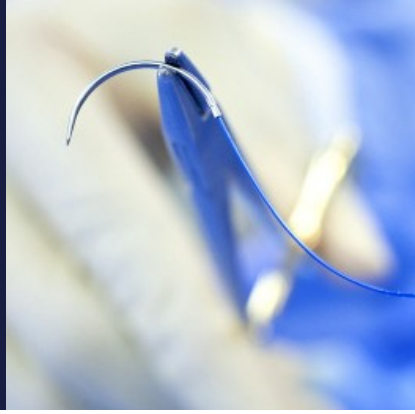
2021 BILLING AND CODING GUIDE
WOUND CLOSURE



2021 Medicare Physician, Hospital Outpatient, ASC Coding and Payment

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 Average rounded to the nearest whole number for 2021 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]	CODE DESCRIPTION	PHYSICIAN[3]	AMBULATORY SURGICAL CENTER (ASC)[4]	HOSPITAL OUTPATIENT[4]
	MASTOPLEXY AND MAMMAPLASTY			
19316	Mastopexy	Facility Only: $811	$2,251	$5,534
19318	Reduction mammaplasty	Facility Only: $1,121	$2,251	$5,534
19325	Mammaplasty, augmentation; with prosthetic implant	Facility Only: $629	$2,788	$8,920
	EXCISION OF BREAST LESION, LUMPECTOMY, AND MASTECTOMY			
19120	Mammaplasty, augmentation; with prosthetic implant	Facility: $429 Non-Facility: $535	$1,176	$3,158
19300	Mastectomy for gynecomastia	Facility: $440 Non-Facility: $599	$1,176	$3,158
19301	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy);	Facility Only: $680	$1,176	$3,158
19302	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	Facility Only: $935	$2,251	$5,534
19303	Mastectomy, simple, complete	Facility Only: $989	$2,251	$5,534
19305	Mastectomy, radical, including pectoral muscles, axillary lymph nodes	Facility Only: $1,181	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: $1,258	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: $1,222	$2,251	$5,534

Medtronic

CPT® CODE[2]	CODE DESCRIPTION	PHYSICIAN[3]	AMBULATORY SURGICAL CENTER (ASC)[4]	HOSPITAL OUTPATIENT[4]
BREAST RECONSTRUCTIVE PROCEDURES				
11970	Replacement of tissue expander with permanent prosthesis	Facility Only: $575	NA	$6,265
11971	Removal of tissue expander(s) without insertion of prosthesis	Facility Only: $561	NA	$2,370
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	Facility Only: $776	$2,251	$5,534
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	Facility: $780 Non-Facility: NA	$2,788	$8,920
19350	Nipple/areola reconstruction	Facility: $688 Non-Facility: $855	$1,176	$3,158
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	Facility Only: $1,193	$5,622	$14,929
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant	Facility Only: $1,600	Inpatient only, not reimbursed for hospital outpatient or ASC	
19364	Breast reconstruction with free flap	Facility Only: $2,797	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: $1,816	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: $2,232	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: $2,073	Inpatient only, not reimbursed for hospital outpatient or ASC	
19370	Open periprosthetic capsulotomy, breast	Facility Only: $686	$1,176	$3,158
19371	Periprosthetic capsulectomy, breast	Facility Only: $730	$1,176	$3,158
19380	Revision of reconstructed breast	Facility Only: $827	$2,251	$5,534

CPT® CODE[2]	CODE DESCRIPTION	PHYSICIAN[3]	AMBULATORY SURGICAL CENTER (ASC)[4]	HOSPITAL OUTPATIENT[4]
	CABG			
33510	Coronary artery bypass, vein only; single coronary venous graft	Facility Only: $1,971	Inpatient only, not reimbursed for hospital outpatient or ASC	
33511	Coronary artery bypass, vein only; 2 coronary venous grafts	Facility Only: $2,164	Inpatient only, not reimbursed for hospital outpatient or ASC	
33512	Coronary artery bypass, vein only; 3 coronary venous grafts	Facility Only: $2,468	Inpatient only, not reimbursed for hospital outpatient or ASC	
33513	Coronary artery bypass, vein only; 4 coronary venous grafts	Facility Only: $2,535	Inpatient only, not reimbursed for hospital outpatient or ASC	
33514	Coronary artery bypass, vein only; 5 coronary venous grafts	Facility Only: $2,671	Inpatient only, not reimbursed for hospital outpatient or ASC	
33516	Coronary artery bypass, vein only; 6 or more coronary venous grafts	Facility Only: $2,754	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: $191	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: $419	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: $554	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:$665	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: $747	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: $847	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: $535	Inpatient only, not reimbursed for hospital outpatient or ASC	
33533	Coronary artery bypass, using arterial graft(s); single arterial graft	Facility Only: $1,908	Inpatient only, not reimbursed for hospital outpatient or ASC	
33534	Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts	Facility Only: $2,240	Inpatient only, not reimbursed for hospital outpatient or ASC	
33535	Coronary artery bypass, using arterial graft(s); 3 coronary arterial grafts	Facility Only: $2,496	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: $2,685	Inpatient only, not reimbursed for hospital outpatient or ASC	

