



Medicare Hospital and Chargemaster Version LifePoint Custom

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 OPPI 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

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.

Processing Manual, Chapter 4 § 180.7, Medicare Claims Processing Manual Transmittal 3238>

- 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_HCPCHS, column AU “SEPARATE_PROCEDURE” available on the OCE homepage. The 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 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 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 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 OPPS Final Rule, included in the materials behind the outline, lists the six devices with pass-through status expiring December 31, 2022. CMS determined that only 5 of these devices met the statutory language for extension. Device C1823 was previously extended through December 31, 2022 through CMS’ equitable authority and not further extended. <CAA of 2023; Medicare Claims Processing Manual Transmittal 11801>

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 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 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. 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 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. The list is included in the materials behind the outline.
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>*

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 | DESCRIPTION | STATUS_ INDICATOR | SEPARATE_ PROCEDURE | LO_ VERSION | HI_ VERSION |
|-------|------------------------------|----------------------|------------------------|----------------|----------------|
| 21750 | Repair of sternum separation | C | 1 | 86 | 93 |
| 21825 | Treat sternum fracture | C | 1 | 86 | 93 |
| 22010 | I&d p-spine c/t/cerv-thor | C | 1 | 86 | 93 |
| 22015 | I&d abscess p-spine l/s/l | C | 1 | 86 | 93 |
| 22110 | Remove part of neck vertebra | C | 1 | 86 | 93 |
| 22112 | Remove part thorax vertebra | C | 1 | 86 | 93 |
| 22114 | Remove part lumbar vertebra | C | 1 | 86 | 93 |
| 22116 | Remove extra spine segment | C | 1 | 86 | 93 |
| 22206 | Incis spine 3 column thorac | C | 1 | 86 | 93 |
| 22207 | Incis spine 3 column lumbar | C | 1 | 86 | 93 |
| 22208 | Incis spine 3 column adl seg | C | 1 | 86 | 93 |
| 22210 | Incis 1 vertebral seg cerv | C | 1 | 86 | 93 |
| 27005 | Incision of hip tendon | C | 1 | 86 | 93 |
| 27090 | Removal of hip prosthesis | C | 1 | 86 | 93 |
| 27140 | Transplant femur ridge | C | 1 | 86 | 93 |
| 27161 | Incision of neck of femur | C | 1 | 86 | 93 |
| 31725 | Clearance of airways | C | 1 | 66 | 93 |
| 32220 | Release of lung | C | 1 | 66 | 93 |
| 32225 | Partial release of lung | C | 1 | 66 | 93 |
| 32310 | Removal of chest lining | C | 1 | 66 | 93 |
| 33140 | Heart revascularize (tmr) | C | 1 | 66 | 93 |
| 33496 | Repair prosth valve clot | C | 1 | 66 | 93 |
| 33800 | Aortic suspension | C | 1 | 89 | 93 |
| 38100 | Removal of spleen total | C | 1 | 66 | 93 |
| 38101 | Removal of spleen partial | C | 1 | 66 | 93 |
| 38562 | Removal pelvic lymph nodes | C | 1 | 86 | 93 |
| 38564 | Removal abdomen lymph nodes | C | 1 | 66 | 93 |
| 38765 | Remove groin lymph nodes | C | 1 | 66 | 93 |
| 38770 | Remove pelvis lymph nodes | C | 1 | 66 | 93 |
| 38780 | Remove abdomen lymph nodes | C | 1 | 66 | 93 |
| 43848 | Revision gastroplasty | C | 1 | 66 | 93 |
| 44005 | Freeing of bowel adhesion | C | 1 | 66 | 93 |
| 44130 | Bowel to bowel fusion | C | 1 | 66 | 93 |
| 44300 | Open bowel to skin | C | 1 | 86 | 93 |
| 44314 | Revision of ileostomy | C | 1 | 86 | 93 |
| 44316 | Devise bowel pouch | C | 1 | 66 | 93 |
| 44322 | Colostomy with biopsies | C | 1 | 66 | 93 |
| 44345 | Revision of colostomy | C | 1 | 86 | 93 |
| 44346 | Revision of colostomy | C | 1 | 86 | 93 |
| 44680 | Surgical revision intestine | C | 1 | 66 | 93 |
| 44820 | Excision of mesentery lesion | C | 1 | 66 | 93 |
| 44850 | Repair of mesentery | C | 1 | 66 | 93 |
| 47460 | Incise bile duct sphincter | C | 1 | 66 | 93 |
| 47480 | Incision of gallbladder | C | 1 | 66 | 93 |
| 47900 | Suture bile duct injury | C | 1 | 66 | 93 |

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

| HCPCS | DESCRIPTION | STATUS_ INDICATOR | SEPARATE_ PROCEDURE | LO_ VERSION | HI_ VERSION |
|-------|------------------------------|----------------------|------------------------|----------------|----------------|
| 49000 | Exploration of abdomen | C | 1 | 66 | 93 |
| 49010 | Exploration behind abdomen | C | 1 | 86 | 93 |
| 49255 | Removal of omentum | C | 1 | 86 | 93 |
| 50100 | Trnsxj/repos abrrnt rnl vsls | C | 1 | 90 | 93 |
| 50340 | Removal of kidney | C | 1 | 66 | 93 |
| 50600 | Exploration of ureter | C | 1 | 66 | 93 |
| 50650 | Removal of ureter | C | 1 | 66 | 93 |
| 50900 | Repair of ureter | C | 1 | 66 | 93 |
| 51525 | Removal of bladder lesion | C | 1 | 66 | 93 |
| 51570 | Removal of bladder | C | 1 | 66 | 93 |
| 57270 | Repair of bowel pouch | C | 1 | 66 | 93 |
| 58400 | Suspension of uterus | C | 1 | 66 | 93 |
| 58605 | Division of fallopian tube | C | 1 | 66 | 93 |
| 58700 | Removal of fallopian tube | C | 1 | 66 | 93 |
| 58720 | Removal of ovary/tube(s) | C | 1 | 66 | 93 |
| 60521 | Removal of thymus gland | C | 1 | 66 | 93 |
| 60522 | Removal of thymus gland | C | 1 | 66 | 93 |
| 60540 | Explore adrenal gland | C | 1 | 66 | 93 |
| 60545 | Explore adrenal gland | C | 1 | 66 | 93 |
| 61210 | Pierce skull implant device | C | 1 | 66 | 93 |
| 61535 | Remove brain electrodes | C | 1 | 66 | 93 |

