



Medicare Hospital Version

KEY CONCEPTS OUTLINE

Module 8: 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 8.2, 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 6.6.2 (Supplement)>
 - b. Billing

- i. The HCPCS code for the inpatient-only procedure should be reported with the -CA modifier. <IOCE Specifications, Section 6.6.2 (Supplement)>
- ii. The patient discharge status code (UB-04, FL 17) must reflect the patient expired or was transferred. <IOCE Specifications, Section 6.6.2 (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 code. <IOCE Specifications, Section 6.6.2, 6.6.2.1 and Section 8.2, 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” (\$8,237.41). <68 Fed. Reg. 63467; 80 Fed. Reg. 70339; CY2024 OPSS Addendum A>
- ii. Limitations <IOCE Specifications, Section 6.6.2 (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 6.6.2 (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.

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 6.6.2 and Section 8.2, 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 6.6.2 and Section 8.2, Edit 45 (Supplement)>
 - ii. The “separate-procedure list” is available in the IOCE Quarterly Data Files, Report-Table folder, Data_HCPCS, column AU “SEPARATE_PROCEDURE” available on the OCE homepage. The list is included in the materials behind the outline.

Link: OCE Quarterly Files – Specifications and Report Tables 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), are applied first. <See IOCE Specifications, Section 6.3.1 (Supplement)>

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 6.3.1 (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 6.3.1 (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 6.3.1 (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 6.3.1 (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-Table folder, “Offset_HCPCS” available on the IOCE homepage. The list is included in the materials behind the outline.

Link: OCE Quarterly Files – Specifications and Report Tables
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 8.2, 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 6.3.1 (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 8.2, 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 6.3.2 (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 6.3.1 (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 6.3.1 (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 6.6.1 (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 6.8 and Section 8.2, 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-Table 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-Table folder, “Offset_HCPCS” available on the IOCE homepage. The list is included in the materials behind the outline.
- 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 6.3.1>
 - 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 6.3.1 and Section 8.2, edit 92>
 - a) The list of procedures that bypass edit 92 when reported with modifier -CG is available in the IOCE Quarterly Data Files, Report-Table 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>

- b. Table 84 of the OPPS Final Rule has a list of devices expiring in 2024 and 2025, including in the materials behind the outline.

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-Table folder, “Offset_Codepair” available on the IOCE homepage. The list is included in the materials behind the outline.

Link: OCE Quarterly Files – Specifications and Report Tables 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 6.8.2 and Section 8.2, 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-Table 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>
- 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 made for the non-pass-through supplies. <Medicare Claims Processing Manual, Chapter 4 § 60.4>

Example Contrasting Payment using Implantable Devices Charged to Patients CCR versus the hospital wide outpatient CCR				
Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent insert at previous session (includes tracheal/bronchial dilation as required) (31638) using a disposable single-use pulmonary endoscope (C1601)				
Item HCPCS	Total Charge	Procedure Payment Amount	Payment with Implantable Device CCR .45	Payment with Overall CCR .30
31638	\$13,000	\$6,521	N/A	N/A
C1601	\$3400	N/A	\$1530	\$1,020
Offset applicable for 31368			-\$908	-\$908
Pass-through payment			\$622	\$112
Procedure Payment			+\$6,521	+\$6,521
Total Payment			\$7,143	\$6,633

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 FY2024 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 – FY2024 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 6.6.2>

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 (\$8,237.41) 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 6.6.2>

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 \$1,124.36. CPT code 45380 has status indicator T and payment rate \$1,124.36. 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 (\$1,124.36) and 50% for the other procedure (\$562.18) for a total of \$1,686.54. <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 \$2,248.72. <42 C.F.R. 419.44(a)>