CPT® CODE[2]	CODE DESCRIPTION	PHYSICIAN[3]	AMBULATORY SURGICAL CENTER (ASC)[4]	HOSPITAL OUTPATIENT[4]
	HEART VALVE REPLACEMENT AND REPAIR			
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	Facility Only: $2,314	Inpatient only, not reimbursed for hospital outpatient or ASC	
33406	Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand)	Facility Only: $2,936	Inpatient only, not reimbursed for hospital outpatient or ASC	
33410	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve	Facility Only: $2,590	Inpatient only, not reimbursed for hospital outpatient or ASC	
33411	Replacement aortic valve; with aortic annulus enlargement noncoronary sinus	Facility Only: $3,418	Inpatient only, not reimbursed for hospital outpatient or ASC	
33412	Replacement aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	Facility Only: $3,208	Inpatient only, not reimbursed for hospital outpatient or ASC	
33413	Replacement aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)	Facility Only: $3,285	Inpatient only, not reimbursed for hospital outpatient or ASC	
33425	Valvuloplasty, mitral valve, with cardiopulmonary bypass;	Facility Only: $2,784	Inpatient only, not reimbursed for hospital outpatient or ASC	
33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	Facility Only: $2,426	Inpatient only, not reimbursed for hospital outpatient or ASC	
33427	Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring	Facility Only: $2,485	Inpatient only, not reimbursed for hospital outpatient or ASC	
33430	Replacement, mitral valve, with cardiopulmonary bypass	Facility Only: $2,855	Inpatient only, not reimbursed for hospital outpatient or ASC	
33463	Valvuloplasty, tricuspid valve; without ring insertion	Facility Only: $3,129	Inpatient only, not reimbursed for hospital outpatient or ASC	
33464	Valvuloplasty, tricuspid valve; with ring insertion	Facility Only: $2,484	Inpatient only, not reimbursed for hospital outpatient or ASC	
33465	Replacement, tricuspid valve, with cardiopulmonary bypass	Facility Only: $2,804	Inpatient only, not reimbursed for hospital outpatient or ASC	
33475	Replacement, pulmonary valve	Facility Only: $2,368	Inpatient only, not reimbursed for hospital outpatient or ASC	
27125	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)	Facility Only: $1,164	NA	$12,315
	HIP AND KNEE REPLACEMENT			
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	Facility Only: $1,322	$8,818	$12,315
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	Facility Only: $1,718	NA	$12,315
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	Facility Only: $1,959	NA	$12,315
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	Facility Only: $1,508	NA	$12,315
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	Facility Only: $1,567	NA	$12,315
27445	Arthroplasty, knee, hinge prosthesis (e.g., Walldius type)	Facility Only: $1,291	NA	$12,315
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	Facility Only: $1,187	$8,640	$12,315
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	Facility Only: $1,321	$8,759	$12,315
27486	Revision of total knee arthroplasty, with or without allograft; 1 component	Facility Only: $1,445	NA	$12,315
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	Facility Only: $1,803	NA	$12,315

CPT® CODE[2]	CODE DESCRIPTION	PHYSICIAN[3]	AMBULATORY SURGICAL CENTER (ASC)[4]	HOSPITAL OUTPATIENT[4]
	ABDOMINOPLASTY			
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	Facility Only: $1,201	NA	$5,534
	STERNUM CLOSURE			
21620	Ostectomy of sternum, partial	Facility Only: $522	NA	$6,265
21630	Radical resection of sternum;	Facility Only: $1,226	NA	$6,265
21632	Radical resection of sternum; with mediastinal lymphadenectomy	Facility Only: $1,243	NA	$6,265
21825	Open treatment of sternum fracture with or without skeletal fixation	Facility Only: $561	NA	$6,265
	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		

References:

[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 & Medicaid Services. Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID-19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID-19; Final Rule, Federal Register (85 Fed. Reg. No. 248 84472- 85377) 42 CFR Parts 400, 410, 414, 415, 423, 424, and 425. https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf

[4] Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; Physician-owned Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity To Apply for Available Slots, Radiation Oncology Model; and Reporting Requirements for Hospitals and Critical Access Hospitals (CAHs) to Report COVID-19 Therapeutic Inventory and Usage and to Report Acute Respiratory Illness During the Public Health Emergency (PHE) for Coronavirus Disease 2019 (COVID-19); Final Rule, Federal Register (85 Fed. Reg. No.249 85866-86305) 42 CFR Parts 410, 411, 412, 414, 419, 482, 485 and 512. Addendum B, AA, BB. https://www.govinfo.gov/content/pkg/FR-2020-12-29/pdf/2020-26819.pdf.