| October 2023 IOCE Quarterly Data Files: Device Intensive List with Offset Amounts (Offset_HCPCS) | | | | | | October 2023 IOCE Quarterly Data Files: Device Intensive List with Offset Amounts (Offset_HCPCS) | | | | | |
|--|--------|-------------|-----|---------|-----|--|--------|-------------|-----|---------|-----|
| HCPCS | OFFSET | AMOUNT | LO_ | VERSION | HL_ | HCPCS | OFFSET | AMOUNT | LO_ | VERSION | HL_ |
| 0200T | | \$2,191.43 | 90 | 93 | 93 | 0647T | | \$539.89 | 90 | 93 | 93 |
| 0221T | | \$5,259.29 | 90 | 93 | 93 | 0651T | | \$255.91 | 90 | 93 | 93 |
| 0234T | | \$3,705.80 | 90 | 93 | 93 | 0652T | | \$255.91 | 90 | 93 | 93 |
| 0236T | | \$3,825.76 | 90 | 93 | 93 | 0653T | | \$255.91 | 90 | 93 | 93 |
| 0237T | | \$4,754.60 | 90 | 93 | 93 | 0671T | | \$1,177.97 | 90 | 93 | 93 |
| 0238T | | \$8,339.72 | 90 | 93 | 93 | 0707T | | \$922.76 | 90 | 93 | 93 |
| 0253T | | \$1,965.43 | 90 | 93 | 93 | 0744T | | \$1,593.33 | 90 | 93 | 93 |
| 0268T | | \$26,663.37 | 90 | 93 | 93 | 0775T | | \$7,648.84 | 90 | 93 | 93 |
| 0275T | | \$3,753.80 | 90 | 93 | 93 | 0793T | | \$5,325.06 | 92 | 93 | 93 |
| 0308T | | \$7,046.05 | 90 | 93 | 93 | 0797T | | \$5,325.06 | 92 | 93 | 93 |
| 0335T | | \$3,126.07 | 90 | 93 | 93 | 0803T | | \$5,325.06 | 92 | 93 | 93 |
| 0404T | | \$2,146.92 | 90 | 93 | 93 | 0809T | | \$6,788.27 | 92 | 93 | 93 |
| 0408T | | \$26,610.52 | 90 | 93 | 93 | 10035 | | \$217.02 | 90 | 93 | 93 |
| 0409T | | \$20,616.35 | 90 | 93 | 93 | 11970 | | \$1,991.00 | 90 | 93 | 93 |
| 0410T | | \$2,530.46 | 90 | 93 | 93 | 19281 | | \$807.96 | 90 | 93 | 93 |
| 0414T | | \$14,592.32 | 90 | 93 | 93 | 19283 | | \$319.55 | 90 | 93 | 93 |
| 0421T | | \$3,019.10 | 90 | 93 | 93 | 19285 | | \$356.93 | 90 | 93 | 93 |
| 0424T | | \$46,629.42 | 90 | 93 | 93 | 19287 | | \$202.61 | 90 | 93 | 93 |
| 0425T | | \$7,505.03 | 90 | 93 | 93 | 19296 | | \$3,640.29 | 90 | 93 | 93 |
| 0426T | | \$5,831.67 | 90 | 93 | 93 | 20690 | | \$2,485.12 | 90 | 93 | 93 |
| 0427T | | \$21,452.24 | 90 | 93 | 93 | 20692 | | \$5,764.64 | 90 | 93 | 93 |
| 0431T | | \$21,666.56 | 90 | 93 | 93 | 20696 | | \$11,647.35 | 90 | 93 | 93 |
| 0442T | | \$3,667.03 | 90 | 93 | 93 | 20900 | | \$2,500.99 | 90 | 93 | 93 |
| 0449T | | \$2,143.63 | 90 | 93 | 93 | 20983 | | \$2,389.87 | 90 | 93 | 93 |
| 0505T | | \$5,229.10 | 90 | 93 | 93 | 21122 | | \$1,913.74 | 90 | 93 | 93 |
| 0511T | | \$3,241.83 | 90 | 93 | 93 | 21150 | | \$1,802.14 | 90 | 93 | 93 |
| 0515T | | \$10,384.62 | 90 | 93 | 93 | 21195 | | \$2,697.60 | 90 | 93 | 93 |
| 0516T | | \$2,530.46 | 90 | 93 | 93 | 21243 | | \$11,397.72 | 90 | 93 | 93 |
| 0517T | | \$6,065.75 | 90 | 93 | 93 | 21244 | | \$2,118.78 | 90 | 93 | 93 |
| 0519T | | \$1,382.93 | 90 | 93 | 93 | 21245 | | \$2,426.88 | 90 | 93 | 93 |
| 0520T | | \$7,073.68 | 90 | 93 | 93 | 21256 | | \$2,479.74 | 90 | 93 | 93 |
| 0524T | | \$1,160.31 | 90 | 93 | 93 | 21267 | | \$4,210.86 | 90 | 93 | 93 |
| 0525T | | \$8,246.49 | 90 | 93 | 93 | 21346 | | \$2,385.23 | 90 | 93 | 93 |
| 0526T | | \$2,530.46 | 90 | 93 | 93 | 21347 | | \$1,743.94 | 90 | 93 | 93 |
| 0527T | | \$6,270.64 | 90 | 93 | 93 | 21365 | | \$1,820.83 | 90 | 93 | 93 |
| 0571T | | \$24,503.11 | 90 | 93 | 93 | 21422 | | \$1,609.91 | 90 | 93 | 93 |
| 0572T | | \$4,090.36 | 90 | 93 | 93 | 21450 | | \$202.01 | 90 | 93 | 93 |
| 0583T | | \$430.32 | 90 | 93 | 93 | 21452 | | \$1,736.46 | 90 | 93 | 93 |
| 0587T | | \$4,495.24 | 90 | 93 | 93 | 21453 | | \$1,628.07 | 90 | 93 | 93 |
| 0594T | | \$2,050.54 | 90 | 93 | 93 | 21461 | | \$1,991.16 | 90 | 93 | 93 |
| 0600T | | \$6,085.76 | 90 | 93 | 93 | 21462 | | \$1,916.41 | 90 | 93 | 93 |
| 0601T | | \$2,817.06 | 90 | 93 | 93 | 21470 | | \$2,011.45 | 90 | 93 | 93 |
| 0614T | | \$17,809.70 | 90 | 93 | 93 | 21742 | | \$1,993.77 | 90 | 93 | 93 |
| 0616T | | \$12,947.00 | 90 | 93 | 93 | 21812 | | \$5,834.10 | 90 | 93 | 93 |
| 0617T | | \$14,072.20 | 90 | 93 | 93 | 21813 | | \$757.43 | 90 | 93 | 93 |
| 0618T | | \$11,910.44 | 90 | 93 | 93 | 22551 | | \$5,932.96 | 90 | 93 | 93 |
| 0619T | | \$1,457.68 | 90 | 93 | 93 | 22554 | | \$5,598.93 | 90 | 93 | 93 |
| 0620T | | \$12,123.95 | 90 | 93 | 93 | 22612 | | \$11,745.89 | 90 | 93 | 93 |
| 0627T | | \$6,281.35 | 90 | 93 | 93 | 22630 | | \$13,070.70 | 90 | 93 | 93 |
| 0629T | | \$6,281.35 | 90 | 93 | 93 | 22633 | | \$13,245.88 | 90 | 93 | 93 |
| 0644T | | \$2,836.66 | 90 | 93 | 93 | 22856 | | \$11,461.22 | 90 | 93 | 93 |

October 2023 IOCE Quarterly Data Files: Device Intensive List with Offset Amounts (Offset_HCPCS)

