZ	Excision of left adrenal gland, percutaneous endoscopic approach
0GB34ZZ	Excision of right adrenal gland, percutaneous endoscopic approach
0GB44ZZ	Excision of bilateral adrenal glands, percutaneous endoscopic approach
Total Adrenalectomy	
0GT20ZZ	Resection of left adrenal gland, open approach
0GT30ZZ	Resection of right adrenal gland, open approach
0GT40ZZ	Resection of bilateral adrenal glands, open approach
0GT24ZZ	Resection of left adrenal gland, percutaneous endoscopic approach
0GT34ZZ	Resection of right adrenal gland, percutaneous endoscopic approach
0GT44ZZ	Resection of bilateral adrenal glands, percutaneous endoscopic approach
Appendectomy	
0DTJ0ZZ	Resection of appendix, open approach
0DTJ4ZZ	Resection of appendix, percutaneous endoscopic approach
Cholecystectomy	
0FT40ZZ	Resection of gallbladder, open approach
0FT44ZZ	Resection of gallbladder, percutaneous endoscopic approach
Partial Esophagectomy, Partial Excision of Esophagus, Excision of Lesion of Esophagus	
0DB10ZZ	Excision of upper esophagus, open approach
0DB20ZZ	Excision of middle esophagus, open approach
0DB30ZZ	Excision of lower esophagus, open approach
0DB40ZZ	Excision of esophagogastric junction, open approach
0DB50ZZ	Excision of esophagus, open approach
0DB14ZZ	Excision of upper esophagus, percutaneous endoscopic approach
0DB24ZZ	Excision of middle esophagus, percutaneous endoscopic approach
0DB34ZZ	Excision of lower esophagus, percutaneous endoscopic approach
0DB44ZZ	Excision of esophagogastric junction, percutaneous endoscopic approach
0DB54ZZ	Excision of esophagus, percutaneous endoscopic approach
0DT34ZZ	Resection of lower esophagus, percutaneous endoscopic approach
0DT44ZZ	Resection of esophagogastric junction, percutaneous endoscopic approach
0DT54ZZ	Resection of esophagus, percutaneous endoscopic approach

ICD-10-PCS Code	Description
Partial Gastrectomy, Partial Excision of Stomach, Excision of Lesion of Stomach	
0DB60ZZ	Excision of stomach, open approach
0DB64ZZ	Excision of stomach, percutaneous endoscopic approach
Total Gastrectomy	
0DT60ZZ	Resection of stomach, open approach
0DT64ZZ	Resection of stomach, percutaneous endoscopic approach
Repair of Diaphragmic Hernia (Hiatal Hernia)	
Note that fundoplication for associated GERD is coded separately as below.	
With Implantation of Mesh	
Character 3 is the root operation. When mesh is used to affect the repair, the root operation is U-Supplement because U-Supplement is defined as putting on or in material, such as mesh, that physically reinforces a body part.[6] The codes are then further differentiated by the type of mesh.	
0BUR07Z	Supplement right diaphragm with autologous tissue substitute, open approach
0BUR0JZ	Supplement right diaphragm with synthetic substitute, open approach
0BUR0KZ	Supplement right diaphragm with nonautologous tissue substitute, open approach
0BUS07Z	Supplement left diaphragm with autologous tissue substitute, open approach
0BUS0JZ	Supplement left diaphragm with synthetic substitute, open approach
0BUS0KZ	Supplement left diaphragm with nonautologous tissue substitute, open approach
0BUR47Z	Supplement right diaphragm with autologous tissue substitute, percutaneous endoscopic approach
0BUR4JZ	Supplement right diaphragm with synthetic substitute, percutaneous endoscopic approach
0BUR4KZ	Supplement right diaphragm with nonautologous tissue substitute, percutaneous endoscopic approach
0BUS47Z	Supplement left diaphragm with autologous tissue substitute, percutaneous endoscopic approach
0BUS4JZ	Supplement left diaphragm with synthetic substitute, percutaneous endoscopic approach
0BUS4KZ	Supplement left diaphragm with nonautologous tissue substitute, percutaneous endoscopic approach
Without Implantation of Mesh	
Character 3 is the root operation. When mesh is not used to affect the repair, the root operation is Q-Repair. This root operation is a default.	
0BQR0ZZ	Repair right diaphragm, open approach
0BQRS0ZZ	Repair left diaphragm, open approach
0BQR4ZZ	Repair right diaphragm, percutaneous endoscopic approach
0BQRS4ZZ	Repair left diaphragm, percutaneous endoscopic approach
Fundoplication (EG, for GERD)	
Character 3 is the root operation. For fundoplication, the root operation is V-Restriction because V-Restriction is defined as partially closing a lumen.[2]	
0DV40ZZ	Restriction of esophagogastric junction, open approach
0DV44ZZ	Restriction of esophagogastric junction, percutaneous endoscopic approach
0DV48ZZ	Restriction of esophagogastric junction, via natural or artificial opening endoscopic

