



Medicare Hospital Version

KEY CONCEPTS OUTLINE

Module 6: Outpatient Surgical Services, Including Implantable Devices

I. Inpatient-Only Procedures

- A. CMS has determined certain procedures are not appropriate to be provided in a hospital outpatient department and designates them “inpatient only” procedures. *<Medicare Claims Processing Manual, Chapter 4 § 180.7>*
- B. Inpatient-only procedures have an OPPS status indicator of C on Addendum B. The complete list of inpatient-only procedures is also published in Addendum E to the OPPS Final Rule every year. *<Medicare Claims Processing Manual, Chapter 4 § 180.7>*

Link: OPPS – Regulations and Notices under Medicare-Related Sites – Hospital

C. Inpatient-Only Procedures Performed on an Outpatient Basis

- 1. Subject to certain exceptions discussed below, if an inpatient-only procedure is performed on an outpatient basis, no payment will be made for the inpatient-only procedure, or any other services furnished on the same date as the inpatient-only procedure. *<IOCE Specifications, Section 6.2, Edits 18 and 49>*

D. Exceptions to the Inpatient-Only Rule

1. Emergency Inpatient-Only Procedure and Patient Dies or is Transferred

- a. If an inpatient-only procedure is furnished on an emergency basis while the patient is still an outpatient and the patient dies or is transferred to another hospital prior to being admitted, payment is made for the inpatient-only procedure and all other services provided that day under a single APC. *<IOCE Specifications, Section 5.6.3 (Supplement)>*
- b. Billing
 - i. The HCPCS code for the inpatient-only procedure should be reported with the -CA modifier. *<IOCE Specifications, Section 5.6.3 (Supplement)>*

- ii. The patient discharge status code (UB-04, FL 17) must reflect the patient expired or was transferred. <IOCE Specifications, Section 5.6.3 (Supplement)>

- a) The claim will be returned to the provider if modifier -CA is reported without a patient discharge status code of 20, expired, or a designated transfer code¹. <IOCE Specifications, Section 5.6.3 and Section 6.2, Edit 70 (Supplement)>

c. Payment

- i. Payment for an emergency inpatient-only procedure reported with modifier -CA is made under Comprehensive APC 5881 “Ancillary Outpatient Services When Patient Dies” (\$12,241.93). <68 Fed. Reg. 63467; 80 Fed. Reg. 70339; CY2023 OPPS Addendum A>
- ii. Limitations <IOCE Specifications, Section 5.6.3 (Supplement)>
 - a) Payment will only be made for one -CA procedure.
 - b) All other line items billed on the same day as a -CA procedure paid under APC 5881 are packaged, including line items that trigger other Comprehensive APCs (i.e., assigned to status indicator J1). <IOCE Specifications, Section 5.6.3, 5.6.4.2 (Supplement)>

2. Patient is Admitted as an Inpatient within Three Days of the Procedure

- a. If an inpatient-only procedure is furnished on an outpatient basis, and the patient is admitted as an inpatient within three days, the inpatient-only procedure is included on the inpatient claim according to the usual requirements under the three-day payment window. <Medicare Claims Processing Manual, Chapter 4 § 180.7, Medicare Claims Processing Manual Transmittal 3238>

In general, the three-day payment window requires services on the day of admission and diagnostic services and clinically related non-diagnostic services in the three days before admission be included on the inpatient claim.

¹ **2/82:** Discharged/transferred to a Short Term General Hospital for Inpatient Care/with a Planned Acute Care Hospital Inpatient Readmission; **5/85:** to a Designated Cancer Center or Children’s Hospital/with a Planned Acute Care Hospital Inpatient Readmission; **62/90:** to an Inpatient Rehabilitation Facility (IRF), including Rehabilitation Distinct Part Units of a Hospital/with a Planned Acute Care Hospital Inpatient Readmission; **63/91:** to a Medicare Certified Long Term Care Hospital (LTCH)/with a Planned Acute Care Hospital Inpatient Readmission; **65/93:** to a Psychiatric Hospital or Psychiatric Distinct Part of a Hospital/ with a Planned Acute Care Hospital Inpatient Readmission; or **66/94:** to a Critical Access Hospital (CAH)/with a Planned Acute Care Hospital Inpatient Readmission.

b. Emergency Inpatient-Only Procedure and the Patient Survives

- i. When an inpatient-only procedure is furnished on an emergency basis while the patient is still an outpatient and the patient survives the procedure, the patient should be admitted and an inpatient claim submitted including the inpatient-only procedure. <67 Fed. Reg. 66798; Program Memorandum A-02-129; Medicare Claims Processing Manual Transmittal 3238>

3. Separate Procedure Exception

- a. Inpatient-only procedures on the separate procedure list are bypassed when performed incidental to a surgical procedure with Status Indicator T or J1. <IOCE Specifications, Section 5.6.3 and Section 6.2, Edit 45 (Supplement)>
 - i. If an inpatient-only procedure on the separate-procedure list is billed with a status indicator T or J1 procedure, the inpatient-only code is rejected and the claim is processed according to the usual OPPS rules. <IOCE Specifications, Section 5.6.3 and Section 6.2, Edit 45 (Supplement)>
 - ii. The “separate-procedure list” is available in the IOCE Quarterly Data Files, Report-Tables folder, DATA_HCPCS, column AU “SEPARATE_PROCEDURE” available on the OCE homepage. The current list is included in the materials behind the outline.

Link: OCE Specifications under Medicare-Related Sites – Hospital

Case Study 1

Facts: A Medicare patient presents to the emergency department at 1 a.m. during an acute myocardial infarction. A percutaneous transluminal revascularization of a subtotal occlusion of the coronary artery and placement of a non-drug eluting stent is performed (CPT code 92941, OPPS status indicator C).

Following the procedure, based on facility protocols, the cardiologist anticipates discharging the patient late on the following day (i.e., after a one-night stay at the hospital). The cardiologist did not write an inpatient order because she did not expect a two midnight stay for the patient.

Under what APC, if any, will the hospital be paid for the surgical procedure and emergency department care?

Modified Facts: During the procedure, the patient experienced a cardiac arrest and expired. Due to the emergency nature of the patient's condition and urgency of the procedure, the cardiologist never entered an inpatient order to admit the patient.

Under what APC, if any, will the hospital be paid for the surgical procedure and emergency department care? Are there any special coding requirements?

II. Multiple Procedure Reduction for Surgical Services

A. Multiple Procedure Reduction Mechanics

Surgical services subject to a multiple procedure discount are assigned status indicator T "Procedure or Service, Multiple Reduction Applies"

1. If more than one surgical procedure with a status indicator of T is performed during a single surgical encounter:
 - a. Full payment is made for the procedure with the highest payment rate; and
 - b. All other "T" procedures are discounted 50%. <42 C.F.R. 419.44(a); *Medicare Claims Processing Manual*, Chapter 4 § 10.5>
 - c. For purposes of determining the highest paying procedure, any applicable offset and terminated procedure discount (discussed below), if applicable, are applied first. <See *IOCE Specifications*, Section 5.2.1>

B. Multiple “T” Procedures Performed During Separate Encounters on the Same Day

1. The multiple procedure reduction is not applicable if the status indicator T procedures are performed in separate surgical encounters on the same day. <42 C.F.R. 419.44(a); *IOCE Specifications*, Section 5.2.1 (Supplement)>

2. Reporting:

- a. If multiple status indicator T procedures are performed during separate encounters on the same day, one of the following modifiers must be reported so the multiple procedure reduction is not applied by the IOCE:
 - i. -76 – procedure repeated the same day by the same physician
 - ii. -77 – procedure repeated the same day by a different physician
 - iii. -78 – return to the operating room for a related procedure during the postoperative period (presumably the same day)
 - iv. -79 – unrelated procedure or service by the same physician during the postoperative period (presumably the same day) <*IOCE Specifications*, Section 5.2.1 (Supplement)>

Caution: Although modifier -59 may be used to override NCCI edits when services occur in different patient encounters, it does not turn off the multiple procedure reduction when appropriate.

- b. Multiple unrelated procedures or services by different physicians
 - i. Modifier -79 contains the phrase “same physician” and does not address multiple unrelated procedures by *different physicians* in the postoperative period, presumably because this situation does not require a modifier for reporting by physicians. Arguably, the phrase “same physician” would be read as “same facility” in the hospital outpatient reporting context.
 - ii. Reporting modifier -79 for unrelated procedures by different physicians in the postoperative period (i.e., in separate encounters) results in no multiple procedure reduction applying to the procedures, as is appropriate under the policy. <42 C.F.R. 419.44(a); *IOCE Specifications*, Section 5.2.1 (Supplement)>

Case Study 2

Facts: A Medicare patient presented to the hospital outpatient surgery department for drainage of a rectal abscess (45005) and a colon biopsy by colonoscopy (45380). Although the procedures were unrelated, as a convenience to the patient, the physician performed both procedures during the same surgical session. There is no NCCI edit applicable to this code pair. Will Medicare pay separately for both these procedures and if so, how much? What modifier or modifier(s) should the hospital report?

Modified Facts: The physician performed the colonoscopy in the morning and the abscess drainage in a separate surgical encounter in the afternoon. How much will Medicare pay for the two procedures? What modifier or modifier(s) should the hospital report?

III. Terminated/Discontinued Procedures

A. Termination of Procedures When Anesthesia is Planned or Provided

1. The term “anesthesia” includes local anesthesia, regional blocks, conscious sedation, deep sedation and general anesthesia for purposes of reporting terminated procedures. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(A)>
 - a. “Procedural pre-medication” is not considered anesthesia for purposes of reporting terminated procedures. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(A)>
2. Three Possible Scenarios
 - a. Termination prior to the patient being prepped and taken to the procedure room.
 - i. The procedure is not reported at all. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(C)>
 - b. Termination after the patient has been prepped and taken to the procedure room but before anesthesia was provided.
 - i. Under these circumstances, the terminated procedure is reported with modifier -73. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(B)>

- ii. Payment for procedures not assigned to a device intensive APC, reported with modifier -73, is reduced by 50%. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(B), 42 C.F.R. 419.44(b)(2)>
- iii. Payment for device intensive procedures (discussed below), reported with modifier -73, is reduced by the device offset amount for the HCPCS code, and then the result is further reduced by 50%. <See IOCE Specifications, Section 5.7 (Supplement); Medicare Claims Processing Manual, Chapter 4 § 20.6.4(B)>
 - a) The list of device intensive procedures and corresponding device offset amounts are available in the IOCE Quarterly Data Files, Report-Tables folder, “OFFSET_HCPCS” available on the IOCE homepage. The current list is included in the materials behind the outline.