| HCPCS | OFFSET AMOUNT | LO_ VERSION | HL_ VERSION |
|-------|------------------|----------------|----------------|
| 22867 | \$13,499.89 | 90 | 93 |
| 22869 | \$9,821.29 | 90 | 93 |
| 22899 | \$72.31 | 90 | 93 |
| 23395 | \$2,292.63 | 90 | 93 |
| 23470 | \$6,766.73 | 90 | 93 |
| 23472 | \$7,877.13 | 90 | 93 |
| 23473 | \$6,496.64 | 90 | 93 |
| 23485 | \$5,514.12 | 90 | 93 |
| 23491 | \$4,505.50 | 90 | 93 |
| 23515 | \$2,539.36 | 90 | 93 |
| 23552 | \$2,487.10 | 90 | 93 |
| 23585 | \$2,499.01 | 90 | 93 |
| 23615 | \$5,655.04 | 90 | 93 |
| 23616 | \$11,476.55 | 90 | 93 |
| 23630 | \$2,173.57 | 90 | 93 |
| 23680 | \$4,870.85 | 90 | 93 |
| 24126 | \$3,305.99 | 90 | 93 |
| 24340 | \$2,282.05 | 90 | 93 |
| 24344 | \$2,230.45 | 90 | 93 |
| 24360 | \$3,473.34 | 90 | 93 |
| 24361 | \$11,450.27 | 90 | 93 |
| 24362 | \$8,155.05 | 90 | 93 |
| 24363 | \$13,101.35 | 90 | 93 |
| 24365 | \$7,158.18 | 90 | 93 |
| 24366 | \$7,224.72 | 90 | 93 |
| 24370 | \$5,531.08 | 90 | 93 |
| 24371 | \$11,572.90 | 90 | 93 |
| 24400 | \$2,035.32 | 90 | 93 |
| 24420 | \$2,733.17 | 90 | 93 |
| 24430 | \$5,289.69 | 90 | 93 |
| 24435 | \$5,687.66 | 90 | 93 |
| 24498 | \$4,471.58 | 90 | 93 |
| 24515 | \$4,891.73 | 90 | 93 |
| 24516 | \$5,167.04 | 90 | 93 |
| 24545 | \$5,863.81 | 90 | 93 |
| 24546 | \$5,909.48 | 90 | 93 |
| 24575 | \$5,452.79 | 90 | 93 |
| 24579 | \$4,552.48 | 90 | 93 |
| 24586 | \$5,373.20 | 90 | 93 |
| 24587 | \$6,257.86 | 90 | 93 |
| 24615 | \$2,202.67 | 90 | 93 |
| 24635 | \$2,682.89 | 90 | 93 |
| 24666 | \$7,305.62 | 90 | 93 |
| 24685 | \$2,164.31 | 90 | 93 |
| 25126 | \$1,121.31 | 90 | 93 |
| 25332 | \$964.74 | 90 | 93 |
| 25350 | \$2,859.50 | 90 | 93 |
| 25390 | \$2,397.80 | 90 | 93 |
| 25391 | \$6,319.19 | 90 | 93 |
| 25400 | \$2,715.31 | 90 | 93 |
| 25405 | \$2,659.08 | 90 | 93 |

October 2023 IOCE Quarterly Data Files: Device Intensive List with Offset Amounts (Offset_HCPCS)

| HCPCS | OFFSET AMOUNT | LO_ VERSION | HL_ VERSION |
|-------|------------------|----------------|----------------|
| 25415 | \$2,262.20 | 90 | 93 |
| 25420 | \$2,397.14 | 90 | 93 |
| 25426 | \$1,101.66 | 90 | 93 |
| 25441 | \$8,051.97 | 90 | 93 |
| 25442 | \$13,394.78 | 90 | 93 |
| 25443 | \$3,475.99 | 90 | 93 |
| 25444 | \$8,289.45 | 90 | 93 |
| 25445 | \$3,530.23 | 90 | 93 |
| 25446 | \$14,629.81 | 90 | 93 |
| 25515 | \$2,402.43 | 90 | 93 |
| 25526 | \$2,275.43 | 90 | 93 |
| 25545 | \$2,136.53 | 90 | 93 |
| 25574 | \$2,573.75 | 90 | 93 |
| 25575 | \$2,458.00 | 90 | 93 |
| 25607 | \$2,824.45 | 90 | 93 |
| 25608 | \$2,842.97 | 90 | 93 |
| 25609 | \$2,866.12 | 90 | 93 |
| 25652 | \$2,245.01 | 90 | 93 |
| 25800 | \$2,899.85 | 90 | 93 |
| 25805 | \$2,538.69 | 90 | 93 |
| 25810 | \$5,340.58 | 90 | 93 |
| 25820 | \$2,842.97 | 90 | 93 |
| 25825 | \$2,289.98 | 90 | 93 |
| 26530 | \$2,448.07 | 90 | 93 |
| 26531 | \$3,071.83 | 90 | 93 |
| 26536 | \$2,575.08 | 90 | 93 |
| 26541 | \$895.68 | 90 | 93 |
| 26568 | \$3,409.84 | 90 | 93 |
| 26820 | \$2,406.40 | 90 | 93 |
| 26843 | \$2,126.60 | 90 | 93 |
| 26844 | \$2,457.34 | 90 | 93 |
| 27110 | \$2,350.84 | 90 | 93 |
| 27130 | \$6,591.89 | 90 | 93 |
| 27279 | \$15,302.06 | 90 | 93 |
| 27357 | \$2,751.02 | 90 | 93 |
| 27381 | \$2,395.16 | 90 | 93 |
| 27396 | \$1,989.68 | 90 | 93 |
| 27403 | \$3,200.82 | 90 | 93 |
| 27412 | \$4,777.09 | 90 | 93 |
| 27415 | \$7,301.71 | 90 | 93 |
| 27427 | \$2,524.14 | 90 | 93 |
| 27428 | \$5,186.61 | 90 | 93 |
| 27429 | \$5,198.36 | 90 | 93 |
| 27430 | \$2,465.27 | 90 | 93 |
| 27438 | \$4,600.75 | 90 | 93 |
| 27440 | \$5,837.71 | 90 | 93 |
| 27442 | \$5,750.29 | 90 | 93 |
| 27443 | \$6,672.79 | 90 | 93 |
| 27446 | \$5,925.13 | 90 | 93 |
| 27447 | \$6,139.12 | 90 | 93 |
| 27477 | \$3,043.39 | 90 | 93 |

| October 2023 IOCE Quarterly Data Files: Device Intensive List with Offset Amounts (Offset_HCPCS) | | | | | |
|--|------------------|----------------|----------------|--|--|
| HCPCS | OFFSET AMOUNT | LO_ VERSION | HL_ VERSION | | |
| 27509 | \$3,177.67 | 90 | 93 | | |
| 27637 | \$2,757.64 | 90 | 93 | | |
| 27647 | \$1,152.56 | 90 | 93 | | |
| 27652 | \$2,429.55 | 90 | 93 | | |
| 27654 | \$2,286.02 | 90 | 93 | | |
| 27656 | \$1,148.10 | 90 | 93 | | |
| 27695 | \$2,131.90 | 90 | 93 | | |
| 27696 | \$2,358.12 | 90 | 93 | | |
| 27698 | \$2,369.36 | 90 | 93 | | |
| 27700 | \$3,488.56 | 90 | 93 | | |
| 27702 | \$14,581.63 | 90 | 93 | | |
| 27705 | \$2,233.10 | 90 | 93 | | |
| 27709 | \$5,968.19 | 90 | 93 | | |
| 27720 | \$2,655.77 | 90 | 93 | | |
| 27722 | \$2,073.03 | 90 | 93 | | |
| 27726 | \$2,594.92 | 90 | 93 | | |
| 27745 | \$2,553.91 | 90 | 93 | | |
| 27756 | \$2,612.78 | 90 | 93 | | |
| 27758 | \$5,690.27 | 90 | 93 | | |
| 27759 | \$4,848.67 | 90 | 93 | | |
| 27792 | \$2,401.11 | 90 | 93 | | |
| 27814 | \$2,386.56 | 90 | 93 | | |
| 27822 | \$2,375.98 | 90 | 93 | | |
| 27823 | \$2,367.38 | 90 | 93 | | |
| 27826 | \$2,042.60 | 90 | 93 | | |
| 27827 | \$5,016.99 | 90 | 93 | | |
| 27828 | \$5,433.22 | 90 | 93 | | |
| 27829 | \$2,489.09 | 90 | 93 | | |
| 27832 | \$4,157.29 | 90 | 93 | | |
| 27870 | \$6,680.62 | 90 | 93 | | |
| 27871 | \$5,537.61 | 90 | 93 | | |
| 28102 | \$3,159.81 | 90 | 93 | | |
| 28103 | \$2,545.31 | 90 | 93 | | |
| 28202 | \$1,989.02 | 90 | 93 | | |
| 28210 | \$2,344.22 | 90 | 93 | | |
| 28261 | \$893.71 | 90 | 93 | | |
| 28262 | \$2,211.93 | 90 | 93 | | |
| 28291 | \$2,951.45 | 90 | 93 | | |
| 28297 | \$3,423.07 | 90 | 93 | | |
| 28298 | \$2,190.77 | 90 | 93 | | |
| 28299 | \$2,221.85 | 90 | 93 | | |
| 28300 | \$2,381.93 | 90 | 93 | | |
| 28302 | \$2,685.54 | 90 | 93 | | |
| 28305 | \$2,031.35 | 90 | 93 | | |
| 28309 | \$2,062.44 | 90 | 93 | | |
| 28310 | \$1,989.02 | 90 | 93 | | |
| 28320 | \$5,529.78 | 90 | 93 | | |
| 28322 | \$2,546.63 | 90 | 93 | | |
| 28415 | \$2,502.98 | 90 | 93 | | |
| 28420 | \$5,734.63 | 90 | 93 | | |
| 28436 | \$2,112.71 | 90 | 93 | | |