ICD-10-PCS Code	Description
Partial Hepatectomy, Partial Excision of Liver, Excision of Lesion of Liver	
0FB00ZZ	Excision of liver, open approach
0FB10ZZ	Excision of right lobe liver, open approach
0FB20ZZ	Excision of left lobe liver, open approach
0FB04ZZ	Excision of liver, percutaneous endoscopic approach
0FB14ZZ	Excision of right lobe liver, percutaneous endoscopic approach
0FB24ZZ	Excision of left lobe liver, percutaneous endoscopic approach
Total Lobectomy of Liver	
0FT10ZZ	Resection of right lobe liver, open approach
0FT20ZZ	Resection of left lobe liver, open approach
0FT14ZZ	Resection of right lobe liver, percutaneous endoscopic approach
0FT24ZZ	Resection of left lobe liver, percutaneous endoscopic approach
Total Hepatectomy	
0FT00ZZ	Resection of liver, open approach
0FT04ZZ	Resection of liver, percutaneous endoscopic approach
Lymph Node Procedures	
Character 3 is the root operation. For lymph nodes, root operation B-Excision is used for partial removal of a lymph chain, including removal of a single node or sampling selected nodes within a chain. When an entire chain of lymph nodes is removed, including radical resection, root operation T-Resection is used.	
Character 7 is the qualifier, which adds further information to the code. Qualifier X-Diagnostic is used when the intent is to biopsy the lymph nodes, as is typically the case for biopsy, sampling, and other partial removals. Qualifier Z-No Qualifier is used when the intent is therapeutic or when the entire lymph chain is removed.	
Biopsy, Sampling, and Selective Removal of Lymph Nodes, and Partial Removal of Lymph Node Chain	
07B00ZX	Excision of head lymphatic, open approach, diagnostic
07B10ZX	Excision of right neck lymphatic, open approach, diagnostic
07B20ZX	Excision of left neck lymphatic, open approach, diagnostic
07B30ZX	Excision of right upper extremity lymphatic, open approach, diagnostic
07B40ZX	Excision of left upper extremity lymphatic, open approach, diagnostic
07B50ZX	Excision of right axillary lymphatic, open approach, diagnostic
07B60ZX	Excision of left axillary lymphatic, open approach, diagnostic
07B70ZX	Excision of thorax lymphatic, open approach, diagnostic
07B80ZX	Excision of right internal mammary lymphatic, open approach, diagnostic
07B90ZX	Excision of left internal mammary lymphatic, open approach, diagnostic
07BB0ZX	Excision of mesenteric lymphatic, open approach, diagnostic
07BC0ZX	Excision of pelvis lymphatic, open approach, diagnostic
07BD0ZX	Excision of aortic lymphatic, open approach, diagnostic
07BF0ZX	Excision of right lower extremity lymphatic, open approach, diagnostic
07BG0ZX	Excision of left lower extremity lymphatic, open approach, diagnostic

ICD-10-PCS Procedure Code	Description
07BJ0ZX	Excision of left inguinal lymphatic, open approach, diagnostic
07B74ZX	Excision of thorax lymphatic, percutaneous endoscopic approach, diagnostic
07B84ZX	Excision of right internal mammary lymphatic, percutaneous endoscopic approach, diagnostic
07B94ZX	Excision of left internal mammary lymphatic, percutaneous endoscopic approach, diagnostic
07BB4ZX	Excision of mesenteric lymphatic, percutaneous endoscopic approach, diagnostic
07BC4ZX	Excision of pelvis lymphatic, percutaneous endoscopic approach, diagnostic
07BD4ZX	Excision of aortic lymphatic, percutaneous endoscopic approach, diagnostic
07BH4ZX	Excision of right inguinal lymphatic, percutaneous endoscopic approach, diagnostic
07BJ4ZX	Excision of left inguinal lymphatic, percutaneous endoscopic approach, diagnostic
Total Removal of Lymph Node Chain	
07T00ZZ	Resection of head lymphatic, open approach
07T10ZZ	Resection of right neck lymphatic, open approach
07T20ZZ	Resection of left neck lymphatic, open approach
07T30ZZ	Resection of right upper extremity lymphatic, open approach
07T40ZZ	Resection of left upper extremity lymphatic, open approach
07T50ZZ	Resection of right axillary lymphatic, open approach
07T60ZZ	Resection of left axillary lymphatic, open approach
07T70ZZ	Resection of thorax lymphatic, open approach
07T80ZZ	Resection of right internal mammary lymphatic, open approach
07T90ZZ	Resection of left internal mammary lymphatic, open approach
07TB0ZZ	Resection of mesenteric lymphatic, open approach
07TC0ZZ	Resection of pelvis lymphatic, open approach
07TD0ZZ	Resection of aortic lymphatic, open approach
07TF0ZZ	Resection of right lower extremity lymphatic, open approach
07TG0ZZ	Resection of left lower extremity lymphatic, open approach
07TH0ZZ	Resection of right inguinal lymphatic, open approach
07TJ0ZZ	Resection of left inguinal lymphatic, open approach
07T74ZZ	Resection of thorax lymphatic, percutaneous endoscopic approach
07T84ZZ	Resection of right internal mammary lymphatic, percutaneous endoscopic approach
07T94ZZ	Resection of left internal mammary lymphatic, percutaneous endoscopic approach
07TB4ZZ	Resection of mesenteric lymphatic, percutaneous endoscopic approach
07TC4ZZ	Resection of pelvis lymphatic, percutaneous endoscopic approach
07TD4ZZ	Resection of aortic lymphatic, percutaneous endoscopic approach
07TH4ZZ	Resection of right inguinal lymphatic, percutaneous endoscopic approach
07TJ4ZZ	Resection of left inguinal lymphatic, percutaneous endoscopic approach

