Medtronic

2022 Billing and Coding Guide
Wound Closure

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 National Unadjusted Average rounded to the nearest whole number for 2022 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 wound closure 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]
Mastopexy and Mammaplasty				
19316	Mastopexy	Facility Only: $811	$2,308	$5,652
19318	Reduction mammaplasty	Facility Only: $1,119	$2,308	$5,652
19325	Mammaplasty, augmentation; with prosthetic implant	Facility Only: $629	$2,854	$9,106
Excision of Breast Lesion, Lumpectomy, and Mastectomy				
19120	Mammaplasty, augmentation; with prosthetic implant	Facility: $430 Non-Facility: $538	$1,206	$3,225
19300	Mastectomy for gynecomastia	Facility: $447 Non-Facility: $608	$1,206	$3,225
19301	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy);	Facility Only: $683	$1,206	$3,225
19302	Mastectomy, partial (e.g., 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

CPT© Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
Breast Reconstructive Procedures				
11970	Replacement of tissue expander with permanent prosthesis	Facility Only: $575	$3,888	$6,397
11971	Removal of tissue expander(s) without insertion of prosthesis	Facility Only: $562	$1,020	$2,422
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	Facility Only: $777	$2,308	$5,652
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	Facility Only: $779	$2,854	$9,106
19350	Nipple/areola reconstruction	Facility: $689 Non-Facility: $853	$1,206	$3,225
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	Facility Only: $1,188	$5,740	$15,238
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant	Facility Only: $1,594	Inpatient only, not reimbursed for hospital outpatient or ASC	
19364	Breast reconstruction with free flap	Facility Only: $2,785	Inpatient only, not reimbursed for hospital outpatient or ASC	
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;	Facility Only: $1,811	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)	Facility Only: $2,222	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	Facility Only: $2,065	Inpatient only, not reimbursed for hospital outpatient or ASC	
19370	Open periprosthetic capsulotomy, breast	Facility Only: $687	$1,206	$3,225
19371	Periprosthetic capsulectomy, breast	Facility Only: $729	$1,206	$3,225
19380	Revision of reconstructed breast	Facility Only: $826	$2,308	$5,652
CABG				
33510	Coronary artery bypass, vein only; single coronary venous graft	Facility Only: $1,965	Inpatient only, not reimbursed for hospital outpatient or ASC	
33511	Coronary artery bypass, vein only; 2 coronary venous grafts	Facility Only: $2,157	Inpatient only, not reimbursed for hospital outpatient or ASC	
33512	Coronary artery bypass, vein only; 3 coronary venous grafts	Facility Only: $2,459	Inpatient only, not reimbursed for hospital outpatient or ASC	
33513	Coronary artery bypass, vein only; 4 coronary venous grafts	Facility Only: $2,518	Inpatient only, not reimbursed for hospital outpatient or ASC	
33514	Coronary artery bypass, vein only; 5 coronary venous grafts	Facility Only:$ 2,650	Inpatient only, not reimbursed for hospital outpatient or ASC	