Link: OCE Specifications under Medicare-Related Sites – Hospital

- c. Termination after anesthesia induction or after the procedure has begun (e.g., incision made, intubation started, scope inserted).
 - i. Under these circumstances, the terminated procedure is reported with modifier -74. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(A)>
 - ii. Paid at 100%. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(B), 42 C.F.R. 419.44(b)(1)>

3. Limitations on the Use of Modifiers -73 and -74

- a. Modifiers -73 and -74 are used when a procedure requiring anesthesia was terminated due to extenuating circumstances or circumstances that threaten the well-being of the patient. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(A)>
 - i. Modifier -74 may also be used if a procedure is discontinued, reduced or cancelled at the physician’s discretion after induction of anesthesia. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(A)>
- b. Modifiers -73 and -74 are only to be used with discontinued surgical and diagnostic procedures when anesthesia was planned or provided. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(A)>
 - i. Modifiers -73 and -74 should not be used to indicate discontinued radiology procedures or the discontinuation of other procedures when anesthesia administration was not planned. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(A)>

B. Termination of Procedures When Anesthesia is not Planned

1. Modifier -52 should be reported if the patient is prepared and taken to the room where the procedure was to be performed and the procedure was discontinued. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4 (B)>
 - a. Modifier -52 is also used to report procedures, especially radiology procedures, when the service described by a code is not performed in its entirety and no code exists for the services that were provided. <Medicare Claims Processing Manual, Chapter 4 § 20.6.6>
2. Codes reported with modifier -52 are paid at 50% of the applicable APC. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4 (B), 42 CFR § 419.44(b)(3)>

Case Study 3

Facts: A 67-year-old Medicare patient presented to the hospital outpatient surgery department for surgical repair of an initial reducible inguinal hernia (49505). The procedure was cancelled due to a scheduling conflict after the patient had been prepped and escorted to the pre-op holding area. How should the hernia repair be billed to Medicare? How will Medicare pay for the procedure?

Modified Facts: The hernia repair was instead cancelled due to an unexpected drop in the patient's vital signs after the patient had been taken to the procedure room but before induction of anesthesia. How should the hernia repair be billed to Medicare? How will Medicare pay for the procedure?

Modified Facts: The hernia repair was instead cancelled due to an unexpected drop in the patient's vital signs after the patient had been taken to the procedure room and anesthesia had been induced, but before an incision had been made. How should the hernia repair be billed to Medicare? How will Medicare pay for the procedure?

IV. Bilateral Procedures

A. Bilateral procedures may be reported with:

1. Inherently bilateral HCPCS codes (i.e., a single code representing the procedure performed bilaterally)
 - a. If a procedure, with a code that is inherently bilateral, is performed more than once in a day, the procedure may be reported on separate lines with a modifier -76 or -77 on the second set of procedures. <Medicare Claims Processing Manual Transmittal 1702>
 - b. If a second or subsequent inherently bilateral code is reported without modifier -76 or -77, the line will trigger a line item rejection and the rest of the lines on the claim will process for payment. <IOCE Specifications, Section 6.2, Edit 17>
2. “Conditional bilateral” HCPCS codes (i.e., a code that is inherently unilateral, but can be reported with a modifier to indicate it was performed bilaterally).
 - a. For OPPS purposes, conditional bilateral codes have a “1” in the “bilateral surgery” field in the Medicare Physician Fee Schedule. <IOCE Specifications, Section 5.2.1 (Supplement)>

Link: Physician Fee Schedule – Online Lookup under Medicare-Related Sites – Physician/Practitioner
 - b. Procedures, with a code that is conditionally bilateral, performed bilaterally, should be reported as a single line item with modifier -50 and a unit of “1.” <Medicare Claims Processing Manual, Chapter 4 §§ 20.6, 20.6.2>
 - i. The -RT and -LT modifiers should not be used when the -50 modifier applies. <Medicare Claims Processing Manual, Chapter 4 §§ 20.6, 20.6.2>
 - ii. If a bilateral procedure is billed with a modifier -50 and units greater than 1, IOCE Edit 74 will trigger causing the claim to be returned to the provider. <IOCE Specifications, Section 6.2, Edit 74 (Supplement)>
 - c. Payment for Procedures Reported with the Modifier -50
 - i. Bilateral procedures with a status indicator other than T or J1, reported with modifier -50, are not subject to the multiple procedure discount. The payment rate for the line item representing both procedures is 2.0 times the payment rate for the procedure. <IOCE Specifications, Section 5.2.2 (Supplement)>

- ii. Bilateral procedures with a status indicator T, reported with modifier -50, are subject to the multiple procedure discount.
 - a) If the payment rate for the procedure done bilaterally is the highest payment rate of all status indicator T procedures on the claim, the payment for the line item representing both procedures will be 1.5 times the payment rate for the procedure. <IOCE Specifications, Section 5.2.1.1 (Supplement)>
 - b) If the payment rate for the procedure done bilaterally is lower than another status indicator T procedure on the claim, the payment for the line item representing both procedures will be 1.0 times the payment rate for the procedure. <IOCE Specifications, Section 5.2.1.1 (Supplement)>
- iii. Bilateral procedures with a status indicator J1, reported with modifier -50, will be packaged to any higher ranking J1 procedures, or if paid as the primary (highest ranking) procedure, may be subject to a complexity adjustment as noted in a prior module. <IOCE Specifications, Section 5.6.2 (Supplement)>

V. Device Intensive Procedures

- A. CMS designates certain procedures as device intensive if they involve an implanted device or single use implanted or inserted device and the device costs associated with the procedure are more than 30% of the procedure's mean costs. <83 Fed. Reg. 58944-948>
- B. Device Dependent Procedure Edits
 - 1. If a device intensive procedure (also sometimes referred to by CMS as a device dependent procedure) is reported without a device code, IOCE edit 92 will trigger the claim to be Returned to the Provider (RTP'd). <83 Fed. Reg. 58948; IOCE Specifications, Section 5.7 and Section 6.2, Edit 92 (Supplement)>
 - a. The lists of procedures and devices for application of IOCE edit 92 is available in the IOCE Quarterly Data Files, Report-Tables folder, "DATA_HCPCS", columns BS "DEVICE_PROCEDURE" and BT "DEVICE" available on the IOCE homepage. The list of device intensive procedures is also available in the IOCE Quarterly Data Files, Report-Tables folder, "OFFSET_HCPCS" available on the IOCE homepage. The current list is included in the materials behind the outline.

Link: OCE Specifications under Medicare-Related Sites – Hospital

- b. Device code C1889 (Implantable/insertable device for device intensive procedure, not otherwise classified) may be used if the device inserted in a device dependent procedure is not described by a specific HCPCS code. <81 Fed. Reg. 79659>
- c. Exceptions to the Device Dependent Procedure Edits
 - i. Terminated and discontinued procedures coded with modifiers -52, -73 or -74 reported without a device will not trigger edit 92 and the claim will not return to the provider. <IOCE Specifications, Section 5.7>
 - ii. Specified procedures where no device was used (e.g., a revision) will not trigger edit 92 when reported with modifier -CG (Policy Criteria Applied). <Medicare Claims Processing Manual, Chapter 4 § 61.2.1; IOCE Specifications, Section 5.7>
 - a) The list of procedures that bypass edit 92 when reported with modifier -CG is available in the IOCE Quarterly Data Files, Report-Tables folder, "DATA_HCPCS", column DC "BYPASS_E92_MODIFIER" available on the IOCE homepage. The current list is included in the materials behind the outline.

VI. Billing and Payment for Implantable Devices

A. Pass-Through Devices

- 1. Separate pass-through payment is made for certain new devices that are "implantable". <42 C.F.R. 419.66(b)(3)>
- 2. Once assigned pass-through status, the device remains a pass-through for at least 2 years, but no more than 3 years. <Medicare Claims Processing Manual, Chapter 17 § 90.2 C>
 - a. Pass-through status expires on a quarterly basis, as close to three full years as possible, when the costs of the device are packaged into the procedures with which they are reported. <87 Fed. Reg. 71886>

The Consolidated Appropriations Act of 2023, Section 4141 extended pass-through status for 1-year for devices with a pass-through status expiring on December 31, 2022. Table 52 of the 2023 OPFS Final Rule, included in the materials behind the outline, lists the six devices with pass-through status expiring December 31, 2022. At the time of publishing, CMS has not issued additional instructions on this provision. The six procedure code pairs and offsets from the October IOCE are also included in the materials behind the outline for reference.

3. Billing and Payment for Pass-Through Devices

- a. The OPPS status indicator for pass through devices is H.
- b. Implantable pass-through devices must be reported with designated HCPCS codes. <Medicare Claims Processing Manual, Chapter 4 § 60.1>
 - i. A list of pass-through devices, associated procedure codes, and associated offset amounts is available in the IOCE Quarterly Data Files, Report-Tables folder, “OFFSET_CODEPAIR” available on the IOCE homepage. The current list is included in the materials behind the outline.