HOSPITAL INPATIENT PROCEDURE CODING FOR WOUND CLOSURE SURGERIES: BREAST PROCEDURES

ICD-10-PCS procedure codes[1] are used by hospitals to report surgeries and procedures performed in the inpatient setting.

Breast Procedures

ICD-10-PCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
MASTOPEXY	
Mastopexy uses root operation S-Reposition, because the objective is to restore the breast to their appropriate location.	
0HST0ZZ	Reposition right breast, open approach
0HSU0ZZ	Reposition left breast, open approach
0HSV0ZZ	Reposition bilateral breasts, open approach
REDUCTION MAMMAPLASTY	
Reduction mammaplasty uses root operation E-Excision, which is defined for removing some of a body part's tissue but not all.	
0HBT0ZZ	Excision right breast, open approach
0HBU0ZZ	Excision left breast, open approach
0HBV0ZZ	Excision bilateral breasts, open approach
AUGMENTATION MAMMAPLASTY (BREAST IMPLANTS, NON-RECONSTRUCTIVE)	
Breast implants placed for non-reconstructive reasons use root operation 0-Alteration which is defined as modifying the anatomic structure of a body part without affecting its function. The sixth character for device is J-Synthetic Substitute, used for silicone and saline implants.	
0H0T0JZ	Alteration of right breast with synthetic substitute, open approach
0H0U0JZ	Alteration of left breast with synthetic substitute, open approach
0H0V0JZ	Alteration of bilateral breasts with synthetic substitute, open approach
EXCISION OF BREAST LESION, LUMPECTOMY AND MASTECTOMY	
The two main root operations for removal of tissue are B-Excision and T-Resection. By definition, B-Excision involves removing a portion of the body part and T-Resection involves removing the entire body part.2 For example, lumpectomy and subtotal mastectomy are both coded to B-Excision, while complete mastectomy is coded to T-Resection.	
LUMPECTOMY, SEGMENTECTOMY, PARTIAL OR SUBTOTAL MASTECTOMY, EXCISION OF LESION OF BREAST	
0HBT0ZZ	Excision of right breast, open approach
0HBU0ZZ	Excision of left breast, open approach
0HBV0ZZ	Excision of bilateral breast, open approach
TOTAL MASTECTOMY	
0HTT0ZZ	Resection of right breast, percutaneous endoscopic approach
0HTU0ZZ	Resection of left breast, percutaneous endoscopic approach
0HTV0ZZ	Resection of bilateral breast, percutaneous endoscopic approach
RADICAL MASTECTOMY, MODIFIED RADICAL MASTECTOMY	
Radical and modified radical mastectomy involve removal of the breast as well as removal of underlying muscles and/or extensive removal of lymph nodes. Mastectomy is coded as above. Additional codes are then assigned to capture removal of underlying muscles and lymph nodes performed.	
BREAST RECONSTRUCTIVE PROCEDURES	
TISSUE EXPANDERS	
Note that replacement of a tissue expander uses two codes: one for insertion of the new expander and one for removal of the prior expander.	
0HHT0NZ	Insertion of tissue expander into right breast, open approach
0HHU0NZ	Insertion of tissue expander into left breast, open approach
0HHV0NZ	Insertion of tissue expander into bilateral breasts, open approach
0HPT0NZ	Removal of tissue expander from right breast, open approach
0HPU0NZ	Removal of tissue expander from left breast, open approach

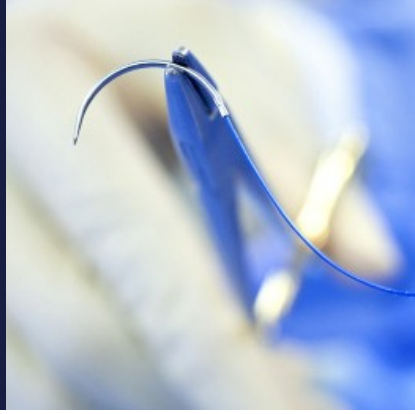
ICD-10-PCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
AUGMENTATION MAMMAPLASTY (BREAST IMPLANTS, RECONSTRUCTIVE)	
When the implants are reconstructive, root operation R-Replacement is used because it is defined as physically taking the place of a body part. If the reconstruction is performed concurrently with the mastectomy, mastectomy is coded separately.[2]	
0HRT0JZ	Replacement of right breast with synthetic substitute, open approach
0HRU0JZ	Replacement of left breast with synthetic substitute, open approach
0HRV0JZ	Replacement of bilateral breasts with synthetic substitute, open approach
FREE GRAFTS, FLAP GRAFTS AND PEDICLE 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