| October 2023 IOCE Quarterly Data Files: Device Intensive List with Offset Amounts (Offset_HCPCS) | | | | | |
|--|------------------|----------------|----------------|--|--|
| HCPCS | OFFSET AMOUNT | LO_ VERSION | HL_ VERSION | | |
| 28445 | \$2,387.22 | 90 | 93 | | |
| 28446 | \$2,827.75 | 90 | 93 | | |
| 28485 | \$2,338.27 | 90 | 93 | | |
| 28555 | \$2,061.12 | 90 | 93 | | |
| 28585 | \$2,602.86 | 90 | 93 | | |
| 28615 | \$2,525.47 | 90 | 93 | | |
| 28705 | \$11,036.41 | 90 | 93 | | |
| 28715 | \$7,124.25 | 90 | 93 | | |
| 28725 | \$6,200.45 | 90 | 93 | | |
| 28730 | \$7,055.10 | 90 | 93 | | |
| 28735 | \$7,155.57 | 90 | 93 | | |
| 28737 | \$6,748.47 | 90 | 93 | | |
| 28740 | \$3,273.58 | 90 | 93 | | |
| 28750 | \$3,059.27 | 90 | 93 | | |
| 28855 | \$3,293.42 | 90 | 93 | | |
| 28856 | \$6,204.36 | 90 | 93 | | |
| 28867 | \$5,473.67 | 90 | 93 | | |
| 29885 | \$3,571.24 | 90 | 93 | | |
| 29888 | \$2,420.95 | 90 | 93 | | |
| 29889 | \$5,116.15 | 90 | 93 | | |
| 29899 | \$2,624.69 | 90 | 93 | | |
| 29907 | \$5,862.50 | 90 | 93 | | |
| 30468 | \$2,013.06 | 90 | 93 | | |
| 30469 | \$1,655.30 | 90 | 93 | | |
| 31636 | \$2,696.33 | 90 | 93 | | |
| 31647 | \$3,579.23 | 90 | 93 | | |
| 31660 | \$3,066.94 | 90 | 93 | | |
| 31661 | \$2,948.76 | 90 | 93 | | |
| 32994 | \$2,077.04 | 90 | 93 | | |
| 33206 | \$5,850.22 | 90 | 93 | | |
| 33207 | \$5,916.32 | 90 | 93 | | |
| 33208 | \$6,331.54 | 90 | 93 | | |
| 33212 | \$4,901.74 | 90 | 93 | | |
| 33213 | \$6,291.25 | 90 | 93 | | |
| 33214 | \$6,125.99 | 90 | 93 | | |
| 33216 | \$3,006.35 | 90 | 93 | | |
| 33217 | \$3,889.56 | 90 | 93 | | |
| 33220 | \$1,156.74 | 90 | 93 | | |
| 33221 | \$11,231.21 | 90 | 93 | | |
| 33224 | \$5,595.09 | 90 | 93 | | |
| 33226 | \$920.20 | 90 | 93 | | |
| 33227 | \$4,706.65 | 90 | 93 | | |
| 33228 | \$6,113.60 | 90 | 93 | | |
| 33229 | \$11,815.65 | 90 | 93 | | |
| 33230 | \$16,739.52 | 90 | 93 | | |
| 33231 | \$23,810.26 | 90 | 93 | | |
| 33233 | \$3,455.30 | 90 | 93 | | |
| 33234 | \$1,308.54 | 90 | 93 | | |
| 33235 | \$1,131.94 | 90 | 93 | | |
| 33240 | \$17,319.10 | 90 | 93 | | |
| 33249 | \$23,287.42 | 90 | 93 | | |

October 2023 IOCE Quarterly Data Files: Device Intensive List with Offset Amounts (Offset_HCPCS)

| HCPCS | OFFSET AMOUNT | LO_ VERSION | HI_ VERSION |
|-------|------------------|----------------|----------------|
| 33262 | \$16,235.23 | 90 | 93 |
| 33263 | \$16,187.32 | 90 | 93 |
| 33264 | \$23,736.48 | 90 | 93 |
| 33270 | \$23,665.92 | 90 | 93 |
| 33271 | \$5,341.72 | 90 | 93 |
| 33274 | \$11,419.67 | 90 | 93 |
| 33275 | \$2,077.83 | 90 | 93 |
| 33285 | \$5,916.38 | 90 | 93 |
| 33289 | \$21,502.82 | 90 | 93 |
| 33900 | \$3,290.75 | 90 | 93 |
| 33901 | \$3,290.75 | 90 | 93 |
| 33902 | \$5,325.06 | 90 | 93 |
| 33903 | \$3,290.75 | 90 | 93 |
| 33999 | \$334.55 | 90 | 93 |
| 34421 | \$1,184.74 | 90 | 93 |
| 35881 | \$2,125.80 | 90 | 93 |
| 36253 | \$1,716.17 | 90 | 93 |
| 36254 | \$916.93 | 90 | 93 |
| 36583 | \$1,629.82 | 90 | 93 |
| 36835 | \$1,472.50 | 90 | 93 |
| 36836 | \$6,924.29 | 90 | 93 |
| 36837 | \$8,832.72 | 90 | 93 |
| 36903 | \$5,548.62 | 90 | 93 |
| 36904 | \$1,611.56 | 90 | 93 |
| 36906 | \$8,523.53 | 90 | 93 |
| 37183 | \$1,887.97 | 90 | 93 |
| 37184 | \$4,741.86 | 90 | 93 |
| 37187 | \$5,385.15 | 90 | 93 |
| 37191 | \$2,051.28 | 90 | 93 |
| 37192 | \$957.74 | 90 | 93 |
| 37211 | \$1,647.29 | 90 | 93 |
| 37221 | \$4,216.40 | 90 | 93 |
| 37224 | \$1,983.94 | 90 | 93 |
| 37225 | \$5,845.85 | 90 | 93 |
| 37226 | \$5,206.81 | 90 | 93 |
| 37227 | \$9,387.56 | 90 | 93 |
| 37228 | \$3,394.78 | 90 | 93 |
| 37229 | \$8,112.98 | 90 | 93 |
| 37230 | \$7,650.90 | 90 | 93 |
| 37231 | \$7,750.53 | 90 | 93 |
| 37236 | \$4,011.53 | 90 | 93 |
| 37238 | \$4,374.57 | 90 | 93 |
| 37241 | \$3,841.68 | 90 | 93 |
| 37242 | \$4,288.59 | 90 | 93 |
| 41512 | \$1,727.38 | 90 | 93 |
| 42900 | \$1,103.57 | 90 | 93 |
| 43210 | \$2,897.94 | 90 | 93 |
| 43212 | \$2,915.41 | 90 | 93 |
| 43229 | \$1,818.49 | 90 | 93 |
| 43240 | \$3,267.06 | 90 | 93 |
| 43266 | \$2,976.20 | 90 | 93 |