Link: OCE Specifications under Medicare-Related Sites – Hospital

- ii. If a pass-through device code is reported without its associated procedure code, edit 98 of the IOCE will cause the claim to be returned to the provider. <IOCE Specifications, Section 5.7.2 and Section 6.2, Edit 98 (Supplement)>
- c. Payment for pass-through devices is made based on the hospital’s costs determined by applying the hospital’s “Implantable Devices Charged to Patients” cost to charge ratio (CCR) less a device offset representing the amount already included in the associated APC for previously packaged devices. <Medicare Claims Processing Manual, Chapter 4 § 50.4, 81 Fed. Reg. 79656>
 - i. The device offset amount for purposes of calculating pass-through device payment is different for each procedure code billed with the pass-through device. The offset amount is published in the IOCE Quarterly Data Files, Report-Tables folder, “OFFSET_CODEPAIR” available on the IOCE homepage. The current list is included in the materials behind the outline.
 - ii. If the hospital’s “Implantable Devices Charged to Patients” CCR is not available, the hospital wide outpatient CCR is used to calculate pass-through device payment. <81 Fed. Reg. 79656>

Percutaneous vertebral augmentation of 1 thoracic vertebral body (22513) using intravertebral body fracture augmentation with polymer implant (C1062)				
Item HCPCS	Total Charge	Procedure Payment Amount	Payment with Implantable Device CCR .45	Payment with Overall CCR .30
22513	\$14,000	\$6,615	N/A	N/A
C1062	\$5700	N/A	\$2,565	\$1,710
Offset applicable for 22513			-\$1,320	-\$1,320
Pass-through payment			\$1,245	\$ 390
Procedure Payment			+\$6,615	+\$6,615
Total Payment			\$7,860	\$7,005

- d. If the pass-through device is purchased as part of a kit with other non-pass-through supplies, the pass-through device should be billed on a separate line with the appropriate HCPCS code to ensure no pass-through payment is received for the non-pass-through supplies. <Medicare Claims Processing Manual, Chapter 4 § 60.4>

B. Brachytherapy Seeds and Sources

1. Brachytherapy seeds and sources are paid separately as provided by statute. <Medicare Claims Processing Manual Transmittal 1326>
2. Brachytherapy seeds and sources have an OPPS status indicator of U.
3. Brachytherapy seeds and sources are paid separately based on a PPS median cost rate established from hospital claims data. <74 Fed. Reg. 60537>
4. Unused Brachytherapy Sources

- a. Medicare allows for the billing of unused brachytherapy sources. <Medicare Claims Processing Manual, Chapter 4 § 61.4.3>

Unused brachytherapy sources may be billed to Medicare if:

- They are specifically acquired for the particular patient according to the physician's order
- The number prescribed is consistent with standard clinical practice to ensure a clinically appropriate number of sources is available for implantation
- They are not implanted in another patient
- They are disposed of according to their handling guidelines
- The number not implanted generally represents a small fraction of the sources implanted

5. Supervision, Handling and Loading of Brachytherapy Sources

- a. Hospital should bill the supervision, handling and loading of brachytherapy sources in one of two methods. <Medicare Claims Processing Manual, Chapter 4 § 61.4.4>
- i. Report the charge on a separate line using the packaged CPT code 77790; or
 - ii. In the charge on the line reporting the application of the sources.

C. Packaged Devices

1. Covered devices that have a HCPCS code with an OPPS status indicator of N or covered devices that do not have a specific HCPCS code are packaged.
2. Billing and Payment for Packaged Devices
 - a. As with all packaged items/services under OPPS, no separate payment is made for packaged devices, however, charges should be billed for packaged devices so that their costs can be accumulated for purposes of calculating outlier payments, future rate setting, etc. <Medicare Claims Processing Manual, Chapter 4 § 10.4(A)>
 - b. HCPCS Codes
 - i. Hospitals must report a HCPCS code for all devices furnished, including packaged devices, subject to edits discussed above. <Medicare Claims Processing Manual, Chapter 4 § 61.1>

VII. No Cost/Full Credit and Partial Credit Devices

- A. The payment for certain procedures is discounted if the hospital receives a device implanted during the procedure at a discount of 50% or more of the cost of the device. <80 *Fed. Reg.* 70423-424, 72 *Fed. Reg.* 47250-251>
 1. For outpatient surgeries, the policy applies to device intensive procedures. <82 *Fed. Reg.* 59336>
 - a. The list of device intensive procedures is available in the IOCE Quarterly Data Files, Report-Tables folder, “OFFSET_HCPCS” available on the IOCE homepage. The current list is included in the materials behind the outline.
 2. For inpatient surgeries, the policy applies to a list of designated MS-DRGs, published in the IPPS Final Rule. The current list is available in the rule or downloaded from the FY2023 IPPS Final Rule Home Page, MAC Implementation File 7 and is included in the materials behind the outline. The applicable MS-DRGs are also noted on Table 5 included in the Supplement to these materials. <86 *Fed. Reg.* 44958-961; *Medicare Claims Processing Manual*, Transmittal 10360>

Link: IPPS – FY2023 IPPS Final Rule Home Page under Medicare-Related Sites – Hospital

B. Billing Procedures for No Cost/Full Credit and Partial Credit Devices

1. Value Code FD
 - a. If a provider receives a credit of 50% or greater of the cost of a device implanted in a procedure subject the policy, the provider must report the amount of the credit with value code FD. <80 *Fed. Reg.* 70423-424; *Medicare Claims Processing Manual*, Chapter 3 § 100.8; *Medicare One Time Notification Transmittal 1494*>
 - b. If a provider reports Value Code FD with an amount greater than zero; a charge reported in revenue codes 0275, 0276 or 0278; and Value Code 17 returned with an outlier amount greater than zero the claim will suspend for MAC review. <*Medicare One Time Notification Transmittal 11488*>
 - i. The MAC will review the claim to verify no charges are reported for devices that received full credit or was a no cost device and bypass the edit for verified charges or return the claim to the provider for correction is the charges are not reported correctly. <*Medicare One Time Notification Transmittal 11488*>

2. Condition Codes

- a. Condition code 49 is used if a credit is received because a device was replaced due to a malfunction prior to the anticipated lifecycle of the product. <Medicare Claims Processing Manual, Chapter 3 § 100.8; Medicare Claims Processing Manual, Chapter 4 § 61.3.5>
- b. Condition code 50 is used if a credit is received due to a FDA or manufacturer's recall of the product. <Medicare Claims Processing Manual, Chapter 3 § 100.8, Medicare Claims Processing Manual, Chapter 4 § 61.3.5>
- c. Condition code 53 is used if the device was received for initial placement as part of a clinical trial or as a free sample. <Medicare Claims Processing Manual, Chapter 4 § 61.3.5; Medicare Claims Processing Manual, Chapter 32 § 67.2.1>

3. Charges for free devices

- a. Devices received for free should be reported with a \$0 charge, or if the hospital's system requires a charge for each line item, the hospital may report the item with a token charge (e.g. \$1.00). <Medicare Claims Processing Manual, Chapter 4 § 61.3.5>

C. Payment for Procedures Implanting Devices Received at Reduced Cost

1. For outpatient procedures, the lesser of the amount of the credit reported with value code FD or the offset amount for the HCPCS procedure code is deducted from the payment for the procedure. <Medicare Claims Processing Manual, Chapter 4 § 61.3.6>
 - a. The device offset amount for each device intensive procedure is available in the IOCE Quarterly Data Files, Report-Tables folder, "OFFSET_HCPCS" available on the IOCE homepage.
2. For inpatient procedures, the amount of the credit reported with value code FD is subtracted from the otherwise applicable MS-DRG payment amount. <Medicare Claims Processing Manual, Chapter 3 § 100.8>

D. Options for Billing Cases Subject to the Reduction

1. Hospital may submit a claim for the service without the applicable condition code and submit an adjustment claim with the correct condition code, once a credit has been determined. This process is presumably used in cases where the credit is not determined by the manufacturer until the device is submitted to them for testing, or

2. Hold the claim until a determination is made on the amount of the credit. <72
Fed. Reg. 47250>

Version 01/09/2023
Check for Updates

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: A Medicare patient presents to the emergency department at 1 a.m. during an acute myocardial infarction. A percutaneous transluminal revascularization of a subtotal occlusion of the coronary artery and placement of a non-drug eluting stent is performed (CPT code 92941, OPPS status indicator C).

Following the procedure, based on facility protocols, the cardiologist anticipates discharging the patient late on the following day (i.e., after a one-night stay at the hospital). The cardiologist did not write an inpatient order because she did not expect a two midnight stay for the patient.

Under what APC, if any, will the hospital be paid for the surgical procedure and emergency department care?

Analysis: The hospital will not be paid for the procedure or the emergency department care because the procedure is designated an inpatient-only procedure and the patient was not admitted prior to their discharge from the hospital. <OPPS Addendum B; IOCE Specifications, Section 5.6.3>

Modified Facts: During the procedure, the patient experienced a cardiac arrest and expired. Due to the emergency nature of the patient's condition and urgency of the procedure, the cardiologist never entered an inpatient order to admit the patient.

Under what APC, if any, will the hospital be paid for the surgical procedure and emergency department care? Are there any special coding requirements?

Analysis: The hospital will be paid C-APC 5881 for Ancillary Outpatient Services When Patient Dies (\$12,241.93) for all services during the encounter, including the procedure and emergency department care. The hospital must report modifier -CA on the procedure code 92941 and patient status code 20. <OPPS Addendum B; IOCE Specifications, Section 5.6.3>

Case Study 2

Facts: A Medicare patient presented to the hospital outpatient surgery department for drainage of a rectal abscess (45005) and a colon biopsy by colonoscopy (45380). Although the procedures were unrelated, as a convenience to the patient, the physician performed both procedures during the same surgical session. There is no NCCI edit applicable to this code pair. Will Medicare pay separately for both these procedures and if so, how much? What modifier or modifier(s) should the hospital report?

Analysis: CPT code 45005 has status indicator T and payment rate \$1,082.91. CPT code 45380 has status indicator T and payment rate \$1,082.91. No modifier is necessary because there are no NCCI edits applicable to this pair of codes. The procedures are subject to a multiple procedure reduction, i.e., they have status indicator T. Payment will be 100% for one procedure (\$1,082.91) and 50% for the other procedure (\$541.46) for a total of \$1,624.37. <42 C.F.R. 419.44(a)>

Modified Facts: The physician performed the colonoscopy in the morning and the abscess drainage in a separate surgical encounter in the afternoon. How much will Medicare pay for the two procedures? What modifier or modifier(s) should the hospital report?