Reference

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

[2]2021 ICD-10-PCS Official Guidelines for Coding and Reporting. https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2020-ICD-10-PCS-Guidelines.pdf

HOSPITAL INPATIENT PROCEDURE CODING FOR WOUND CLOSURE SURGERIES: CARDIAC PROCEDURES



CABG

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

CHARACTER	DESCRIPTION
4: Body Part	The fourth character shows the number of coronary artery sites that are being bypassed.
6: Device	The device character refers to a free graft between the vessels and specifies the type of tissue or other material used: **9-**Autologous Venous Tissue, 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

Examples

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

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

Heart Valve Replacement

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

CHARACTER	DESCRIPTION
5: Approach	**0-**Open includes various less invasive techniques such as mini-sternotomy or right anterior thoracotomy, because there is still an incision that directly exposes the surgical site **4-**Percutaneous Endoscopic refers to procedures performed via thoracoscopy
6: Device	The device character specifies the type of tissue or material used for the new valve: **7-** Autologous Tissue Substitute, 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

Examples

Open replacement of aortic valve with Open Pivot mechanical valve

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

Open replacement of aortic valve with Open Pivot mechanical valve

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

Heart Valve Repair via Annuloplasty

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

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

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

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

Examples

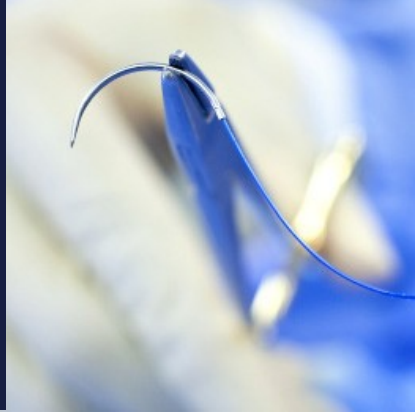
Open annuloplasty of the tricuspid valve using a Contour 3D ring

- 02UJ0JZ - Supplement tricuspid valve with synthetic substitute, open approach

Open replacement of aortic valve with Open Pivot mechanical valve

- 02UG0JZ - Supplement mitral valve with synthetic substitute, open approach

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



Hip Replacement

Codes for hip replacement are constructed from code table 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

Examples

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

- 0SRB03A - Replacement of left hip joint with ceramic synthetic substitute, uncemented, open approach

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

- 0SRR019 - Replacement of right hip joint, femoral surface with metal synthetic substitute, cemented, open approach

Knee Replacement

Like hip replacement, codes for knee replacement are also constructed from code table 0SR.

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

Example

Total knee replacement, left knee, cemented

- 0SRD0J9 - Replacement of left knee joint with synthetic substitute, cemented, open approach

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

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

CHARACTER	DESCRIPTION
3: Root Operation	Do ***not*** use root operation W-Revision for this scenario. W-Revision is used when an implanted device is corrected without being replaced, such as repositioning a displaced prosthesis or recementing a loose prosthesis.[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 assigning 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

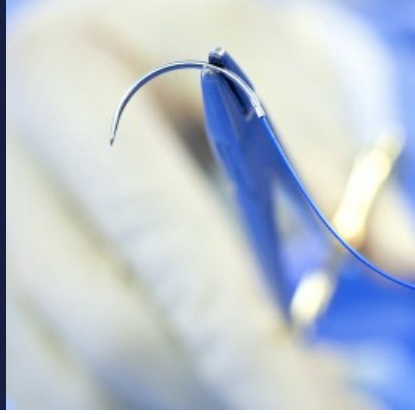
- 0SRC0JZ- Replacement of right knee joint with synthetic substitute, open approach