October 2023 IOCE Quarterly Data Files: Device Intensive List with Offset Amounts (Offset_HCPCS)

| HCPCS | OFFSET AMOUNT | LO_ VERSION | HI_ VERSION |
|-------|------------------|----------------|----------------|
| 43284 | \$4,415.52 | 90 | 93 |
| 43497 | \$1,010.81 | 90 | 93 |
| 43647 | \$7,807.43 | 90 | 93 |
| 43770 | \$4,183.79 | 90 | 93 |
| 44370 | \$3,343.06 | 90 | 93 |
| 44390 | \$360.26 | 90 | 93 |
| 44402 | \$1,817.48 | 90 | 93 |
| 44405 | \$461.10 | 90 | 93 |
| 45327 | \$3,456.25 | 90 | 93 |
| 45347 | \$3,467.26 | 90 | 93 |
| 45389 | \$3,380.26 | 90 | 93 |
| 46707 | \$1,011.86 | 90 | 93 |
| 47383 | \$2,546.66 | 90 | 93 |
| 47538 | \$2,281.36 | 90 | 93 |
| 47539 | \$1,762.75 | 90 | 93 |
| 47540 | \$2,208.39 | 90 | 93 |
| 47553 | \$1,129.52 | 90 | 93 |
| 47556 | \$2,224.02 | 90 | 93 |
| 50570 | \$1,049.68 | 90 | 93 |
| 50593 | \$4,153.80 | 90 | 93 |
| 51715 | \$1,209.29 | 90 | 93 |
| 51992 | \$1,933.71 | 90 | 93 |
| 52327 | \$2,225.54 | 90 | 93 |
| 53440 | \$7,660.68 | 90 | 93 |
| 53444 | \$10,766.91 | 90 | 93 |
| 53445 | \$13,969.60 | 90 | 93 |
| 53447 | \$13,331.37 | 90 | 93 |
| 53451 | \$9,018.65 | 90 | 93 |
| 53452 | \$6,368.51 | 90 | 93 |
| 54400 | \$8,212.77 | 90 | 93 |
| 54401 | \$13,817.27 | 90 | 93 |
| 54405 | \$13,636.03 | 90 | 93 |
| 54410 | \$12,889.82 | 90 | 93 |
| 54411 | \$11,794.62 | 90 | 93 |
| 54416 | \$12,689.29 | 90 | 93 |
| 54417 | \$7,101.37 | 90 | 93 |
| 54660 | \$1,854.54 | 90 | 93 |
| 55873 | \$4,136.71 | 90 | 93 |
| 55874 | \$2,364.73 | 90 | 93 |
| 55876 | \$427.94 | 90 | 93 |
| 57288 | \$1,460.99 | 90 | 93 |
| 58565 | \$2,651.75 | 90 | 93 |
| 59072 | \$118.65 | 90 | 93 |
| 61626 | \$3,930.85 | 90 | 93 |
| 61885 | \$18,677.48 | 90 | 93 |
| 61886 | \$24,825.53 | 90 | 93 |
| 61888 | \$6,267.94 | 90 | 93 |
| 62350 | \$2,184.77 | 90 | 93 |
| 62360 | \$12,151.65 | 90 | 93 |
| 62361 | \$12,327.81 | 90 | 93 |
| 62362 | \$12,495.50 | 90 | 93 |

| October 2023 IOCE Quarterly Data Files: Device Intensive List with Offset Amounts (Offset_HCPCS) | | | | | | |
|--|-------------|---------|---------|---------|---------|-----|
| HCPCS | OFFSET | LO_ | HI_ | VERSION | VERSION | HL_ |
| | AMOUNT | VERSION | VERSION | | | |
| 63075 | \$2,454.03 | 90 | 93 | | | |
| 63610 | \$877.37 | 90 | 93 | | | |
| 63650 | \$3,114.38 | 90 | 93 | | | |
| 63655 | \$14,383.02 | 90 | 93 | | | |
| 63663 | \$3,451.83 | 90 | 93 | | | |
| 63664 | \$5,774.30 | 90 | 93 | | | |
| 63685 | \$24,024.04 | 90 | 93 | | | |
| 63741 | \$2,750.12 | 90 | 93 | | | |
| 63744 | \$1,981.49 | 90 | 93 | | | |
| 64448 | \$359.62 | 90 | 93 | | | |
| 64553 | \$6,627.71 | 90 | 93 | | | |
| 64555 | \$4,676.19 | 90 | 93 | | | |
| 64561 | \$3,181.73 | 90 | 93 | | | |
| 64568 | \$24,094.50 | 90 | 93 | | | |
| 64569 | \$8,492.32 | 90 | 93 | | | |
| 64575 | \$8,503.07 | 90 | 93 | | | |
| 64580 | \$14,529.32 | 90 | 93 | | | |
| 64581 | \$4,223.82 | 90 | 93 | | | |
| 64582 | \$25,163.15 | 90 | 93 | | | |
| 64583 | \$3,705.30 | 90 | 93 | | | |
| 64590 | \$17,618.93 | 90 | 93 | | | |
| 64628 | \$7,443.93 | 90 | 93 | | | |
| 64716 | \$971.56 | 90 | 93 | | | |
| 64802 | \$542.13 | 90 | 93 | | | |
| 64858 | \$1,432.98 | 90 | 93 | | | |
| 64865 | \$2,715.52 | 90 | 93 | | | |
| 64886 | \$2,091.47 | 90 | 93 | | | |
| 64891 | \$3,968.55 | 90 | 93 | | | |
| 64892 | \$2,874.31 | 90 | 93 | | | |
| 64893 | \$2,747.03 | 90 | 93 | | | |
| 64897 | \$2,394.23 | 90 | 93 | | | |
| 64910 | \$2,873.07 | 90 | 93 | | | |
| 64912 | \$3,255.53 | 90 | 93 | | | |
| 65770 | \$3,615.27 | 90 | 93 | | | |
| 65779 | \$1,113.32 | 90 | 93 | | | |
| 65781 | \$1,971.82 | 90 | 93 | | | |
| 66175 | \$1,549.49 | 90 | 93 | | | |
| 66179 | \$1,283.78 | 90 | 93 | | | |
| 66180 | \$1,384.07 | 90 | 93 | | | |
| 66183 | \$2,079.70 | 90 | 93 | | | |
| 66989 | \$2,318.65 | 86 | 93 | | | |
| 66991 | \$2,318.65 | 86 | 93 | | | |
| 69705 | \$2,268.29 | 90 | 93 | | | |
| 69706 | \$2,246.93 | 90 | 93 | | | |
| 69714 | \$7,978.90 | 90 | 93 | | | |
| 69716 | \$4,044.90 | 90 | 93 | | | |
| 69717 | \$3,834.50 | 90 | 93 | | | |
| 69719 | \$4,044.90 | 90 | 93 | | | |
| 69729 | \$4,044.90 | 90 | 93 | | | |
| 69730 | \$4,044.90 | 90 | 93 | | | |
| 69930 | \$26,636.29 | 90 | 93 | | | |