Version 3.1/2024
Check for updates

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)>

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

HCPCS	DESCRIPTION	STATUS_ INDICATOR	SEPARATE_ PROCEDURE	LO_ VERS	HI_ VERS
21750	Repair of sternum separation	C	1	86	94
21825	Treat sternum fracture	C	1	86	94
22010	I&d p-spine c/t/cerv-thor	C	1	86	94
22015	I&d abscess p-spine l/s/l	C	1	86	94
22110	Remove part of neck vertebra	C	1	86	94
22112	Remove part thorax vertebra	C	1	86	94
22114	Remove part lumbar vertebra	C	1	86	94
22116	Remove extra spine segment	C	1	86	94
22206	Incis spine 3 column thorac	C	1	86	94
22207	Incis spine 3 column lumbar	C	1	86	94
22208	Incis spine 3 column adl seg	C	1	86	94
22210	Incis 1 vertebral seg cerv	C	1	86	94
27005	Incision of hip tendon	C	1	86	94
27090	Removal of hip prosthesis	C	1	86	94
27140	Transplant femur ridge	C	1	86	94
27161	Incision of neck of femur	C	1	86	94
31725	Clearance of airways	C	1	67	94
32220	Release of lung	C	1	67	94
32225	Partial release of lung	C	1	67	94
32310	Removal of chest lining	C	1	67	94
33140	Heart revascularize (tmr)	C	1	67	94
33496	Repair prosth valve clot	C	1	67	94
33800	Aortic suspension	C	1	89	94
38100	Removal of spleen total	C	1	67	94
38101	Removal of spleen partial	C	1	67	94
38562	Removal pelvic lymph nodes	C	1	86	94
38564	Removal abdomen lymph nodes	C	1	67	94
38765	Remove groin lymph nodes	C	1	67	94
38770	Remove pelvis lymph nodes	C	1	67	94
38780	Remove abdomen lymph nodes	C	1	67	94
43848	Revision gastroplasty	C	1	67	94
44005	Freeing of bowel adhesion	C	1	67	94
44130	Bowel to bowel fusion	C	1	67	94
44300	Open bowel to skin	C	1	86	94
44314	Revision of ileostomy	C	1	86	94
44316	Devise bowel pouch	C	1	67	94
44322	Colostomy with biopsies	C	1	67	94
44345	Revision of colostomy	C	1	86	94
44346	Revision of colostomy	C	1	86	94
44680	Surgical revision intestine	C	1	67	94
44820	Excision of mesentery lesion	C	1	67	94
44850	Repair of mesentery	C	1	67	94
47460	Incise bile duct sphincter	C	1	67	94
47480	Incision of gallbladder	C	1	67	94
47900	Suture bile duct injury	C	1	67	94

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

49000	Exploration of abdomen	C	1	67	94
49010	Exploration behind abdomen	C	1	86	94
49255	Removal of omentum	C	1	86	94
50100	Trnsxj/repos abrrnt rnl vsls	C	1	90	94
50340	Removal of kidney	C	1	67	94
50600	Exploration of ureter	C	1	67	94
50650	Removal of ureter	C	1	67	94
50900	Repair of ureter	C	1	67	94
51525	Removal of bladder lesion	C	1	67	94
51570	Removal of bladder	C	1	67	94
57270	Repair of bowel pouch	C	1	67	94
58400	Suspension of uterus	C	1	67	94
58605	Division of fallopian tube	C	1	67	94
58700	Removal of fallopian tube	C	1	67	94
58720	Removal of ovary/tube(s)	C	1	67	94
60521	Removal of thymus gland	C	1	67	94
60522	Removal of thymus gland	C	1	67	94
60540	Explore adrenal gland	C	1	67	94
60545	Explore adrenal gland	C	1	67	94
61210	Pierce skull implant device	C	1	67	94
61535	Remove brain electrodes	C	1	67	94