PLUS

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

HOSPITAL INPATIENT PROCEDURE CODING

FOR WOUND CLOSURE SURGERIES: ABDOMINOPLASTY, STERNUM CLOSURE



ICD-10-PCS PROCEDURE CODE	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 DRGS FOR WOUND CLOSURE SURGERIES

DRG Assignment FY2021—effective October 1, 2020

Under Medicare's MS-DRG methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 750 diagnosis-related groups, based on the ICD-10 codes assigned to the diagnoses and procedures. 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[3]	DESCRIPTION	MEDICARE NATIONAL AVERAGE
	MASTOPEXY AND MAMMAPLASTY	
584	Breast Biopsy, Local Excision and Other Breast Procedures W CC/ MCC	$11,668
585	Breast Biopsy, Local Excision and Other Breast Procedures W/O CC/MCC	$11,107
	EXCISDION OF BREAST LESION, LUMPECTOMY AND MASTECTOMY, RECONSTRUCTIVE PROCEDURES	
582	Mastectomy for Malignancy W CC/MCC	$10,465
583	Mastectomy for Malignancy W/O CC/MCC	$9,828
584	Breast Biopsy, Local Excision and Other Breast Procedures W CC/ MCC	$11,668
585	Breast Biopsy, Local Excision and Other Breast Procedures W/O CC/MCC	$11,107
	CABG	
231	Coronary Bypass W PTCA W MCC	$54,126
232	Coronary Bypass W PTCA W/O MCC	$37,602
233	Coronary Bypass W Cardiac Cath W MCC	$49,679
234	Coronary Bypass W Cardiac Cath W/O MCC	$33,899
235	Coronary Bypass W/O Cardiac Cath W MCC	$38,443
236	Coronary Bypass W/O Cardiac Cath W/O MCC	$26,016
	HEART VALVE REPLACEMENT, HEART VALVE REPAIR VIA ANNULOPLASTY	
216	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W MCC	$66,493
217	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W CC	$41,392
218	Cardiac Valve and Other Major Cardiothoracic Procedures W Cardiac Cath W/O CC/MCC	$32,789
219	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W MCC	$51,352
220	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W CC	$34,425
221	Cardiac Valve and Other Major Cardiothoracic Procedures W/O Cardiac Cath W/O CC/MCC	$29,022
	HIP REPLACEMENT AND KNEE REPLACEMENT	
461	Bilateral or Multiple Major Joint Procedures of Lower Extremity W MCC	$38,737
462	Bilateral or Multiple Major Joint Procedures of Lower Extremity W/O MC	$20,045
469	Major Joint Replacement or Reattachment of Lower Extremity W MCC	$19,663
470	Major Joint Replacement or Reattachment of Lower Extremity W/O MCC	$12,112
	REVISION OF HIP AND KLNEE REPLACEMENT	
466	Revision of Hip or Knee Replacement W MCC	$34,075
467	Revision of Hip or Knee Replacement W CC	$22,799
468	Revision of Hip or Knee Replacement W/O CC/MCC	$17,876

MS-DRG[3]	DESCRIPTION	MEDICARE NATIONAL AVERAGE
	ABDOMINOPLASTY	
Alteration Cosmetic Abdominoplasty		
579	Other Skin, Subcutaneous Tissue and Breast Procedures W MCC	$18,665
580	Other Skin, Subcutaneous Tissue and Breast Procedures W CC	$10,220
581	Other Skin, Subcutaneous Tissue and Breast Procedures W/O CC/MCC	$8,032
Excision 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	$18,082
571	Skin Debridement W CC	$10,409
572	Skin Debridement W/O CC/MCC	$7,029
622	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders W MCC	$23,032
623	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders W CC	$11,940
624	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders W/O CC/MCC	$6,976
Plication These DRGS assume the diagnosis involve some sort of abdominal wall separation		
353	Hernia Procedures Except Inguinal and Femoral W MCC	$19,178
354	Hernia Procedures Except Inguinal and Femoral W CC	$11,367
355	Hernia Procedures Except Inguinal and Femoral W/O CC/MCC	$8,665
	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	$34,075
467	Revision of Hip or Knee Replacement W CC	$22,799
468	Revision of Hip or Knee Replacement W/O CC/MCC	$17,876

Reference:

[1.] Centers for Medicare & Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2020 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals; Final Rule, Federal Register (84 Fed Reg. No. 159 42044 – 42701) 42 CFR Parts 412, 413, and 495. https://www.govinfo.gov/content/pkg/FR-2019-08-16/pdf/2019-16762.pdf. Published August 16, 2019. See also – Correction Notice, Federal Register (84 Fed. Reg. No. 195 53603 – 53630) 42 CFR Parts 412, 413, and 495. https://www.govinfo.gov/content/ pkg/FR-2019-10-08/pdf/2019-21865.pdf. Published October 8, 2019. The payment rate shown is the standardized amounts for facilities with a wage index greater than one. The average standard amounts shown also assume facilities receive the full quality update. The payment will also be adjusted by the Wage Index for specific geographic locality. Therefore, payment for a specific hospital will vary from the stated Medicare national average payment levels shown. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.

Medtronic