| October 2023 IOCE Quarterly Data Files: Device Intensive List with Offset Amounts (Offset_HCPCS) | | | | | | |
|--|-------------|---------|---------|---------|---------|-----|
| HCPCS | OFFSET | LO_ | HI_ | VERSION | VERSION | HL_ |
| | AMOUNT | VERSION | VERSION | | | |
| 75741 | \$1,053.36 | 90 | 93 | | | |
| 75831 | \$912.76 | 90 | 93 | | | |
| 75870 | \$940.16 | 90 | 93 | | | |
| 75898 | \$1,860.37 | 90 | 93 | | | |
| 92920 | \$1,609.99 | 90 | 93 | | | |
| 92924 | \$5,485.99 | 90 | 93 | | | |
| 92928 | \$3,703.68 | 90 | 93 | | | |
| 92933 | \$8,831.00 | 90 | 93 | | | |
| 92937 | \$3,509.42 | 90 | 93 | | | |
| 92943 | \$4,536.98 | 90 | 93 | | | |
| 92986 | \$1,709.61 | 90 | 93 | | | |
| 92987 | \$3,658.04 | 90 | 93 | | | |
| 93580 | \$11,675.61 | 90 | 93 | | | |
| 93581 | \$9,777.49 | 90 | 93 | | | |
| 93582 | \$11,100.17 | 90 | 93 | | | |
| 93590 | \$7,252.38 | 90 | 93 | | | |
| 93591 | \$6,317.92 | 90 | 93 | | | |
| 93600 | \$2,758.41 | 90 | 93 | | | |
| 93602 | \$2,122.84 | 90 | 93 | | | |
| 93603 | \$474.64 | 90 | 93 | | | |
| 93619 | \$2,176.02 | 90 | 93 | | | |
| 93650 | \$3,247.88 | 90 | 93 | | | |
| 93653 | \$9,218.75 | 90 | 93 | | | |
| 93654 | \$10,780.26 | 90 | 93 | | | |
| 93656 | \$11,144.22 | 90 | 93 | | | |
| 95938 | \$166.40 | 90 | 93 | | | |
| 95961 | \$339.55 | 90 | 93 | | | |
| C9600 | \$3,969.06 | 90 | 93 | | | |
| C9602 | \$9,562.77 | 90 | 93 | | | |
| C9604 | \$4,097.51 | 90 | 93 | | | |
| C9607 | \$8,853.34 | 90 | 93 | | | |
| C9728 | \$512.81 | 90 | 93 | | | |
| C9739 | \$2,968.02 | 90 | 93 | | | |
| C9740 | \$6,273.53 | 90 | 93 | | | |
| C9764 | \$5,611.25 | 90 | 93 | | | |
| C9765 | \$9,026.83 | 90 | 93 | | | |
| C9766 | \$9,938.96 | 90 | 93 | | | |
| C9767 | \$10,048.90 | 90 | 93 | | | |
| C9769 | \$6,164.84 | 90 | 93 | | | |
| C9771 | \$1,992.76 | 90 | 93 | | | |
| C9772 | \$4,581.57 | 90 | 93 | | | |
| C9773 | \$8,193.72 | 90 | 93 | | | |
| C9774 | \$9,293.08 | 90 | 93 | | | |
| C9775 | \$9,143.64 | 90 | 93 | | | |
| C9777 | \$1,010.81 | 90 | 93 | | | |
| C9778 | \$1,436.88 | 90 | 93 | | | |
| C9780 | \$2,557.66 | 85 | 93 | | | |
| C9781 | \$4,044.90 | 90 | 93 | | | |
| C9782 | \$5,425.16 | 90 | 93 | | | |
| C9783 | \$3,290.75 | 90 | 93 | | | |

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

| HCPCS | DESCRIPTION | BYPASS_E92_ | | |
|-------|------------------------------|-------------|------------|------------|
| | | MODIFIER | LO_VERSION | HI_VERSION |
| 0200T | Perq sacral augmt unilat inj | 1 | 78 | 93 |
| 0627T | Perq njx algc fluor Imbr 1st | 1 | 90 | 93 |
| 0629T | Perq njx algc ct Imbr 1st | 1 | 90 | 93 |
| 10035 | Perq dev soft tiss 1st imag | 1 | 90 | 93 |
| 19281 | Perq device breast 1st imag | 1 | 90 | 93 |
| 19283 | Perq dev breast 1st strtctc | 1 | 82 | 93 |
| 19285 | Perq dev breast 1st us imag | 1 | 82 | 93 |
| 19287 | Perq dev breast 1st mr guide | 1 | 90 | 93 |
| 20900 | Removal of bone for graft | 1 | 86 | 93 |
| 21122 | Reconstruction of chin | 1 | 90 | 93 |
| 21150 | Lefort ii anterior intrusion | 1 | 90 | 93 |
| 21195 | Reconst lwr jaw w/o fixation | 1 | 86 | 93 |
| 21256 | Reconstruction of orbit | 1 | 86 | 93 |
| 21267 | Revise eye sockets | 1 | 86 | 93 |
| 21346 | Opn tx nasomax fx w/fixj | 1 | 90 | 93 |
| 21347 | Opn tx nasomax fx multiple | 1 | 90 | 93 |
| 21422 | Treat mouth roof fracture | 1 | 90 | 93 |
| 21450 | Treat lower jaw fracture | 1 | 86 | 93 |
| 21452 | Treat lower jaw fracture | 1 | 86 | 93 |
| 21453 | Treat lower jaw fracture | 1 | 90 | 93 |
| 21461 | Treat lower jaw fracture | 1 | 74 | 93 |
| 21742 | Repair stern/nuss w/o scope | 1 | 90 | 93 |
| 22551 | Arthrd ant ntrbdy cervical | 1 | 86 | 93 |
| 22612 | Arthrd pst tq 1ntrspc lumbar | 1 | 90 | 93 |
| 22630 | Arthrd pst tq 1ntrspc lum | 1 | 86 | 93 |
| 22633 | Arthrd cmbn 1ntrspc lumbar | 1 | 90 | 93 |
| 22899 | Unlisted procedure spine | 1 | 90 | 93 |
| 23395 | Muscle transfer shoulder/arm | 1 | 90 | 93 |
| 23473 | Revis reconst shoulder joint | 1 | 74 | 93 |
| 23485 | Revision of collar bone | 1 | 86 | 93 |
| 23515 | Optx clavicular fx w/int fix | 1 | 90 | 93 |
| 23552 | Optx acrcvl dscl aq/chrn grf | 1 | 90 | 93 |
| 23585 | Optx scapular fx w/int fixj | 1 | 90 | 93 |
| 23615 | Optx prox humrl fx w/int fix | 1 | 90 | 93 |
| 23616 | Optx prx hmrl fx fix rpr rpl | 1 | 90 | 93 |
| 23630 | Optx gr hmrl tbrs fx int fix | 1 | 90 | 93 |
| 23680 | Optx sho dislc neck fx fixj | 1 | 90 | 93 |
| 24126 | Exc/crtg b1 cst/tum rds algr | 1 | 90 | 93 |
| 24340 | Tenodesis biceps tdn at elbw | 1 | 90 | 93 |
| 24344 | Reconstruct elbow lat ligmnt | 1 | 86 | 93 |
| 24370 | Revise reconst elbow joint | 1 | 74 | 93 |
| 24371 | Revise reconst elbow joint | 1 | 74 | 93 |
| 24400 | Revision of humerus | 1 | 90 | 93 |
| 24420 | Revision of humerus | 1 | 86 | 93 |