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	OFFSET		
HCPCS	AMOUNT	LO_VERSION	HI_VERSION
0200T	\$2,091.25	94	94
0221T	\$2,879.90	94	94
0234T	\$4,956.85	94	94
0237T	\$5,077.39	94	94
0238T	\$8,565.84	94	94
0253T	\$1,905.57	94	94
0266T	\$39,708.44	94	94
0268T	\$25,748.95	94	94
0275T	\$3,919.39	94	94
0308T	\$6,438.59	94	94
0335T	\$2,661.78	94	94
0339T	\$3,362.26	94	94
0408T	\$25,054.84	94	94
0409T	\$20,291.39	94	94
0414T	\$14,362.31	94	94
0421T	\$3,754.98	94	94
0441T	\$737.32	94	94
0442T	\$2,866.29	94	94
0449T	\$2,674.65	94	94
0505T	\$4,947.41	94	94
0511T	\$3,340.68	94	94
0515T	\$15,496.47	94	94
0516T	\$6,280.51	94	94
0517T	\$7,549.23	94	94
0519T	\$4,428.81	94	94
0520T	\$3,153.99	94	94
0524T	\$1,182.92	94	94
0526T	\$2,509.33	94	94
0527T	\$6,218.28	94	94
0571T	\$21,587.98	94	94
0572T	\$4,056.21	94	94
0583T	\$450.45	94	94
0587T	\$4,745.81	94	94
0594T	\$4,731.90	94	94
0600T	\$5,288.34	94	94
0601T	\$5,007.84	94	94
0614T	\$15,703.09	94	94
0616T	\$11,728.31	94	94
0617T	\$12,148.18	94	94
0618T	\$8,399.09	94	94
0619T	\$4,678.36	94	94
0620T	\$21,172.63	94	94

	OFFSET		
HCPCS	AMOUNT	LO_VERSION	HI_VERSION
0627T	\$9,062.53	94	94
0629T	\$9,062.53	94	94
0651T	\$387.88	94	94
0652T	\$562.03	94	94
0671T	\$2,926.13	94	94
0707T	\$1,532.15	94	94
0744T	\$1,623.14	94	94
0784T	\$4,023.47	94	94
0786T	\$4,023.47	94	94
0816T	\$6,461.28	94	94
0817T	\$6,461.28	94	94
10035	\$270.62	94	94
19105	\$1,776.31	94	94
19281	\$780.56	94	94
19283	\$342.89	94	94
19285	\$358.17	94	94
19287	\$206.74	94	94
19296	\$3,684.26	94	94
19298	\$2,157.24	94	94
20690	\$2,385.03	94	94
20692	\$4,852.91	94	94
20696	\$6,862.80	94	94
20900	\$2,153.28	94	94
20983	\$2,710.85	94	94
21121	\$1,915.12	94	94
21125	\$2,319.49	94	94
21141	\$1,734.73	94	94
21150	\$1,883.15	94	94
21195	\$2,818.87	94	94
21196	\$2,166.60	94	94
21215	\$2,120.29	94	94
21243	\$8,087.99	94	94
21244	\$2,480.18	94	94
21245	\$1,736.96	94	94
21246	\$2,073.98	94	94
21256	\$2,683.84	94	94
21346	\$2,318.37	94	94
21347	\$2,374.72	94	94
21365	\$1,758.72	94	94
21395	\$1,842.42	94	94
21422	\$2,159.35	94	94
21452	\$2,020.97	94	94

	OFFSET		
HCPCS	AMOUNT	LO_VERSION	HI_VERSION
21461	\$1,768.77	94	94
21462	\$2,078.44	94	94
21470	\$2,145.40	94	94
21742	\$2,065.68	94	94
21743	\$1,086.50	94	94
21812	\$6,012.00	94	94
21813	\$808.54	94	94
22551	\$5,364.53	94	94
22554	\$5,084.90	94	94
22612	\$8,539.00	94	94
22630	\$10,113.98	94	94
22633	\$10,502.84	94	94
22856	\$8,931.41	94	94
22867	\$10,160.14	94	94
22869	\$9,175.39	94	94
22899	\$72.64	94	94
23195	\$2,129.42	94	94
23460	\$3,129.38	94	94
23470	\$6,287.47	94	94
23472	\$10,513.49	94	94
23473	\$5,823.49	94	94
23485	\$4,832.85	94	94
23491	\$5,005.90	94	94
23515	\$2,513.18	94	94
23550	\$2,147.83	94	94
23552	\$2,428.66	94	94
23585	\$2,438.88	94	94
23615	\$5,176.44	94	94
23616	\$8,901.22	94	94
23680	\$4,811.53	94	94
24116	\$3,215.94	94	94
24126	\$3,406.80	94	94
24360	\$2,151.23	94	94
24361	\$10,394.53	94	94
24362	\$7,837.39	94	94
24363	\$10,176.12	94	94
24365	\$6,988.44	94	94
24366	\$6,570.87	94	94
24370	\$5,257.95	94	94
24371	\$7,970.79	94	94
24430	\$4,946.96	94	94
24435	\$4,824.07	94	94