CPT© Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
33516	Coronary artery bypass, vein only; 6 or more coronary venous grafts	Facility Only: $2,744	Inpatient only, not reimbursed for hospital outpatient or ASC	
33517	Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (List separately in addition to code for primary procedure)	Facility Only: $190	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)	Facility Only: $416	Inpatient only, not reimbursed for hospital outpatient or ASC	
33519	Coronary artery bypass, using venous graft(s) and arterial graft(s); 3 venous grafts (List separately in addition to code for primary procedure)	Facility Only:$ 552	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)	Facility Only: $661	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)	Facility Only: $742	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)	Facility Only: $840	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)	Facility Only: $532	Inpatient only, not reimbursed for hospital outpatient or ASC	
33533	Coronary artery bypass, using arterial graft(s); single arterial graft	Facility Only: $1,901	Inpatient only, not reimbursed for hospital outpatient or ASC	
33534	Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts	Facility Only: $2,232	Inpatient only, not reimbursed for hospital outpatient or ASC	
33535	Coronary artery bypass, using arterial graft(s); 3 coronary arterial grafts	Facility Only: $2,484	Inpatient only, not reimbursed for hospital outpatient or ASC	
33536	Coronary artery bypass, using arterial graft(s); 4 or more coronary arterial grafts	Facility Only: $2,676	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	Facility Only: $2,305	Inpatient only, not reimbursed for hospital outpatient or ASC	
33406	Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand)	Facility Only: $2,918	Inpatient only, not reimbursed for hospital outpatient or ASC	
33410	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve	Facility Only: $2,579	Inpatient only, not reimbursed for hospital outpatient or ASC	
33411	Replacement aortic valve; with aortic annulus enlargement noncoronary sinus	Facility Only: $3,404	Inpatient only, not reimbursed for hospital outpatient or ASC	
33412	Replacement aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	Facility Only: $3,194	Inpatient only, not reimbursed for hospital outpatient or ASC	

CPT© Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
33413	Replacement aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)	Facility Only: $3,273	Inpatient only, not reimbursed for hospital outpatient or ASC	
33425	Valvuloplasty, mitral valve, with cardiopulmonary bypass;	Facility Only: $2,772	Inpatient only, not reimbursed for hospital outpatient or ASC	
33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	Facility Only: $2,417	Inpatient only, not reimbursed for hospital outpatient or ASC	
33427	Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring	Facility Only: $2,474	Inpatient only, not reimbursed for hospital outpatient or ASC	
33430	Replacement, mitral valve, with cardiopulmonary bypass	Facility Only: $2,844	Inpatient only, not reimbursed for hospital outpatient or ASC	
33463	Valvuloplasty, tricuspid valve; without ring insertion	Facility Only: $3,116	Inpatient only, not reimbursed for hospital outpatient or ASC	
33464	Valvuloplasty, tricuspid valve; with ring insertion	Facility Only: $2,474	Inpatient only, not reimbursed for hospital outpatient or ASC	
33465	Replacement, tricuspid valve, with cardiopulmonary bypass	Facility Only: $2,793	Inpatient only, not reimbursed for hospital outpatient or ASC	
33475	Replacement, pulmonary valve	Facility Only: $2,356	Inpatient only, not reimbursed for hospital outpatient or ASC	
27125	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)	Facility Only: $1,161	Inpatient only, not reimbursed for hospital outpatient or ASC	
Hip and Knee Replacement				
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	Facility Only: $1,316	$9,027	$12,593
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	Facility Only: $1,711	Inpatient only, not reimbursed for hospital outpatient or ASC	
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	Facility Only: $1,949	Inpatient only, not reimbursed for hospital outpatient or ASC	
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	Facility Only: $1,501	Inpatient only, not reimbursed for hospital outpatient or ASC	
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	Facility Only: $1,560	Inpatient only, not reimbursed for hospital outpatient or ASC	
27445	Arthroplasty, knee, hinge prosthesis (e.g., Walldius type)	Facility Only: $1,287	Inpatient only, not reimbursed for hospital outpatient or ASC	
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	Facility Only: $1,314	$8,967	$12,593
27486	Revision of total knee arthroplasty, with or without allograft; 1 component	Facility Only: $1,438	Inpatient only, not reimbursed for hospital outpatient or ASC	
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	Facility Only: $1,794	Inpatient only, not reimbursed for hospital outpatient or ASC	

CPT© Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	Facility Only: $1,183	$8,844	$12,593
Abdominoplasty				
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	Facility Only: $1,199	$2,308	$5,652
Sternum Closure				
21620	Ostectomy of sternum, partial	Facility Only: $521	Inpatient only, not reimbursed for hospital outpatient or ASC	
21630	Radical resection of sternum;	Facility Only: $1,345	Inpatient only, not reimbursed for hospital outpatient or ASC	
21632	Radical resection of sternum; with mediastinal lymphadenectomy	Facility Only: $1,243	Inpatient only, not reimbursed for hospital outpatient or ASC	
21825	Open treatment of sternum fracture with or without skeletal fixation	Facility Only: $566	Inpatient only, not reimbursed for hospital outpatient or ASC	
Robotic Assistance				
S2900	Surgical techniques requiring use of robotic surgical system	Not paid separately. 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 Wound Closure Surgeries: Breast Procedures