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

| | | | | |
|-------|------------------------------|---|----|----|
| 24430 | Repair of humerus | 1 | 86 | 93 |
| 24435 | Repair humerus with graft | 1 | 86 | 93 |
| 24545 | Treat humerus fracture | 1 | 74 | 93 |
| 24546 | Treat humerus fracture | 1 | 90 | 93 |
| 24575 | Treat humerus fracture | 1 | 78 | 93 |
| 24579 | Treat humerus fracture | 1 | 74 | 93 |
| 24586 | Treat elbow fracture | 1 | 86 | 93 |
| 24615 | Treat elbow dislocation | 1 | 86 | 93 |
| 24635 | Treat elbow fracture | 1 | 74 | 93 |
| 24666 | Treat radius fracture | 1 | 74 | 93 |
| 24685 | Treat ulnar fracture | 1 | 74 | 93 |
| 25126 | Remove/graft forearm lesion | 1 | 90 | 93 |
| 25332 | Revise wrist joint | 1 | 90 | 93 |
| 25350 | Revision of radius | 1 | 86 | 93 |
| 25390 | Shorten radius or ulna | 1 | 86 | 93 |
| 25391 | Lengthen radius or ulna | 1 | 86 | 93 |
| 25400 | Repair radius or ulna | 1 | 86 | 93 |
| 25405 | Repair/graft radius or ulna | 1 | 86 | 93 |
| 25415 | Repair radius & ulna | 1 | 86 | 93 |
| 25420 | Repair/graft radius & ulna | 1 | 86 | 93 |
| 25426 | Repair/graft radius & ulna | 1 | 86 | 93 |
| 25515 | Treat fracture of radius | 1 | 74 | 93 |
| 25526 | Treat fracture of radius | 1 | 74 | 93 |
| 25545 | Treat fracture of ulna | 1 | 78 | 93 |
| 25574 | Treat fracture radius & ulna | 1 | 74 | 93 |
| 25575 | Treat fracture radius/ulna | 1 | 74 | 93 |
| 25652 | Treat fracture ulnar styloid | 1 | 86 | 93 |
| 25800 | Fusion of wrist joint | 1 | 86 | 93 |
| 25805 | Fusion/graft of wrist joint | 1 | 86 | 93 |
| 25810 | Fusion/graft of wrist joint | 1 | 86 | 93 |
| 25820 | Fusion of hand bones | 1 | 86 | 93 |
| 25825 | Fuse hand bones with graft | 1 | 86 | 93 |
| 26541 | Repair hand joint with graft | 1 | 90 | 93 |
| 26568 | Lengthen metacarpal/finger | 1 | 86 | 93 |
| 26820 | Thumb fusion with graft | 1 | 86 | 93 |
| 26843 | Fusion of hand joint | 1 | 86 | 93 |
| 26844 | Fusion/graft of hand joint | 1 | 86 | 93 |
| 27396 | Transplant of thigh tendon | 1 | 90 | 93 |
| 27430 | Revision of thigh muscles | 1 | 90 | 93 |
| 27637 | Remove/graft leg bone lesion | 1 | 86 | 93 |
| 27647 | Resect talus/calcaneus tum | 1 | 90 | 93 |
| 27654 | Repair of achilles tendon | 1 | 82 | 93 |
| 27656 | Repair leg fascia defect | 1 | 86 | 93 |
| 27695 | Repair of ankle ligament | 1 | 90 | 93 |
| 27696 | Repair of ankle ligaments | 1 | 82 | 93 |
| 27698 | Repair of ankle ligament | 1 | 90 | 93 |

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

| | | | | |
|-------|------------------------------|---|----|----|
| 27700 | Revision of ankle joint | 1 | 82 | 93 |
| 27705 | Incision of tibia | 1 | 78 | 93 |
| 27792 | Treatment of ankle fracture | 1 | 74 | 93 |
| 27814 | Treatment of ankle fracture | 1 | 74 | 93 |
| 27822 | Treatment of ankle fracture | 1 | 74 | 93 |
| 27823 | Treatment of ankle fracture | 1 | 74 | 93 |
| 27826 | Treat lower leg fracture | 1 | 78 | 93 |
| 27827 | Treat lower leg fracture | 1 | 74 | 93 |
| 27828 | Treat lower leg fracture | 1 | 74 | 93 |
| 27829 | Treat lower leg joint | 1 | 86 | 93 |
| 27832 | Treat lower leg dislocation | 1 | 86 | 93 |
| 28202 | Repair/graft of foot tendon | 1 | 90 | 93 |
| 28210 | Repair/graft of foot tendon | 1 | 86 | 93 |
| 28261 | Revision of foot tendon | 1 | 90 | 93 |
| 28299 | Correction hallux valgus | 1 | 86 | 93 |
| 28300 | Incision of heel bone | 1 | 74 | 93 |
| 28302 | Incision of ankle bone | 1 | 78 | 93 |
| 28310 | Revision of big toe | 1 | 90 | 93 |
| 28415 | Treat heel fracture | 1 | 74 | 93 |
| 28420 | Treat/graft heel fracture | 1 | 74 | 93 |
| 28445 | Treat ankle fracture | 1 | 74 | 93 |
| 28485 | Treat metatarsal fracture | 1 | 74 | 93 |
| 28555 | Repair foot dislocation | 1 | 74 | 93 |
| 28585 | Repair foot dislocation | 1 | 74 | 93 |
| 28615 | Repair foot dislocation | 1 | 74 | 93 |
| 29855 | Tibial arthroscopy/surgery | 1 | 74 | 93 |
| 29856 | Tibial arthroscopy/surgery | 1 | 74 | 93 |
| 29885 | Knee arthroscopy/surgery | 1 | 86 | 93 |
| 30469 | Rpr nsl vlv collapse w/rmdlg | 1 | 90 | 93 |
| 33220 | Repair lead pace-defib dual | 1 | 78 | 93 |
| 33226 | Reposition l ventric lead | 1 | 90 | 93 |
| 33233 | Removal of pm generator | 1 | 78 | 93 |
| 33235 | Removal pacemaker electrode | 1 | 78 | 93 |
| 35881 | Revise graft w/vein | 1 | 90 | 93 |
| 36904 | Thrmhc/nfs dialysis circuit | 1 | 90 | 93 |
| 37192 | Redo endovas vena cava filtr | 1 | 74 | 93 |
| 37241 | Vasc embolize/occlude venous | 1 | 86 | 93 |
| 43210 | Egd esophagogastrc fndoplsty | 1 | 90 | 93 |
| 43497 | Transorl lwr esophgl myotomy | 1 | 86 | 93 |
| 44390 | Colonoscopy for foreign body | 1 | 90 | 93 |
| 45327 | Proctosigmoidoscopy w/stent | 1 | 78 | 93 |
| 57288 | Repair bladder defect | 1 | 74 | 93 |
| 59072 | Umbilical cord occlud w/us | 1 | 78 | 93 |
| 61888 | Revise/remove neuroreceiver | 1 | 82 | 93 |
| 62350 | Implant spinal canal cath | 1 | 74 | 93 |
| 63663 | Revise spine eltrd perq aray | 1 | 74 | 93 |

Procedures that Bypass Edit 92 when Reported with Modifier -CG

(DATA_HCPCS, Column DC "BYPASS_E92_MODIFIER")

| | | | | |
|-------|------------------------------|---|----|----|
| 63664 | Revise spine eltrd plate | 1 | 74 | 93 |
| 64448 | Njx aa&/strd fem nrv nfs img | 1 | 90 | 93 |
| 64569 | Revise/repl vagus n eltrd | 1 | 82 | 93 |
| 64583 | Rev/rplct hpglsl nstm ary pg | 1 | 90 | 93 |
| 64865 | Repair of facial nerve | 1 | 90 | 93 |
| 64886 | Nerve graft head/neck >4 cm | 1 | 82 | 93 |
| 64891 | Nerve graft hand/foot >4 cm | 1 | 74 | 93 |
| 64892 | Nerve graft arm/leg <4 cm | 1 | 90 | 93 |
| 64893 | Nerve graft arm/leg >4 cm | 1 | 90 | 93 |
| 64897 | Nerve graft arm/leg </4 cm | 1 | 90 | 93 |
| 64910 | Nerve repair w/allograft | 1 | 78 | 93 |
| 64912 | Nrv rpr w/nrv algrft 1st | 1 | 78 | 93 |
| 65779 | Cover eye w/membrane suture | 1 | 78 | 93 |
| 66175 | Trluml dil aq o/f can w/st | 1 | 90 | 93 |
| 69719 | Rplcm oi implt sk tc esp<100 | 1 | 90 | 93 |
| 93602 | Intra-atrial recording | 1 | 90 | 93 |
| 93619 | Electrophysiology evaluation | 1 | 90 | 93 |
| 95938 | Somatosensory testing | 1 | 90 | 93 |
| C9782 | Blind myocar trpl bon marrow | 1 | 87 | 93 |
| C9783 | Blind cor sinus reducer impl | 1 | 87 | 93 |