	OFFSET		
HCPCS	AMOUNT	LO_VERSION	HI_VERSION
24498	\$4,623.43	94	94
24515	\$4,338.78	94	94
24516	\$4,598.35	94	94
24545	\$5,308.11	94	94
24546	\$5,452.31	94	94
24575	\$4,087.98	94	94
24579	\$4,136.89	94	94
24586	\$5,096.18	94	94
24587	\$5,640.41	94	94
24615	\$2,866.95	94	94
24635	\$2,334.59	94	94
24666	\$6,582.15	94	94
24685	\$2,152.60	94	94
25350	\$2,816.51	94	94
25390	\$2,358.45	94	94
25391	\$5,334.44	94	94
25400	\$2,660.41	94	94
25405	\$2,634.51	94	94
25415	\$2,087.16	94	94
25420	\$2,460.70	94	94
25426	\$1,141.40	94	94
25431	\$2,284.83	94	94
25441	\$6,688.74	94	94
25442	\$10,712.36	94	94
25443	\$4,646.69	94	94
25444	\$7,349.59	94	94
25445	\$3,314.78	94	94
25446	\$11,427.94	94	94
25515	\$2,380.94	94	94
25525	\$2,074.89	94	94
25545	\$2,076.94	94	94
25574	\$2,753.12	94	94
25575	\$2,561.58	94	94
25607	\$2,744.94	94	94
25608	\$2,810.37	94	94
25609	\$2,824.69	94	94
25652	\$2,111.70	94	94
25800	\$3,008.73	94	94
25805	\$2,689.04	94	94
25810	\$4,978.31	94	94
25820	\$2,703.36	94	94
25825	\$2,272.56	94	94

	OFFSET		
HCPCS	AMOUNT	LO_VERSION	HI_VERSION
26390	\$2,688.36	94	94
26530	\$2,230.98	94	94
26531	\$2,928.30	94	94
26536	\$2,522.04	94	94
26541	\$954.20	94	94
26568	\$2,374.81	94	94
27110	\$2,872.40	94	94
27130	\$6,121.94	94	94
27278	\$5,504.45	94	94
27279	\$12,264.26	94	94
27357	\$3,322.28	94	94
27381	\$2,156.01	94	94
27403	\$2,796.74	94	94
27407	\$2,493.41	94	94
27412	\$5,391.72	94	94
27415	\$7,281.87	94	94
27427	\$2,681.54	94	94
27429	\$4,995.86	94	94
27438	\$4,355.08	94	94
27440	\$4,432.83	94	94
27442	\$5,316.88	94	94
27443	\$5,066.09	94	94
27446	\$5,382.09	94	94
27447	\$5,659.22	94	94
27477	\$3,136.88	94	94
27485	\$2,633.83	94	94
27509	\$2,600.43	94	94
27652	\$2,539.08	94	94
27654	\$2,291.65	94	94
27656	\$1,189.51	94	94
27665	\$2,212.58	94	94
27695	\$2,184.63	94	94
27696	\$2,447.74	94	94
27698	\$2,342.77	94	94
27700	\$3,738.08	94	94
27702	\$11,541.58	94	94
27705	\$2,391.85	94	94
27709	\$5,148.85	94	94
27720	\$2,787.88	94	94
27722	\$2,210.54	94	94
27726	\$2,739.48	94	94
27730	\$1,927.52	94	94