Analysis: Modifier -79 should be reported on the abscess drainage to indicate it was performed in a separate surgical encounter. Payment will be 100% for both procedures for a total of \$2,165.82. <42 C.F.R. 419.44(a)>

Case Study 3

Facts: A 67-year-old Medicare patient presented to the hospital outpatient surgery department for surgical repair of an initial reducible inguinal hernia (49505). The procedure was cancelled due to a scheduling conflict after the patient had been prepped and escorted to the pre-op holding area. How should the hernia repair be billed to Medicare? How will Medicare pay for the procedure?

Analysis: The hernia repair should not be billed to Medicare because the procedure was cancelled for a reason unrelated to the patient's condition. Medicare will not pay for the procedure. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(A)>

Modified Facts: The hernia repair was instead cancelled due to an unexpected drop in the patient's vital signs after the patient had been taken to the procedure room but before induction of anesthesia. How should the hernia repair be billed to Medicare? How will Medicare pay for the procedure?

Analysis: The hernia repair should be billed to Medicare with modifier -73. Medicare will discount payment for the procedure by 50%. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(A)>

Modified Facts: The hernia repair was instead cancelled due to an unexpected drop in the patient's vital signs after the patient had been taken to the procedure room and anesthesia had been induced, but before an incision had been made. How should the hernia repair be billed to Medicare? How will Medicare pay for the procedure?

Analysis: The hernia repair should be billed to Medicare with modifier -74. Medicare will pay 100% for the procedure. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(A)>

Inpatient-Only Separate Procedure Exception List (Data_HCPCS, Column AU "SEPARATE PROCEDURE")

HCPCS	LO_VERSION	HI_VERSION	DESCRIPTION	STATUS_INDICATOR
21750	86	90	Repair of sternum separation	C
21825	86	90	Treat sternum fracture	C
22010	86	90	I&d p-spine c/t/cerv-thor	C
22015	86	90	I&d abscess p-spine l/s/l	C
22110	86	90	Remove part of neck vertebra	C
22112	86	90	Remove part thorax vertebra	C
22114	86	90	Remove part lumbar vertebra	C
22116	86	90	Remove extra spine segment	C
22206	86	90	Incis spine 3 column thorac	C
22207	86	90	Incis spine 3 column lumbar	C
22208	86	90	Incis spine 3 column adl seg	C
22210	86	90	Incis 1 vertebral seg cerv	C
27005	86	90	Incision of hip tendon	C
27090	86	90	Removal of hip prosthesis	C
27140	86	90	Transplant femur ridge	C
27161	86	90	Incision of neck of femur	C
31725	63	90	Clearance of airways	C
32220	63	90	Release of lung	C
32225	63	90	Partial release of lung	C
32310	63	90	Removal of chest lining	C
33140	63	90	Heart revascularize (tmr)	C
33496	63	90	Repair prosth valve clot	C
33800	89	90	Aortic suspension	C
38100	63	90	Removal of spleen total	C
38101	63	90	Removal of spleen partial	C
38562	86	90	Removal pelvic lymph nodes	C
38564	63	90	Removal abdomen lymph nodes	C
38765	63	90	Remove groin lymph nodes	C
38770	63	90	Remove pelvis lymph nodes	C
38780	63	90	Remove abdomen lymph nodes	C
43848	63	90	Revision gastroplasty	C
44005	63	90	Freeing of bowel adhesion	C
44130	63	90	Bowel to bowel fusion	C
44300	86	90	Open bowel to skin	C
44314	86	90	Revision of ileostomy	C
44316	63	90	Devise bowel pouch	C
44322	63	90	Colostomy with biopsies	C
44345	86	90	Revision of colostomy	C
44346	86	90	Revision of colostomy	C
44680	63	90	Surgical revision intestine	C
44820	63	90	Excision of mesentery lesion	C
44850	63	90	Repair of mesentery	C
47460	63	90	Incise bile duct sphincter	C
47480	63	90	Incision of gallbladder	C
47900	63	90	Suture bile duct injury	C
49000	63	90	Exploration of abdomen	C

Inpatient-Only Separate Procedure Exception List (Data_HCPCS, Column AU "SEPARATE PROCEDURE")

49010	86	90	Exploration behind abdomen	C
49255	86	90	Removal of omentum	C
50100	90	90	Trnsxj/repos abrrnt rnl vsls	C
50340	63	90	Removal of kidney	C
50600	63	90	Exploration of ureter	C
50650	63	90	Removal of ureter	C
50900	63	90	Repair of ureter	C
51525	63	90	Removal of bladder lesion	C
51570	63	90	Removal of bladder	C
57270	63	90	Repair of bowel pouch	C
58400	63	90	Suspension of uterus	C
58605	63	90	Division of fallopian tube	C
58700	63	90	Removal of fallopian tube	C
58720	63	90	Removal of ovary/tube(s)	C
60521	63	90	Removal of thymus gland	C
60522	63	90	Removal of thymus gland	C
60540	63	90	Explore adrenal gland	C
60545	63	90	Explore adrenal gland	C
61210	63	90	Pierce skull implant device	C
61535	63	90	Remove brain electrodes	C

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Check for Updates

HCPCS	LO_VERSION	HI_VERSION	OFFSET AMOUNT
0200T	90	90	\$2,191.43
0221T	90	90	\$5,259.29
0234T	90	90	\$3,705.80
0236T	90	90	\$3,825.76
0237T	90	90	\$4,754.60
0238T	90	90	\$8,339.72
0253T	90	90	\$1,965.43
0268T	90	90	\$26,663.37
0275T	90	90	\$3,753.80
0308T	90	90	\$7,046.05
0335T	90	90	\$3,126.07
0404T	90	90	\$2,146.92
0408T	90	90	\$26,610.52
0409T	90	90	\$20,616.35
0410T	90	90	\$2,530.46
0414T	90	90	\$14,592.32
0421T	90	90	\$3,019.10
0424T	90	90	\$46,629.42
0425T	90	90	\$7,505.03
0426T	90	90	\$5,831.67
0427T	90	90	\$21,452.24
0431T	90	90	\$21,666.56
0442T	90	90	\$3,667.03
0449T	90	90	\$2,143.63
0505T	90	90	\$5,229.10
0511T	90	90	\$3,241.83
0515T	90	90	\$10,384.62
0516T	90	90	\$2,530.46
0517T	90	90	\$6,065.75
0519T	90	90	\$1,382.93
0520T	90	90	\$7,073.68
0524T	90	90	\$1,160.31
0525T	90	90	\$8,246.49
0526T	90	90	\$2,530.46
0527T	90	90	\$6,270.64
0571T	90	90	\$24,503.11
0572T	90	90	\$4,090.36
0583T	90	90	\$430.32
0587T	90	90	\$4,495.24
0594T	90	90	\$2,050.54
0600T	90	90	\$6,085.76
0601T	90	90	\$2,817.06
0614T	90	90	\$17,809.70
0616T	90	90	\$12,947.00
0617T	90	90	\$14,072.20
0618T	90	90	\$11,910.44
0619T	90	90	\$1,457.68
0620T	90	90	\$12,123.95
0627T	90	90	\$6,281.35
0629T	90	90	\$6,281.35
0644T	90	90	\$2,836.66
0647T	90	90	\$539.89
0651T	90	90	\$255.91
0652T	90	90	\$255.91
0653T	90	90	\$255.91
0671T	90	90	\$1,177.97
0707T	90	90	\$922.76
0744T	90	90	\$1,593.33
0775T	90	90	\$7,648.84

HCPCS	LO_VERSION	HI_VERSION	OFFSET AMOUNT
10035	90	90	\$217.02
11970	90	90	\$1,991.00
19281	90	90	\$807.96
19283	90	90	\$319.55
19285	90	90	\$356.93
19287	90	90	\$202.61
19296	90	90	\$3,640.29
20690	90	90	\$2,485.12
20692	90	90	\$5,764.64
20696	90	90	\$11,647.35
20900	90	90	\$2,500.99
20983	90	90	\$2,389.87
21122	90	90	\$1,913.74
21150	90	90	\$1,802.14
21195	90	90	\$2,697.60
21243	90	90	\$11,397.72
21244	90	90	\$2,118.78
21245	90	90	\$2,426.88
21256	90	90	\$2,479.74
21267	90	90	\$4,210.86
21346	90	90	\$2,385.23
21347	90	90	\$1,743.94
21365	90	90	\$1,820.83
21422	90	90	\$1,609.91
21450	90	90	\$202.01
21452	90	90	\$1,736.46
21453	90	90	\$1,628.07
21461	90	90	\$1,991.16
21462	90	90	\$1,916.41
21470	90	90	\$2,011.45
21742	90	90	\$1,993.77
21812	90	90	\$5,834.10
21813	90	90	\$757.43
22551	90	90	\$5,932.96
22554	90	90	\$5,598.93
22612	90	90	\$11,745.89
22630	90	90	\$13,070.70
22633	90	90	\$13,245.88
22856	90	90	\$11,461.22
22867	90	90	\$13,499.89
22869	90	90	\$9,821.29
22899	90	90	\$72.31
23395	90	90	\$2,292.63
23470	90	90	\$6,766.73
23472	90	90	\$7,877.13
23473	90	90	\$6,496.64
23485	90	90	\$5,514.12
23491	90	90	\$4,505.50
23515	90	90	\$2,539.36
23552	90	90	\$2,487.10
23585	90	90	\$2,499.01
23615	90	90	\$5,655.04
23616	90	90	\$11,476.55
23630	90	90	\$2,173.57
23680	90	90	\$4,870.85
24126	90	90	\$3,305.99
24340	90	90	\$2,282.05
24344	90	90	\$2,230.45
24360	90	90	\$3,473.34