ICD-10-PCS Code	Description
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, open approach
0HTU0ZZ	Resection of left breast, open approach
0HTV0ZZ	Resection of bilateral breast, open approach
Radical Mastectomy, Modified Radical Mastectomy	
Radical and modified radical mastectomy involves removing the breast and removing underlying muscles and/or extensive removal of lymph nodes. Mastectomy is coded as above. Additional codes are then assigned to capture the removal of underlying muscles and lymph nodes performed.	
Partial or Subtotal Pancreatectomy, Excision of Lesion of Pancreas	
0FBG0ZZ	Excision of pancreas, open approach
0FBG4ZZ	Excision of pancreas, percutaneous endoscopic approach
Total Pancreatectomy	
0FTG0ZZ	Resection of pancreas, open approach
0FTG4ZZ	Resection of pancreas, percutaneous endoscopic approach
Whipple Procedure	
A conventional Whipple involves removing the head of the pancreas, duodenum, a portion of the stomach, gallbladder, and a portion of the bile duct. In a pylorus-sparing Whipple, the stomach is not removed. The subtotal pancreatectomy is coded as above, with additional codes for removal of the stomach and duodenum as performed. Removal of the gallbladder and bile duct is considered inherent and not coded separately. Likewise, the anastomoses are not coded separately.	
Partial or Subtotal Splenectomy, Excision of Lesion of Spleen	
07BP0ZZ	Excision of spleen, open approach
07BP4ZZ	Excision of spleen, percutaneous endoscopic approach
Total Splenectomy	
07TP0ZZ	Resection of spleen, open approach
07TP4ZZ	Resection of spleen, percutaneous endoscopic approach
Robotic Assistance	
Codes for robotic assistance are assigned separately in addition to the primary procedure code.	
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

Hospital Inpatient DRG's for General Surgery

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 and surgical supplies 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[7]	Description	FY 2022 Payment
Adrenalectomy		
614	Adrenal and Pituitary Procedures W CC/MCC	$15,758
615	Adrenal and Pituitary Procedures W/O CC/MCC	$10,386
Appendectomy		
338	Appendectomy W Complicated Principal Diagnosis W MCC	$18,446
339	Appendectomy W Complicated Principal Diagnosis W CC	$11,193
340	Appendectomy W Complicated Principal Diagnosis W/O CC/MCC	$8,100
341	Appendectomy W/O Complicated Principal Diagnosis W MCC	$15,314
342	Appendectomy W/O Complicated Principal Diagnosis W CC	$9,449
343	Appendectomy W/O Complicated Principal Diagnosis W/O CC/MCC	$18,446
Cholecystectomy		
411	Cholecystectomy W C.D.E. W MCC	$24,751
412	Cholecystectomy W C.D.E. W CC	$15,018
413	Cholecystectomy W C.D.E. W/O CC/MCC	$11,414
414	Cholecystectomy Except by Laparoscope W/O C.D.E. W MCC	$23,926
415	Cholecystectomy Except by Laparoscope W/O C.D.E. W CC	$13,398
416	Cholecystectomy Except by Laparoscope W/O C.D.E. W/O CC/MCC	$9,379
417	Laparoscopic Cholecystectomy W/O C.D.E. W MCC	$15,986
418	Laparoscopic Cholecystectomy W/O C.D.E. W CC	$11,138
419	Laparoscopic Cholecystectomy W/O C.D.E. W/O CC/MCC	$8,673
Esophagectomy - The DRG clusters vary depending on whether the principal diagnosis is related to ENT (DRGs 133-134) or the digestive system (DRGs 326-328).		
143	Other Ear, Nose, Mouth and Throat O.R. Procedures W CC/MCC	$19,650
145	Other Ear, Nose, Mouth and Throat O.R. Procedures W/O CC/MCC	$8,075
326	Stomach, Esophageal and Duodenal Procedures W MCC	$35,057
327	Stomach, Esophageal and Duodenal Procedures W CC	$16,912
328	Stomach, Esophageal and Duodenal Procedures W/O CC/MCC	$10,992
Gastrectomy		
326	Stomach, Esophageal and Duodenal Procedures W MCC	$35,057
327	Stomach, Esophageal and Duodenal Procedures W CC	$16,912
328	Stomach, Esophageal and Duodenal Procedures W/O CC/MCC	$10,992