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	Procedure Code Description
Mastopexy	
Mastopexy uses root operation S-Reposition, because the objective is to restore the breast to its 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 the device is J-Synthetic Substitute, used for silicone and saline implants.	
0H0T0JZ	Alteration of right breast with synthetic substitute, open approach
0H0U0JZ	Alteration of left breast with synthetic substitute, open approach
0H0V0JZ	Alteration of bilateral breasts with synthetic substitute, open approach
Excision of Breast Lesion, Lumpectomy, and Mastectomy	
The two main root operations for removal of tissue are B-Excision and T-Resection. By definition, B-Excision involves removing a portion of the body part and T-Resection involves removing the entire body part.[2] For example, lumpectomy and subtotal mastectomy are both coded to B-Excision, while complete mastectomy is coded to T-Resection.	
Lumpectomy, Segmentectomy, Partial or Subtotal Mastectomy, Excision of Lesion of Breast	
0HBT0ZZ	Excision of right breast, open approach
0HBU0ZZ	Excision of left breast, open approach
0HBV0ZZ	Excision of bilateral breast, open approach
Total Mastectomy	
0HTT0ZZ	Resection of right breast, percutaneous endoscopic approach
0HTU0ZZ	Resection of left breast, percutaneous endoscopic approach
0HTV0ZZ	Resection of bilateral breast, percutaneous endoscopic approach
Radical Mastectomy, Modified Radical Mastectomy	
Radical and modified radical mastectomy involves removal of the breast as well as the removal of underlying muscles and/or extensive removal of lymph nodes. Mastectomy is coded as above. Additional codes are then assigned to capture removal of underlying muscles and lymph nodes performed.	
Breast Reconstruction Procedures – Tissue Expanders	
Note that replacement of a tissue expander uses two codes: one for insertion of the new expander and one for removal of the prior expander.	
0HHT0NZ	Insertion of tissue expander into right breast, open approach
0HHU0NZ	Insertion of tissue expander into left breast, open approach
0HHV0NZ	Insertion of tissue expander into bilateral breasts, open approach
0HPT0NZ	Removal of tissue expander from right breast, open approach
0HPU0NZ	Removal of tissue expander from left breast, open approach

ICD-10-PCS Procedure Code	Procedure Code Description
Augmentation Mammaplasty (Breast Implants, Reconstructive)	
When the implants are reconstructive, root operation R-Replacement is used because it is defined as physically taking the place of a body part. If the reconstruction is performed concurrently with the mastectomy, mastectomy is coded separately.[2]	
0HRT0JZ	Replacement of right breast with synthetic substitute, open approach
0HRU0JZ	Replacement of left breast with synthetic substitute, open approach
0HRV0JZ	Replacement of bilateral breasts with synthetic substitute, open approach
Free Grafts, Flap Grafts, and Pedicle Grafts	
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

CABG

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

Character	Description
4: Body Part	The fourth character shows the number of coronary artery sites that are being bypassed.
6: Device	The device character refers to a free graft between the vessels and specifies the type of tissue or other material used: 9-Autologous Venous Tissue, e.g., saphenous vein graft A-Autologous Arterial Tissue, e.g., radial artery graft J-Synthetic Substitute, e.g., PTFE graft K-Nonautologous Tissue Substitute, e.g., 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, i.e. the vessel now supplying the blood.