HCPCS	LO_VERSION	HI_VERSION	OFFSET AMOUNT
24361	90	90	\$11,450.27
24362	90	90	\$8,155.05
24363	90	90	\$13,101.35
24365	90	90	\$7,158.18
24366	90	90	\$7,224.72
24370	90	90	\$5,531.08
24371	90	90	\$11,572.90
24400	90	90	\$2,035.32
24420	90	90	\$2,733.17
24430	90	90	\$5,289.69
24435	90	90	\$5,687.66
24498	90	90	\$4,471.58
24515	90	90	\$4,891.73
24516	90	90	\$5,167.04
24545	90	90	\$5,863.81
24546	90	90	\$5,909.48
24575	90	90	\$5,452.79
24579	90	90	\$4,552.48
24586	90	90	\$5,373.20
24587	90	90	\$6,257.86
24615	90	90	\$2,202.67
24635	90	90	\$2,682.89
24666	90	90	\$7,305.62
24685	90	90	\$2,164.31
25126	90	90	\$1,121.31
25332	90	90	\$964.74
25350	90	90	\$2,859.50
25390	90	90	\$2,397.80
25391	90	90	\$6,319.19
25400	90	90	\$2,715.31
25405	90	90	\$2,659.08
25415	90	90	\$2,262.20
25420	90	90	\$2,397.14
25426	90	90	\$1,101.66
25441	90	90	\$8,051.97
25442	90	90	\$13,394.78
25443	90	90	\$3,475.99
25444	90	90	\$8,289.45
25445	90	90	\$3,530.23
25446	90	90	\$14,629.81
25515	90	90	\$2,402.43
25526	90	90	\$2,275.43
25545	90	90	\$2,136.53
25574	90	90	\$2,573.75
25575	90	90	\$2,458.00
25607	90	90	\$2,824.45
25608	90	90	\$2,842.97
25609	90	90	\$2,866.12
25652	90	90	\$2,245.01
25800	90	90	\$2,899.85
25805	90	90	\$2,538.69
25810	90	90	\$5,340.58
25820	90	90	\$2,842.97
25825	90	90	\$2,289.98
26530	90	90	\$2,448.07
26531	90	90	\$3,071.83
26536	90	90	\$2,575.08
26541	90	90	\$895.68
26568	90	90	\$3,409.84

HCPCS	LO_VERSION	HI_VERSION	OFFSET AMOUNT
26820	90	90	\$2,406.40
26843	90	90	\$2,126.60
26844	90	90	\$2,457.34
27110	90	90	\$2,350.84
27130	90	90	\$6,591.89
27279	90	90	\$15,302.06
27357	90	90	\$2,751.02
27381	90	90	\$2,395.16
27396	90	90	\$1,989.68
27403	90	90	\$3,200.82
27412	90	90	\$4,777.09
27415	90	90	\$7,301.71
27427	90	90	\$2,524.14
27428	90	90	\$5,186.61
27429	90	90	\$5,198.36
27430	90	90	\$2,465.27
27438	90	90	\$4,600.75
27440	90	90	\$5,837.71
27442	90	90	\$5,750.29
27443	90	90	\$6,672.79
27446	90	90	\$5,925.13
27447	90	90	\$6,139.12
27477	90	90	\$3,043.39
27509	90	90	\$3,177.67
27637	90	90	\$2,757.64
27647	90	90	\$1,152.56
27652	90	90	\$2,429.55
27654	90	90	\$2,286.02
27656	90	90	\$1,148.10
27695	90	90	\$2,131.90
27696	90	90	\$2,358.12
27698	90	90	\$2,369.36
27700	90	90	\$3,488.56
27702	90	90	\$14,581.63
27705	90	90	\$2,233.10
27709	90	90	\$5,968.19
27720	90	90	\$2,655.77
27722	90	90	\$2,073.03
27726	90	90	\$2,594.92
27745	90	90	\$2,553.91
27756	90	90	\$2,612.78
27758	90	90	\$5,690.27
27759	90	90	\$4,848.67
27792	90	90	\$2,401.11
27814	90	90	\$2,386.56
27822	90	90	\$2,375.98
27823	90	90	\$2,367.38
27826	90	90	\$2,042.60
27827	90	90	\$5,016.99
27828	90	90	\$5,433.22
27829	90	90	\$2,489.09
27832	90	90	\$4,157.29
27870	90	90	\$6,680.62
27871	90	90	\$5,537.61
28102	90	90	\$3,159.81
28103	90	90	\$2,545.31
28202	90	90	\$1,989.02
28210	90	90	\$2,344.22
28261	90	90	\$893.71

HCPCS	LO_VERSION	HI_VERSION	OFFSET AMOUNT
28262	90	90	\$2,211.93
28291	90	90	\$2,951.45
28297	90	90	\$3,423.07
28298	90	90	\$2,190.77
28299	90	90	\$2,221.85
28300	90	90	\$2,381.93
28302	90	90	\$2,685.54
28305	90	90	\$2,031.35
28309	90	90	\$2,062.44
28310	90	90	\$1,989.02
28320	90	90	\$5,529.78
28322	90	90	\$2,546.63
28415	90	90	\$2,502.98
28420	90	90	\$5,734.63
28436	90	90	\$2,112.71
28445	90	90	\$2,387.22
28446	90	90	\$2,827.75
28485	90	90	\$2,338.27
28555	90	90	\$2,061.12
28585	90	90	\$2,602.86
28615	90	90	\$2,525.47
28705	90	90	\$11,036.41
28715	90	90	\$7,124.25
28725	90	90	\$6,200.45
28730	90	90	\$7,055.10
28735	90	90	\$7,155.57
28737	90	90	\$6,748.47
28740	90	90	\$3,273.58
28750	90	90	\$3,059.27
29855	90	90	\$3,293.42
29856	90	90	\$6,204.36
29867	90	90	\$5,473.67
29885	90	90	\$3,571.24
29888	90	90	\$2,420.95
29889	90	90	\$5,116.15
29899	90	90	\$2,624.69
29907	90	90	\$5,862.50
30468	90	90	\$2,013.06
30469	90	90	\$1,655.30
31636	90	90	\$2,696.33
31647	90	90	\$3,579.23
31660	90	90	\$3,066.94
31661	90	90	\$2,948.76
32994	90	90	\$2,077.04
33206	90	90	\$5,850.22
33207	90	90	\$5,916.32
33208	90	90	\$6,331.54
33212	90	90	\$4,901.74
33213	90	90	\$6,291.25
33214	90	90	\$6,125.99
33216	90	90	\$3,006.35
33217	90	90	\$3,889.56
33220	90	90	\$1,156.74
33221	90	90	\$11,231.21
33224	90	90	\$5,595.09
33226	90	90	\$920.20
33227	90	90	\$4,706.65
33228	90	90	\$6,113.60
33229	90	90	\$11,815.65

HCPCS	LO_VERSION	HI_VERSION	OFFSET AMOUNT
33230	90	90	\$16,739.52
33231	90	90	\$23,810.26
33233	90	90	\$3,455.30
33234	90	90	\$1,308.54
33235	90	90	\$1,131.94
33240	90	90	\$17,319.10
33249	90	90	\$23,287.42
33262	90	90	\$16,235.23
33263	90	90	\$16,187.32
33264	90	90	\$23,736.48
33270	90	90	\$23,665.92
33271	90	90	\$5,341.72
33274	90	90	\$11,419.67
33275	90	90	\$2,077.83
33285	90	90	\$5,916.38
33289	90	90	\$21,502.82
33900	90	90	\$3,290.75
33901	90	90	\$3,290.75
33902	90	90	\$5,325.06
33903	90	90	\$3,290.75
33999	90	90	\$334.55
34421	90	90	\$1,184.74
35881	90	90	\$2,125.80
36253	90	90	\$1,716.17
36254	90	90	\$916.93
36583	90	90	\$1,629.82
36835	90	90	\$1,472.50
36836	90	90	\$6,924.29
36837	90	90	\$8,832.72
36903	90	90	\$5,548.62
36904	90	90	\$1,611.56
36906	90	90	\$8,523.53
37183	90	90	\$1,887.97
37184	90	90	\$4,741.86
37187	90	90	\$5,385.15
37191	90	90	\$2,051.28
37192	90	90	\$957.74
37211	90	90	\$1,647.29
37221	90	90	\$4,216.40
37224	90	90	\$1,983.94
37225	90	90	\$5,845.85
37226	90	90	\$5,206.81
37227	90	90	\$9,387.56
37228	90	90	\$3,394.78
37229	90	90	\$8,112.98
37230	90	90	\$7,650.90
37231	90	90	\$7,750.53
37236	90	90	\$4,011.53
37238	90	90	\$4,374.57
37241	90	90	\$3,841.68
37242	90	90	\$4,288.59
41512	90	90	\$1,727.38
42900	90	90	\$1,103.57
43210	90	90	\$2,897.94
43212	90	90	\$2,915.41
43229	90	90	\$1,818.49
43240	90	90	\$3,267.06
43266	90	90	\$2,976.20
43284	90	90	\$4,415.52

HCPCS	LO_VERSION	HI_VERSION	OFFSET AMOUNT
43497	90	90	\$1,010.81
43647	90	90	\$7,807.43
43770	90	90	\$4,183.79
44370	90	90	\$3,343.06
44390	90	90	\$360.26
44402	90	90	\$1,817.48
44405	90	90	\$461.10
45327	90	90	\$3,456.25
45347	90	90	\$3,467.26
45389	90	90	\$3,380.26
46707	90	90	\$1,011.86
47383	90	90	\$2,546.66
47538	90	90	\$2,281.36
47539	90	90	\$1,762.75
47540	90	90	\$2,208.39
47553	90	90	\$1,129.52
47556	90	90	\$2,224.02
50570	90	90	\$1,049.68
50593	90	90	\$4,153.80
51715	90	90	\$1,209.29
51992	90	90	\$1,933.71
52327	90	90	\$2,225.54
53440	90	90	\$7,660.68
53444	90	90	\$10,766.91
53445	90	90	\$13,969.60
53447	90	90	\$13,331.37
53451	90	90	\$9,018.65
53452	90	90	\$6,368.51
54400	90	90	\$8,212.77
54401	90	90	\$13,817.27
54405	90	90	\$13,636.03
54410	90	90	\$12,889.82
54411	90	90	\$11,794.62
54416	90	90	\$12,689.29
54417	90	90	\$7,101.37
54660	90	90	\$1,854.54
55873	90	90	\$4,136.71
55874	90	90	\$2,364.73
55876	90	90	\$427.94
57288	90	90	\$1,460.99
58565	90	90	\$2,651.75
59072	90	90	\$118.65
61626	90	90	\$3,930.85
61885	90	90	\$18,677.48
61886	90	90	\$24,825.53
61888	90	90	\$6,267.94
62350	90	90	\$2,184.77
62360	90	90	\$12,151.65
62361	90	90	\$12,327.81
62362	90	90	\$12,495.50
63075	90	90	\$2,454.03
63610	90	90	\$877.37
63650	90	90	\$3,114.38
63655	90	90	\$14,383.02
63663	90	90	\$3,451.83
63664	90	90	\$5,774.30
63685	90	90	\$24,024.04
63741	90	90	\$2,750.12
63744	90	90	\$1,981.49