MS-DRG[7]	MS-DRG Description	FY 2022 Payment
Repair of Diaphragmatic Hernia (Hiatal Hernia)		
326	Stomach, Esophageal and Duodenal Procedures W MCC	$35,057
327	Stomach, Esophageal and Duodenal Procedures W CC	$16,912
328	Stomach, Esophageal and Duodenal Procedures W/O CC/MCC	$10,992
Fundoplication (EG, for GERD)		
326	Stomach, Esophageal and Duodenal Procedures W MCC	$35,057
327	Stomach, Esophageal and Duodenal Procedures W CC	$16,912
328	Stomach, Esophageal and Duodenal Procedures W/O CC/MCC	$10,992
Hepatectomy		
405	Pancreas, Liver and Shunt Procedures W MCC	$37,835
406	Pancreas, Liver and Shunt Procedures W CC	$18,997
407	Pancreas, Liver and Shunt Procedures W/O CC/MCC	$13,967
Lymph Node Procedures		
On an inpatient basis, many lymph node procedures are performed in association with another primary procedure, e.g., mastectomy with lymphadenectomy, and the DRG is assigned based on the primary procedure. When the lymph node procedure is itself the primary procedure or is the only procedure, numerous different DRGs can be assigned depending on the principal diagnosis.		
Mastectomy		
582	Mastectomy for Malignancy W CC/MCC	$10,835
583	Mastectomy for Malignancy W/O CC/MCC	$10,165
584	Breast Biopsy, Local Excision and Other Breast Procedures W CC/MCC	$12,112
585	Breast Biopsy, Local Excision and Other Breast Procedures W/O CC/MCC	$11,471
Pancreatectomy - The DRG clusters vary depending on whether the principal diagnosis is related to the hepatobiliary system and the pancreas (DRGs 405-407) or the endocrine system (DRGs 628-630).		
405	Pancreas, Liver and Shunt Procedures W MCC	$37,835
406	Pancreas, Liver and Shunt Procedures W CC	$18,997
407	Pancreas, Liver and Shunt Procedures W/O CC/MCC	$13,967
Lymph Node Procedures		
629	Other Endocrine, Nutritional and Metabolic O.R. Procedures W CC	$15,465
630	Other Endocrine, Nutritional and Metabolic O.R. Procedures W/O CC/MCC	$9,293
Splenectomy		
799	Splenectomy W MCC	$33,943
800	Splenectomy W CC	$19,479
801	Splenectomy W/O CC/MCC	$11,105

For more information, contact the Medtronic MITG Reimbursement Hotline: 877-278-7482 or via email at: Rs.MedtronicMITGReimbursement@medtronic.com

[1]Centers for Medicare & Medicaid Services. Alpha-numeric HCPCS. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

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[3]Centers for Medicare and Medicaid Services. Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Federal Register (86 Fed. Reg. No. 221 64996-66031) https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf Published November 19, 2021. Physician Fee Schedule – January 2022 Release. https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/rvu22a

[4]Centers for Medicare and Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Final Rule, Federal Register (86 Fed. Reg. No.218 63458-63477), https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf Published November 16, 2021. ASC Payment Rates – Addenda January 2022 ASC Approved HCPCS Code and Payment Rates-Updated January 4, 2022. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates

[5]Department of Health and Human Services, Centers for Medicare & Medicaid Services. International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS). https://www.cms.gov/medicare/icd-10/2022-icd-10-cm

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

[7]Centers for Medicare and Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the LongTerm Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2022 Rates; Final Rule, Federal Register (86 Fed. Reg. No. 154 44774-45615), https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf Published August 13, 2021.