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

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

- 021109W - Bypass coronary artery, two sites from aorta with autologous venous tissue, open approach
- 02100Z9 - Bypass coronary artery, one site from left internal mammary artery, open approach

Heart Valve Replacement

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

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

Open replacement of aortic valve with Open Pivot mechanical valve

- 02RF0JZ - Replacement of aortic valve with synthetic substitute, open approach

Open replacement of aortic valve with Open Pivot mechanical valve

- 02RG08Z - Replacement of mitral valve with zooplastic tissue, open approach

Heart Valve Repair via Annuloplasty

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

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

SECTION 0 Medical and Surgical BODY SYSTEM 2 Heart and Great Vessels OPERATION U Supplement: Putting in or on biological or synthetic material that physically reinforces and/or augments the function of a portion of a body part			
Body Part	Approach	Device	Qualifier
5 Atrial Septum 6 Atrium, Right 7 Atrium, Left 9 Choradae Tendineae A Heart D Papillary Muscle F Aortic Valve D Mitral Valve H Pulmonary Valve J Tricuspid Valve	0 Open 3 Percutaneous 4 Percutaneous Endoscopic	7 Autologous Tissue Substitute 8 Zooplastic Tissue J Synthetic Substitute K Nonautologous Tissue Substitute	Z No Qualifier

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

Hip Replacement

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

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.[1] When a previously implanted joint replacement device is removed, and a new joint replacement device is placed, the procedure requires two codes: one for removing the previously implanted joint replacement prosthesis using root operation P-Removal, and one for placing the new joint prosthesis device using root operation R-Replacement. [1,2] The code for removing the previously placed prosthesis is assigned from code table 0SP below. The code for implanting the new prosthesis is assigned from code table 0SR.

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

Examples

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

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

PLUS

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

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

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

PLUS

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

"Revision" of Knee Replacement - Replacement of Previously Implanted Prosthesis

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

Example

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

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

PLUS

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

Hospital Inpatient Procedure Coding for Wound Closure Surgeries: Abdominoplasty, Sternum Closure

ICDD-10-PCS Procedure Code	Description
Abdominoplasty	
The root operation varies depending on the precise nature of the abdominoplasty: 0-Alteration, e.g. cosmetic abdominoplasty of any kind B-Excision, e.g. therapeutic removal of excess skin and subcutaneous tissue Q-Repair, e.g., therapeutic suture plication	
0W0F0ZZ	Alteration of abdominal wall, open approach
0JB80ZZ	Excision of abdomen subcutaneous tissue and fascia, open approach
0WQF0ZZ	Repair abdominal wall, open approach
Sternal Closure	
Sternal closure is not coded separately when sternotomy was performed to reach another operative site. For example, sternal closure following CABG or valve replacement is considered inherent to the primary procedure. It is inherent to primary sternal procedures as well.	
The two main root operations for removal of tissue are B-Excision and T-Resection. By definition, B-Excision involves removing a portion of the body part, and T-Resection involves removing the entire body part.	
Excision of Lesion of Sternum, Partial Ostectomy of Sternum	
0PB00ZZ	Excision of sternum, open approach
Total Removal of Sternum	
0PT00ZZ	Resection of sternum, open approach
Radical Resection of Sternum	
Radical sternal resection involves complete removal of the sternum as well as extensive removal of lymph nodes. Total removal of the sternum is coded as above. Additional codes are then assigned to capture the lymphadenectomy.	
Robotic 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
8E0Y0CZ	Robotic assisted procedure of lower extremity, open approach
8E0Y4CZ	Robotic assisted procedure of lower extremity, percutaneous endoscopic approach