HCPCS	LO_VERSION	HI_VERSION	OFFSET AMOUNT
64448	90	90	\$359.62
64553	90	90	\$6,627.71
64555	90	90	\$4,676.19
64561	90	90	\$3,181.73
64568	90	90	\$24,094.50
64569	90	90	\$8,492.32
64575	90	90	\$8,503.07
64580	90	90	\$14,529.32
64581	90	90	\$4,223.82
64582	90	90	\$25,163.15
64583	90	90	\$3,705.30
64590	90	90	\$17,618.93
64628	90	90	\$7,443.93
64716	90	90	\$971.56
64802	90	90	\$542.13
64858	90	90	\$1,432.98
64865	90	90	\$2,715.52
64886	90	90	\$2,091.47
64891	90	90	\$3,968.55
64892	90	90	\$2,874.31
64893	90	90	\$2,747.03
64897	90	90	\$2,394.23
64910	90	90	\$2,873.07
64912	90	90	\$3,255.53
65770	90	90	\$3,615.27
65779	90	90	\$1,113.32
65781	90	90	\$1,971.82
66175	90	90	\$1,549.49
66179	90	90	\$1,283.78
66180	90	90	\$1,384.07
66183	90	90	\$2,079.70
66989	86	90	\$2,318.65
66991	86	90	\$2,318.65
69705	90	90	\$2,268.29
69706	90	90	\$2,246.93
69714	90	90	\$7,978.90
69716	90	90	\$4,044.90
69717	90	90	\$3,834.50
69719	90	90	\$4,044.90
69729	90	90	\$4,044.90
69730	90	90	\$4,044.90
69930	90	90	\$26,636.29
75741	90	90	\$1,053.36
75831	90	90	\$912.76
75870	90	90	\$940.16
75898	90	90	\$1,860.37
92920	90	90	\$1,609.99
92924	90	90	\$5,485.99
92928	90	90	\$3,703.68
92933	90	90	\$8,831.00
92937	90	90	\$3,509.42
92943	90	90	\$4,536.98
92986	90	90	\$1,709.61
92987	90	90	\$3,658.04
93580	90	90	\$11,675.61
93581	90	90	\$9,777.49
93582	90	90	\$11,100.17
93590	90	90	\$7,252.38
93591	90	90	\$6,317.92

HCPCS	LO_VERSION	HI_VERSION	OFFSET AMOUNT
93600	90	90	\$2,758.41
93602	90	90	\$2,122.84
93603	90	90	\$474.64
93619	90	90	\$2,176.02
93650	90	90	\$3,247.88
93653	90	90	\$9,218.75
93654	90	90	\$10,780.26
93656	90	90	\$11,144.22
95938	90	90	\$166.40
95961	90	90	\$339.55
C9600	90	90	\$3,969.06
C9602	90	90	\$9,562.77
C9604	90	90	\$4,097.51
C9607	90	90	\$8,853.34
C9728	90	90	\$512.81
C9739	90	90	\$2,968.02
C9740	90	90	\$6,273.53
C9764	90	90	\$5,611.25
C9765	90	90	\$9,026.83
C9766	90	90	\$9,938.96
C9767	90	90	\$10,048.90
C9769	90	90	\$6,164.84
C9771	90	90	\$1,992.76
C9772	90	90	\$4,581.57
C9773	90	90	\$8,193.72
C9774	90	90	\$9,293.08
C9775	90	90	\$9,143.64
C9777	90	90	\$1,010.81
C9778	90	90	\$1,436.88
C9780	85	90	\$2,557.66
C9781	90	90	\$4,044.90
C9782	90	90	\$5,425.16
C9783	90	90	\$3,290.75

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Procedures that Bypass Edit 92 when Reported with Modifier -CG
(DATA_HPCPCS, Column DC "BYPASS_E92_MODIFIER")

HPCPCS	LO_ VERSION	HI_ VERSION	DESCRIPTION	BYPASS_E92_ MODIFIER
0200T	78	90	Perq sacral augmt unilat inj	1
0627T	90	90	Perq njx algc fluor lmbr 1st	1
0629T	90	90	Perq njx algc ct lmbr 1st	1
19281	90	90	Perq device breast 1st imag	1
19283	82	90	Perq dev breast 1st strtctc	1
19285	82	90	Perq dev breast 1st us imag	1
20900	86	90	Removal of bone for graft	1
21122	90	90	Reconstruction of chin	1
21150	90	90	Lefort ii anterior intrusion	1
21195	86	90	Reconst lwr jaw w/o fixation	1
21256	86	90	Reconstruction of orbit	1
21267	86	90	Revise eye sockets	1
21346	90	90	Opn tx nasomax fx w/fixj	1
21347	90	90	Opn tx nasomax fx multiple	1
21422	90	90	Treat mouth roof fracture	1
21450	86	90	Treat lower jaw fracture	1
21452	86	90	Treat lower jaw fracture	1
21453	90	90	Treat lower jaw fracture	1
21461	74	90	Treat lower jaw fracture	1
21742	90	90	Repair stern/nuss w/o scope	1
22551	86	90	Arthrd ant ntrbdy cervical	1
22612	90	90	Arthrd pst tq 1ntrspc lumbar	1
22630	86	90	Arthrd pst tq 1ntrspc lum	1
22633	90	90	Arthrd cmbn 1ntrspc lumbar	1
22899	90	90	Unlisted procedure spine	1
23395	90	90	Muscle transfer shoulder/arm	1
23473	74	90	Revis reconst shoulder joint	1
23485	86	90	Revision of collar bone	1
23515	90	90	Optx clavicular fx w/int fix	1
23552	90	90	Optx acrcvl dslc aq/chrn grf	1
23585	90	90	Optx scapular fx w/int fixj	1
23615	90	90	Optx prox humrl fx w/int fix	1
23616	90	90	Optx prx hmrl fx fix rpr rpl	1
23630	90	90	Optx gr hmrl tbrs fx int fix	1
23680	90	90	Optx sho dislc neck fx fixj	1
24126	90	90	Exc/crtg b1 cst/tum rds algr	1
24340	90	90	Tenodesis biceps tdn at elbw	1
24344	86	90	Reconstruct elbow lat ligmnt	1
24370	74	90	Revise reconst elbow joint	1
24371	74	90	Revise reconst elbow joint	1
24400	90	90	Revision of humerus	1
24420	86	90	Revision of humerus	1
24430	86	90	Repair of humerus	1
24435	86	90	Repair humerus with graft	1
24545	74	90	Treat humerus fracture	1
24546	90	90	Treat humerus fracture	1
24575	78	90	Treat humerus fracture	1
24579	74	90	Treat humerus fracture	1
24586	86	90	Treat elbow fracture	1
24615	86	90	Treat elbow dislocation	1
24635	74	90	Treat elbow fracture	1
24666	74	90	Treat radius fracture	1

Procedures that Bypass Edit 92 when Reported with Modifier -CG
(DATA_HPCPCS, Column DC "BYPASS_E92_MODIFIER")

HPCPCS	LO_ VERSION	HI_ VERSION	DESCRIPTION	BYPASS_E92_ MODIFIER
24685	74	90	Treat ulnar fracture	1
25126	90	90	Remove/graft forearm lesion	1
25350	86	90	Revision of radius	1
25390	86	90	Shorten radius or ulna	1
25391	86	90	Lengthen radius or ulna	1
25400	86	90	Repair radius or ulna	1
25405	86	90	Repair/graft radius or ulna	1
25415	86	90	Repair radius & ulna	1
25420	86	90	Repair/graft radius & ulna	1
25426	86	90	Repair/graft radius & ulna	1
25515	74	90	Treat fracture of radius	1
25526	74	90	Treat fracture of radius	1
25545	78	90	Treat fracture of ulna	1
25574	74	90	Treat fracture radius & ulna	1
25575	74	90	Treat fracture radius/ulna	1
25652	86	90	Treat fracture ulnar styloid	1
25800	86	90	Fusion of wrist joint	1
25805	86	90	Fusion/graft of wrist joint	1
25810	86	90	Fusion/graft of wrist joint	1
25820	86	90	Fusion of hand bones	1
25825	86	90	Fuse hand bones with graft	1
26541	90	90	Repair hand joint with graft	1
26568	86	90	Lengthen metacarpal/finger	1
26820	86	90	Thumb fusion with graft	1
26843	86	90	Fusion of hand joint	1
26844	86	90	Fusion/graft of hand joint	1
27396	90	90	Transplant of thigh tendon	1
27430	90	90	Revision of thigh muscles	1
27637	86	90	Remove/graft leg bone lesion	1
27647	90	90	Resect talus/calcaneus tum	1
27654	82	90	Repair of achilles tendon	1
27656	86	90	Repair leg fascia defect	1
27695	90	90	Repair of ankle ligament	1
27696	82	90	Repair of ankle ligaments	1
27698	90	90	Repair of ankle ligament	1
27700	82	90	Revision of ankle joint	1
27705	78	90	Incision of tibia	1
27792	74	90	Treatment of ankle fracture	1
27814	74	90	Treatment of ankle fracture	1
27822	74	90	Treatment of ankle fracture	1
27823	74	90	Treatment of ankle fracture	1
27826	78	90	Treat lower leg fracture	1
27827	74	90	Treat lower leg fracture	1
27828	74	90	Treat lower leg fracture	1
27829	86	90	Treat lower leg joint	1
27832	86	90	Treat lower leg dislocation	1
28202	90	90	Repair/graft of foot tendon	1
28210	86	90	Repair/graft of foot tendon	1
28261	90	90	Revision of foot tendon	1
28299	86	90	Correction hallux valgus	1
28300	74	90	Incision of heel bone	1
28302	78	90	Incision of ankle bone	1