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 |

(Editorial note: C1824, C1982, C1839, C1734, and C2596 were extended through 12/31/23 by the Consolidated Appropriations Act of 2023)

| CODE1 | | CODE2 | | AMOUNT | LO_VERS | HI_VERS |
|--------------|------------------------------|--------------|-------------------------------|---------------|----------------|----------------|
| C1052 | Hemostatic agent, gi, topic | 43227 | Esophagoscopy control bleed | \$0.00 | 82 | 93 |
| C1052 | Hemostatic agent, gi, topic | 43255 | Egd control bleeding any | \$45.28 | 90 | 93 |
| C1052 | Hemostatic agent, gi, topic | 44366 | Small bowel endoscopy | \$32.39 | 90 | 93 |
| C1052 | Hemostatic agent, gi, topic | 44378 | Small bowel endoscopy | \$63.22 | 90 | 93 |
| C1052 | Hemostatic agent, gi, topic | 44391 | Colonoscopy for bleeding | \$0.00 | 82 | 93 |
| C1052 | Hemostatic agent, gi, topic | 45334 | Sigmoidoscopy for bleeding | \$26.10 | 90 | 93 |
| C1052 | Hemostatic agent, gi, topic | 45382 | Colonoscopy w/ control bleed | \$32.16 | 90 | 93 |
| C1062 | Intravertebral fx aug impl | 22513 | Perq vertebral augmentation | \$1,320.28 | 90 | 93 |
| C1062 | Intravertebral fx aug impl | 22514 | Perq vertebral augmentation | \$1,320.28 | 90 | 93 |
| C1062 | Intravertebral fx aug impl | 22515 | Perq vertebral augmentation | \$0.00 | 82 | 93 |
| C1734 | Orth/devic/drug bn/bn,tis/bn | 27870 | Fusion of ankle joint open | \$0.00 | 78 | 93 |
| C1734 | Orth/devic/drug bn/bn,tis/bn | 28705 | Fusion of foot bones | \$0.00 | 78 | 93 |
| C1734 | Orth/devic/drug bn/bn,tis/bn | 28715 | Fusion of foot bones | \$0.00 | 78 | 93 |
| C1734 | Orth/devic/drug bn/bn,tis/bn | 28725 | Fusion of foot bones | \$0.00 | 78 | 93 |
| C1747 | Endo, single, urinary tract | 50080 | Perq nl/pl lithotrp smpl<2cm | \$1,050.86 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 50081 | Perq nl/pl lithotrp cplx>2cm | \$1,026.05 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 50575 | Kidney endoscopy | \$570.84 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 50951 | Endoscopy of ureter | \$169.87 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 50953 | Endoscopy of ureter | \$442.95 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 50955 | Ureter endoscopy & biopsy | \$423.20 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 50957 | Ureter endoscopy & treatment | \$416.14 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 50961 | Ureter endoscopy & treatment | \$461.75 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 50970 | Ureter endoscopy | \$312.82 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 50972 | Ureter endoscopy & catheter | \$760.57 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 50974 | Ureter endoscopy & biopsy | \$1,069.75 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 50976 | Ureter endoscopy & treatment | \$2,043.10 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 50980 | Ureter endoscopy & treatment | \$405.33 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 52344 | Cysto/uretero stricture tx | \$507.69 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 52345 | Cysto/uretero w/up stricture | \$511.54 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 52346 | Cystouretero w/renal strict | \$602.82 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 52351 | Cystouretero & or pyeloscope | \$169.55 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 52352 | Cystouretero w/stone remove | \$320.51 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 52353 | Cystouretero w/ lithotripsy | \$252.04 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 52354 | Cystouretero w/ biopsy | \$428.37 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 52355 | Cystouretero w/excise tumor | \$371.94 | 90 | 93 |
| C1747 | Endo, single, urinary tract | 52356 | Cysto/uretero w/ lithotripsy | \$474.45 | 90 | 93 |
| C1747 | Endo, single, urinary tract | C9761 | Cysto, litho, vacuum kidney | \$789.86 | 90 | 93 |
| C1761 | Cath, trans intra litho/coro | 92928 | Prq card stent w/angio 1 vsl | \$0.00 | 84 | 93 |
| C1761 | Cath, trans intra litho/coro | 92933 | Prq card stent/ath/andio | \$8,831.00 | 90 | 93 |
| C1761 | Cath, trans intra litho/coro | 92943 | Prq card revasc chronic 1 vsl | \$4,536.98 | 90 | 93 |
| C1761 | Cath, trans intra litho/coro | C9600 | Perc drug-el cor stent sing | \$0.00 | 84 | 93 |
| C1761 | Cath, trans intra litho/coro | C9602 | Perc d-e cor stent ather s | \$9,562.77 | 90 | 93 |
| C1761 | Cath, trans intra litho/coro | C9607 | Perc d-e cor revasc chro sin | \$8,853.34 | 90 | 93 |
| C1824 | Generator, ccm, implant | 0408T | Insj/rplc cardiac modulj sys | \$12,314.74 | 86 | 93 |
| C1825 | Gen, neuro, carot sinus baro | 0266T | Implt/rpl crtd sns dev total | \$5,487.10 | 90 | 93 |
| C1826 | Gen, neuro, carot sinus baro | 63685 | Insrt/redo spine n generator | \$24,024.04 | 90 | 93 |
| C1827 | Gen, neuro, imp led, ex cntr | 64568 | Opn impltj crnl nrv nea&pg | \$24,094.50 | 90 | 93 |
| C1831 | Personalized Interbody cage | 22630 | Arthrd pst tq 1ntrspc lum | \$0.00 | 85 | 93 |
| C1831 | Personalized Interbody cage | 22633 | Arthrd cmbn 1ntrspc lumbar | \$0.00 | 85 | 93 |
| C1832 | Auto cell process sys | 15100 | skin splt grft trnk/arm/leg | \$9.66 | 90 | 93 |

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

6 - 34

| | | | | | | |
|-------|-----------------------------|-------|------------------------------|------------|----|----|
| C1832 | Auto cell process sys | 15110 | Epidrm autogrft trnk/arm/leg | \$0.00 | 90 | 93 |
| C1832 | Auto cell process sys | 15115 | Epidrm a-grft face/nck/hf/g | \$0.00 | 90 | 93 |
| C1832 | Auto cell process sys | 15120 | Skn splt a-grft fac/nck/hf/g | \$62.13 | 90 | 93 |
| C1833 | Cardiac monitor sys | 0525T | Insj/rplcmt compl iims | \$8,246.49 | 90 | 93 |
| C1833 | Cardiac monitor sys | 0526T | Insj/rplcmt iims eltrd only | \$2,530.46 | 90 | 93 |
| C1833 | Cardiac monitor sys | 0527T | Insj/rplcmt iims implt mntr | \$6,270.64 | 90 | 93 |
| C1833 | Cardiac monitor sys | 0528T | Prgrmg dev eval iims ip | \$0.00 | 86 | 93 |
| C1839 | Iris prosthesis | 0616T | Insertion of iris prosthesis | \$657.47 | 86 | 93 |
| C1839 | Iris prosthesis | 0617T | Insj iris prosth w/rmvl&insj | \$1,239.87 | 86 | 93 |
| C1839 | Iris prosthesis | 0618T | Insj iris prosth sec io lens | \$1,239.87 | 86 | 93 |
| C1982 | Cath, pressure, valve-occlu | 37242 | Vasc embolize/occlude artery | \$4,089.03 | 86 | 93 |
| C1982 | Cath, pressure, valve-occlu | 37243 | Vasc embolize/occlude organ | \$2,234.30 | 86 | 93 |
| C2596 | Probe, robotic, water-jet | 0421T | Waterjet prostate abltj cmpl | \$0.00 | 78 | 93 |

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 |