Hospital Inpatient DRG's for Wound Closure Surgeries

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. 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[6]	Description	FY 2022 Payment
Mastopexy and Mammaplasty		
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
Excision of Breast Lesion, Lumpectomy and Mastectomy, Reconstructive Procedures		
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
CABG		
231	Coronary Bypass W PTCA W MCC	$57,475
232	Coronary Bypass W PTCA W/O MCC	$39,261
233	Coronary Bypass W Cardiac Cath W MCC	$52,242
234	Coronary Bypass W Cardiac Cath W/O MCC	$35,187
235	Coronary Bypass W/O Cardiac Cath W MCC	$40,252
236	Coronary Bypass W/O Cardiac Cath W/O MCC	$27,017
Heart Valve Replacement, Heart Valve Repair via Annuloplasty		
216	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W MCC	$66,202
217	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W CC	$42,754
218	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W/O CC/MCC	$40,286
219	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W MCC	$53,134
220	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W CC	$35,644
221	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W/O CC/MCC	$30,201
Hip and Knee Replacement		
461	Bilateral or Multiple Major Joint Procedures of Lower Extremity W MCC	$40,104
462	Bilateral or Multiple Major Joint Procedures of Lower Extremity W/O MC	$20,715
469	Major Joint Replacement or Reattachment of Lower Extremity W MCC	$20,349
470	Major Joint Replacement or Reattachment of Lower Extremity W/O MCC	$12,531
Revision of Hip and Knee Replacement		
466	Revision of Hip or Knee Replacement W MCC	$35,251
467	Revision of Hip or Knee Replacement W CC	$23,591
468	Revision of Hip or Knee Replacement W/O CC/MCC	$18,480

MS-DRG[6]	Description	FY 2022 Payment
Abdominoplasty		
Alteration Cosmetic Abdominoplasty		
579	Other Skin, Subcutaneous Tissue and Breast Procedures W MCC	$20,738
580	Other Skin, Subcutaneous Tissue and Breast Procedures W CC	$11,400
581	Other Skin, Subcutaneous Tissue and Breast Procedures W/O CC/MCC	$9,079
The DRG clusters vary depending on whether the principal diagnosis is related to the skin and subcutaneous tissue (570-572) or obesity e.g. symptomatic pannus (DRG 622-624)		
570	Skin Debridement W MCC	$18,739
571	Skin Debridement W CC	$10,784
572	Skin Debridement W/O CC/MCC	$7,283
622	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders W MCC	$23,838
623	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders W CC	$12,341
624	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders W/O CC/MCC	$7,246
Plication These DRGs assume the diagnosis involve some sort of abdominal wall separation		
353	Hernia Procedures Except Inguinal and Femoral W MCC	$19,947
354	Hernia Procedures Except Inguinal and Femoral W CC	$11,769
355	Hernia Procedures Except Inguinal and Femoral W/O CC/MCC	$8,969
STERNAL CLOSURE The DRG clusters vary depending on whether the principal diagnosis is related to the respiratory systems (166-168) or the musculoskeletal system, e.g., pannus (DRGs 515-517)		
466	Revision of Hip or Knee Replacement W MCC	$35,251
467	Revision of Hip or Knee Replacement W CC	$23,591
468	Revision of Hip or Knee Replacement W/O CC/MCC	$18,480

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/Alpha-Numeric-HCPCS-Items/2020-Alpha-Numeric-HCPCS-File

[2]CPT copyright 2020 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

[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]ICD-10-PCS: Department of Health and Human Services, Centers for Medicare & Medicaid Services. International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS). https://www.cms.gov/medicare/icd-10/2021-icd-10-pcs

[6]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.

Medtronic provides this information for your convenience only. It does not constitute legal advice or a recommendation regarding clinical practice. Information provided is gathered from third-party sources and is subject to change without notice due to frequently changing laws, rules and regulations. The provider has the responsibility to determine medical necessity and to submit appropriate 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. This document provides assistance for FDA approved or cleared indications. Where reimbursement is sought for use of a product that may be inconsistent with, or not expressly specified in, the FDA cleared or approved labeling (e.g., instructions for use, operator's manual or package insert), consult with your billing advisors or payers on handling such billing issues. Some payers may have policies that make it inappropriate to submit claims for such items or related service.

© 2022 Medtronic. All rights reserved. Medtronic, Medtronic logo and Engineering the extraordinary are trademarks of Medtronic. ™* Third party brands are trademarks of their respective owners. All other brands are trademarks of a Medtronic company 01/2022 US-WC-2100003