Procedures that Bypass Edit 92 when Reported with Modifier -CG
(DATA_HCPCS, Column DC "BYPASS_E92_MODIFIER")

HCPCS	LO_ VERSION	HI_ VERSION	DESCRIPTION	BYPASS_E92_ MODIFIER
28310	90	90	Revision of big toe	1
28415	74	90	Treat heel fracture	1
28420	74	90	Treat/graft heel fracture	1
28445	74	90	Treat ankle fracture	1
28485	74	90	Treat metatarsal fracture	1
28555	74	90	Repair foot dislocation	1
28585	74	90	Repair foot dislocation	1
28615	74	90	Repair foot dislocation	1
29855	74	90	Tibial arthroscopy/surgery	1
29856	74	90	Tibial arthroscopy/surgery	1
29885	86	90	Knee arthroscopy/surgery	1
30469	90	90	Rpr nsl vlv collapse w/rmdlg	1
33220	78	90	Repair lead pace-defib dual	1
33226	90	90	Reposition l ventric lead	1
33233	78	90	Removal of pm generator	1
33235	78	90	Removal pacemaker electrode	1
35881	90	90	Revise graft w/vein	1
36904	90	90	Thrmhc/nfs dialysis circuit	1
37192	74	90	Redo endovas vena cava filtr	1
37241	86	90	Vasc embolize/occlude venous	1
43210	90	90	Egd esophagogastrc fndoplsty	1
43497	86	90	Transorl lwr esophgl myotomy	1
44390	90	90	Colonoscopy for foreign body	1
45327	78	90	Proctosigmoidoscopy w/stent	1
57288	74	90	Repair bladder defect	1
59072	78	90	Umbilical cord occlud w/us	1
61888	82	90	Revise/remove neuroreceiver	1
62350	74	90	Implant spinal canal cath	1
63663	74	90	Revise spine eltrd perq aray	1
63664	74	90	Revise spine eltrd plate	1
64448	90	90	Njx aa&/strd fem nrv nfs img	1
64569	82	90	Revise/repl vagus n eltrd	1
64583	90	90	Rev/rplct hpglsl nstm ary pg	1
64865	90	90	Repair of facial nerve	1
64886	82	90	Nerve graft head/neck >4 cm	1
64891	74	90	Nerve graft hand/foot >4 cm	1
64892	90	90	Nerve graft arm/leg <4 cm	1
64893	90	90	Nerve graft arm/leg >4 cm	1
64897	90	90	Nerve graft arm/leg <4 cm	1
64910	78	90	Nerve repair w/allograft	1
64912	78	90	Nrv rpr w/nrv algrft 1st	1
65779	78	90	Cover eye w/membrane suture	1
66175	90	90	Trluml dil aq o/f can w/st	1
69719	90	90	Rplcm oi implt sk tc esp<100	1
93602	90	90	Intra-atrial recording	1
93619	90	90	Electrophysiology evaluation	1
95938	90	90	Somatosensory testing	1
C9782	87	90	Blind myocar trpl bon marrow	1
C9783	87	90	Blind cor sinus reducer impl	1

We utilized our equitable adjustment authority at section 1833(t)(2)(E) of the Act to provide separate payment for C1823 for four quarters in CY 2022 for C1823, as its pass-through payment status expired on December 31, 2021 (86

FR 63570). Separate payment for HCPCS code C1823 under our equitable adjustment authority will end on December 31, 2022. Table 52 includes this date for the device described by HCPCS code C1823 and includes the

specific expiration dates for devices with pass-through status expiring at the end of the fourth quarter of 2022, in 2023, or in 2024.

BILLING CODE 4120-01-P

TABLE 52: DEVICES WITH PASS-THROUGH STATUS (OR ADJUSTED SEPARATE PAYMENT) EXPIRING AT THE END OF THE FOURTH QUARTER OF 2022, IN 2023, OR IN 2024

HCPCS Code	Long Descriptor	Effective Date	Pass-Through Expiration Date
C1823	Generator, neurostimulator (implantable), nonrechargeable, with transvenous sensing and stimulation leads	1/1/2019	12/31/2022*
C1824	Generator, cardiac contractility modulation (implantable)	1/1/2020	12/31/2022
C1982	Catheter, pressure-generating, one-way valve, intermittently occlusive	1/1/2020	12/31/2022
C1839	Iris prosthesis	1/1/2020	12/31/2022
C1734	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	1/1/2020	12/31/2022
C2596	Probe, image-guided, robotic, waterjet ablation	1/1/2020	12/31/2022
C1748	Endoscope, single-use (that is, disposable), Upper GI, imaging/illumination device (insertable)	7/1/2020	6/30/2023
C1052	Hemostatic agent, gastrointestinal, topical	1/1/2021	12/31/2023
C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	1/1/2021	12/31/2023
C1825	Generator, neurostimulator (implantable), nonrechargeable with carotid sinus baroreceptor stimulation lead(s)	1/1/2021	12/31/2023
C1761	Catheter, transluminal intravascular lithotripsy, coronary	7/1/2021	6/30/2024

Pass-through Devices, Associated Procedure Codes, and Offset Amounts (set to expire 12/31/22)

(OFFSET_CODEPAIR)

CODE1		CODE2		LO_ VERS	HI_ VERS	OFFSET AMOUNT
C1734	Orth/devic/drug bn/bn,tis/bn	27870	Fusion of ankle joint open	78	89	\$0.00
C1734	Orth/devic/drug bn/bn,tis/bn	28705	Fusion of foot bones	78	89	\$0.00
C1734	Orth/devic/drug bn/bn,tis/bn	28715	Fusion of foot bones	78	89	\$0.00
C1734	Orth/devic/drug bn/bn,tis/bn	28725	Fusion of foot bones	78	89	\$0.00
C1823	Gen, neuro, trans sen/stim	0424T	Insj/rplc nstim apnea compl	86	89	\$8,147.20
C1824	Generator, ccm, implant	0408T	Insj/rplc cardiac modulj sys	86	89	\$12,314.74
C1839	Iris prosthesis	0616T	Insertion of iris prosthesis	81	89	\$657.47
C1839	Iris prosthesis	0617T	Insj iris prosth w/rmvl&insj	81	89	\$1,239.87
C1839	Iris prosthesis	0618T	Insj iris prosth sec io lens	81	89	\$1,239.87
C1982	Intro/sheath, fixed, peel-away	37242	Vasc embolize/occlude artery	86	89	\$4,089.03
C1982	Intro/sheath, fixed, peel-away	37243	Vasc embolize/occlude organ	86	89	\$2,234.30
C2596	Probe, robotic, water-jet	0421T	Waterjet prostate abltj compl	78	89	\$0.00

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January 2023 IOCE Quarterly Data Files
Pass-through Devices, Associated Procedure Codes, and Offset Amounts
(OFFSET_CODEPAIR)

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CODE1		CODE2		LO_	HI_	OFFSET
				VERS	VERS	AMOUNT
C1052	Hemostatic agent, gi, topic	43227	Esophagoscopy control bleed	82	90	\$0.00
C1052	Hemostatic agent, gi, topic	43255	EGD control bleeding any	82	90	\$45.28
C1052	Hemostatic agent, gi, topic	44366	Small bowel endoscopy	82	90	\$32.39
C1052	Hemostatic agent, gi, topic	44378	Small bowel endoscopy	82	90	\$63.22
C1052	Hemostatic agent, gi, topic	44391	Colonoscopy for bleeding	82	90	\$0.00
C1052	Hemostatic agent, gi, topic	45334	Sigmoidoscopy for bleeding	82	90	\$26.10
C1052	Hemostatic agent, gi, topic	45382	Colonoscopy w/ control bleed	82	90	\$32.16
C1062	Intravertebral fx aug impl	22513	Perq vertebral augmentation	82	90	\$1,320.28
C1062	Intravertebral fx aug impl	22514	Perq vertebral augmentation	82	90	\$1,320.28
C1062	Intravertebral fx aug impl	22515	Perq vertebral augmentation	82	90	\$0.00
C1734*	Orth/devic/drug bn/bn,tis/bn	27870	Fusion of ankle joint open	78	90	\$0.00
C1734*	Orth/devic/drug bn/bn,tis/bn	28705	Fusion of foot bones	78	90	\$0.00
C1734*	Orth/devic/drug bn/bn,tis/bn	28715	Fusion of foot bones	78	90	\$0.00
C1734*	Orth/devic/drug bn/bn,tis/bn	28725	Fusion of foot bones	78	90	\$0.00
C1747	Endo, single, urinary tract	50575	Kidney endoscopy	90	90	\$570.84
C1747	Endo, single, urinary tract	50951	Endoscopy of ureter	90	90	\$169.87
C1747	Endo, single, urinary tract	50953	Endoscopy of ureter	90	90	\$442.95
C1747	Endo, single, urinary tract	50955	Ureter endoscopy & biopsy	90	90	\$423.20
C1747	Endo, single, urinary tract	50957	Ureter endoscopy & treatment	90	90	\$416.14
C1747	Endo, single, urinary tract	50961	Ureter endoscopy & treatment	90	90	\$461.75
C1747	Endo, single, urinary tract	50970	Ureter endoscopy	90	90	\$312.82
C1747	Endo, single, urinary tract	50972	Ureter endoscopy & catheter	90	90	\$760.57
C1747	Endo, single, urinary tract	50974	Ureter endoscopy & biopsy	90	90	\$1,069.75
C1747	Endo, single, urinary tract	50976	Ureter endoscopy & treatment	90	90	\$2,043.10
C1747	Endo, single, urinary tract	50980	Ureter endoscopy & treatment	90	90	\$405.33
C1747	Endo, single, urinary tract	52344	Cysto/uretero stricture tx	90	90	\$507.69
C1747	Endo, single, urinary tract	52345	Cysto/uretero w/up stricture	90	90	\$511.54
C1747	Endo, single, urinary tract	52346	Cystouretero w/ renal strict	90	90	\$602.82
C1747	Endo, single, urinary tract	52351	Cystouretero & or pyeloscope	90	90	\$169.55
C1747	Endo, single, urinary tract	52352	Cystouretero w/stone remove	90	90	\$320.51
C1747	Endo, single, urinary tract	52353	Cystouretero w/lithotripsy	90	90	\$252.04
C1747	Endo, single, urinary tract	52354	Cystouretero w/biopsy	90	90	\$428.37
C1747	Endo, single, urinary tract	52355	Cystouretero w/excise tumor	90	90	\$371.94
C1747	Endo, single, urinary tract	52356	Cysto/uretero w/lithotripsy	90	90	\$474.45
C1747	Endo, single, urinary tract	C9761	Cysto, litho, vacuum kidney	90	90	\$789.86
C1748	Endoscope, single, ugi	0652T	Egd flx tansnasal dx br/wa	87	90	\$0.00
C1748	Endoscope, single, ugi	0653T	Egd flx transnasal bx 1/ml	87	90	\$0.00
C1748	Endoscope, single, ugi	0654T	Egd flx transnasal tube/cath	87	90	\$0.00
C1748	Endoscope, single, ugi	43197	Esophagoscopy flex dx brush	87	90	\$0.00
C1748	Endoscope, single, ugi	43198	Esophagosc flex trnsn biopsy	87	90	\$0.00
C1748	Endoscope, single, ugi	43260	Ercp a/ specimen collection	80	90	\$0.00
C1748	Endoscope, single, ugi	43261	Endo cholangiopancreatograph	80	90	\$0.00
C1748	Endoscope, single, ugi	43262	Endo cholangiopancreatograph	80	90	\$0.00

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Pass-through Devices, Associated Procedure Codes, and Offset Amounts
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CODE1		CODE2		LO_ VERS	HI_ VERS	OFFSET AMOUNT
C1748	Endoscope, single, ugi	43263	Ercp sphincter pressure meas	80	90	\$0.00
C1748	Endoscope, single, ugi	43264	Ercp remove duct calculi	80	90	\$0.00
C1748	Endoscope, single, ugi	43265	Ercp lithotripsy calculi	80	90	\$0.00
C1748	Endoscope, single, ugi	43274	Ercp duct stent placement	80	90	\$0.00
C1748	Endoscope, single, ugi	43275	Ercp remove forgn body duct	80	90	\$0.00
C1748	Endoscope, single, ugi	43276	Ercp stent exchange w/dilate	80	90	\$0.00
C1748	Endoscope, single, ugi	43277	Ercp ea duct/ampulla dialte	80	90	\$0.00
C1748	Endoscope, single, ugi	43278	Ercp lesion ablate w/dilate	80	90	\$0.00
C1761	Cath, trans intra litho/coro	92928	Prq card stent w/ angio 1 vsl	84	90	\$0.00
C1761	Cath, trans intra litho/coro	92933	Prq card stent/ath/angio	84	90	\$8,831.00
C1761	Cath, trans intra litho/coro	92943	Prq card revasc chronic 1vsl	84	90	\$4,536.98
C1761	Cath, trans intra litho/coro	C9600	Perc drug-el cor stent sing	84	90	\$0.00
C1761	Cath, trans intra litho/coro	C9602	Perc d-e cor stent ather s	84	90	\$9,562.77
C1761	Cath, trans intra litho/coro	C9607	Perc d-e cor revasc chro sin	84	90	\$8,853.34
C1824*	Generator, ccm, implant	0408T	Insj/rplc cardiac modulj sys	86	90	\$12,314.74
C1825	Gen,neuro, carot sinus baro	0266T	Implt/rpl crt'd sns dev total	82	90	\$5,487.10
C1826	Gen,neuro, clo loop, rechg	63685	Insrt/redo spine n generator	90	90	\$24,024.04
C1827	Gen, neuro, imp led, ex cntr	64568	Inc for vagus n elect impl	90	90	\$24,094.50
C1831	Personalized interbody cage	22630	Arthrd pst tq 1ntrspc lum	85	90	\$0.00
C1831	Personalized interbody cage	22633	Arthrd cmbn 1ntrspc lumbar	85	90	\$0.00
C1832	Auto cell process sys	15100	Skin spl't grft trnk/arm/leg	86	90	\$9.66
C1832	Auto cell process sys	15110	Epidrm autogrft trnk/arm/leg	86	90	\$0.00
C1832	Auto cell process sys	15115	Epidrm a-grft face/nck/hf/g	86	90	\$0.00
C1832	Auto cell process sys	15120	Skn spl't a-grft fac/nck/hf/g	86	90	\$62.13
C1833	Cardiac monitor sys	0525T	Insj/replcmt compl iims	86	90	\$8,246.49
C1833	Cardiac monitor sys	0526T	Insj/rplcmnt iims eltrd only	86	90	\$2,530.46
C1833	Cardiac monitor sys	0527T	Insj/rplcmt iims implt mntr	86	90	\$6,270.64
C1833	Cardiac monitor sys	0528T	Pgrmg dev eval iims ip	86	90	\$0.00
C1834	Pressure sensor system, IM	20950	Fluid pressure muscle	89	90	\$0.00
C1839*	Iris prosthesis	0616T	Insertion of iris prosthesis	81	90	\$657.47
C1839*	Iris prosthesis	0617T	Insj iris prosth w/rmvl&insj	81	90	\$1,239.87
C1839*	Iris prosthesis	0618T	Insj iris prosth sec io lens	81	90	\$1,239.87
C1982*	Cath, pressure, valve-occlu	37242	Vasc embolize/occlude artery	86	90	\$4,089.03
C1982*	Cath, pressure, valve-occlu	37243	Vasc embolize/occlude organ	86	90	\$2,234.30
C2596*	Probe, robotic, water-jet	0421T	Waterjet prostate abltj compl	78	90	\$0.00

*Expired 12/31/22 per 2023 OPPS Final Rule Table 52, but extended an additional year by the Consolidated Appropriations Act of 2023 (note C1823 was also extended but not included on the January 2023 IOCE Quarterly Data File).

FY 2023**List of MS-DRGs Subject to the IPPS Policy for Replaced Devices Offered Without Cost or****With a Credit**

MDC	MS-DRG	MS-DRG Title
Pre-MDC	001	Heart Transplant or Implant of Heart Assist System with MCC
Pre-MDC	002	Heart Transplant or Implant of Heart Assist System without MCC
01	023	Craniotomy with Major Device Implant or Acute Complex CNS Principal Diagnosis with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator
01	024	Craniotomy with Major Device Implant or Acute Complex CNS Principal Diagnosis without MCC
01	025	Craniotomy and Endovascular Intracranial Procedures with MCC
01	026	Craniotomy and Endovascular Intracranial Procedures with CC
01	027	Craniotomy and Endovascular Intracranial Procedures without CC/MCC
01	040	Peripheral, Cranial Nerve and Other Nervous System Procedures with MCC
01	041	Peripheral, Cranial Nerve and Other Nervous System Procedures with CC or Peripheral Neurostimulator
01	042	Peripheral, Cranial Nerve and Other Nervous System Procedures without CC/MCC
03	140	Major Head and Neck Procedures with MCC
03	141	Major Head and Neck Procedures with CC
03	142	Major Head and Neck Procedures without CC/MCC
05	215	Other Heart Assist System Implant
05	216	Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization with MCC
05	217	Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization with CC
05	218	Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization without CC/MCC
05	219	Cardiac Valve and Other Major Cardiothoracic Procedure without Cardiac Catheterization with MCC
05	220	Cardiac Valve and Other Major Cardiothoracic Procedure without Cardiac Catheterization with CC
05	221	Cardiac Valve and Other Major Cardiothoracic Procedure without Cardiac Catheterization without CC/MCC
05	222	Cardiac Defibrillator Implant with Cardiac Catheterization with AMI/Heart Failure/Shock with MCC
05	223	Cardiac Defibrillator Implant with Cardiac Catheterization with AMI/Heart Failure/Shock without MCC
05	224	Cardiac Defibrillator Implant with Cardiac Catheterization without AMI/Heart Failure/Shock with MCC

MDC	MS-DRG	MS-DRG Title
05	225	Cardiac Defibrillator Implant with Cardiac Catheterization without AMI/Heart Failure/Shock without MCC
05	226	Cardiac Defibrillator Implant without Cardiac Catheterization with MCC
05	227	Cardiac Defibrillator Implant without Cardiac Catheterization without MCC
05	242	Permanent Cardiac Pacemaker Implant with MCC
05	243	Permanent Cardiac Pacemaker Implant with CC
05	244	Permanent Cardiac Pacemaker Implant without CC/MCC
05	245	AICD Generator Procedures
05	258	Cardiac Pacemaker Device Replacement with MCC
05	259	Cardiac Pacemaker Device Replacement without MCC
05	260	Cardiac Pacemaker Revision Except Device Replacement with MCC
05	261	Cardiac Pacemaker Revision Except Device Replacement with CC
05	262	Cardiac Pacemaker Revision Except Device Replacement without CC/MCC
05	265	AICD Lead Procedures
05	266	Endovascular Cardiac Valve Replacement And Supplement Procedures with MCC
05	267	Endovascular Cardiac Valve Replacement And Supplement Procedures without MCC
05	268	Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC
05	269	Aortic and Heart Assist Procedures Except Pulsation Balloon without MCC
05	270	Other Major Cardiovascular Procedures with MCC
05	271	Other Major Cardiovascular Procedures with CC
05	272	Other Major Cardiovascular Procedures without CC/MCC
05	319	Other Endovascular Cardiac Valve Procedures with MCC
05	320	Other Endovascular Cardiac Valve Procedures without MCC
08	461	Bilateral or Multiple Major Joint Procedures Of Lower Extremity with MCC
08	462	Bilateral or Multiple Major Joint Procedures of Lower Extremity without MCC
08	466	Revision of Hip or Knee Replacement with MCC
08	467	Revision of Hip or Knee Replacement with CC
08	468	Revision of Hip or Knee Replacement without CC/MCC
08	469	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement
08	470	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC
08	521	Hip Replacement with Principal Diagnosis of Hip Fracture with MCC

MDC	MS-DRG	MS-DRG Title
08	522	Hip Replacement with Principal Diagnosis of Hip Fracture without MCC

Version 01/09/2023
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