	OFFSET		
HCPCS	AMOUNT	LO_VERSION	HI_VERSION
27745	\$2,734.03	94	94
27756	\$2,393.90	94	94
27758	\$5,025.96	94	94
27759	\$4,518.10	94	94
27792	\$2,280.74	94	94
27814	\$2,415.71	94	94
27822	\$2,455.24	94	94
27823	\$2,368.67	94	94
27826	\$2,232.35	94	94
27827	\$4,679.86	94	94
27828	\$4,936.93	94	94
27829	\$2,788.56	94	94
27832	\$2,654.96	94	94
27848	\$2,500.23	94	94
27870	\$6,396.56	94	94
27871	\$5,280.52	94	94
28102	\$2,291.65	94	94
28103	\$2,901.71	94	94
28202	\$2,401.39	94	94
28210	\$2,335.96	94	94
28261	\$954.02	94	94
28291	\$2,946.02	94	94
28297	\$3,584.71	94	94
28298	\$2,164.87	94	94
28299	\$2,265.07	94	94
28300	\$2,521.36	94	94
28305	\$3,196.18	94	94
28310	\$2,063.98	94	94
28320	\$5,763.30	94	94
28322	\$2,816.51	94	94
28360	\$2,233.71	94	94
28415	\$2,472.28	94	94
28420	\$4,866.70	94	94
28446	\$2,899.67	94	94
28465	\$2,186.68	94	94
28485	\$2,355.04	94	94
28555	\$2,637.24	94	94
28585	\$2,723.81	94	94
28615	\$2,524.09	94	94
28705	\$9,014.86	94	94
28715	\$6,810.38	94	94
28725	\$5,888.70	94	94

	OFFSET		
HCPCS	AMOUNT	LO_VERSION	HI_VERSION
28730	\$6,855.52	94	94
28735	\$6,918.22	94	94
28737	\$6,741.41	94	94
28740	\$3,312.74	94	94
28750	\$3,123.92	94	94
28760	\$2,113.74	94	94
29855	\$3,297.74	94	94
29856	\$6,089.34	94	94
29867	\$5,917.54	94	94
29885	\$3,648.10	94	94
29888	\$2,490.01	94	94
29889	\$5,594.01	94	94
29899	\$2,667.23	94	94
29907	\$4,936.93	94	94
30468	\$2,290.47	94	94
30469	\$1,729.71	94	94
31242	\$1,729.71	94	94
31243	\$1,974.10	94	94
31636	\$2,808.68	94	94
31647	\$3,704.69	94	94
31660	\$3,220.16	94	94
31661	\$3,055.83	94	94
32994	\$3,709.29	94	94
33206	\$5,717.88	94	94
33207	\$5,539.83	94	94
33208	\$5,985.46	94	94
33211	\$3,804.47	94	94
33212	\$4,545.12	94	94
33213	\$5,994.62	94	94
33214	\$5,749.42	94	94
33216	\$2,780.50	94	94
33217	\$3,681.43	94	94
33220	\$1,367.56	94	94
33221	\$11,185.62	94	94
33224	\$5,078.94	94	94
33226	\$966.38	94	94
33227	\$4,471.46	94	94
33228	\$5,769.77	94	94
33229	\$11,432.54	94	94
33230	\$15,022.59	94	94
33231	\$21,515.88	94	94
33233	\$2,772.40	94	94

	OFFSET		
HCPCS	AMOUNT	LO_VERSION	HI_VERSION
33234	\$1,549.40	94	94
33240	\$16,792.33	94	94
33249	\$22,051.90	94	94
33262	\$15,527.91	94	94
33263	\$15,523.42	94	94
33264	\$22,638.07	94	94
33270	\$22,766.59	94	94
33271	\$4,699.73	94	94
33274	\$12,160.30	94	94
33275	\$1,370.30	94	94
33276	\$35,271.39	94	94
33279	\$1,221.22	94	94
33285	\$5,685.65	94	94
33287	\$21,609.83	94	94
33288	\$10,480.50	94	94
33289	\$21,433.97	94	94
33900	\$3,249.36	94	94
33901	\$3,249.36	94	94
33902	\$5,179.27	94	94
33903	\$3,249.36	94	94
33999	\$317.89	94	94
34421	\$1,317.15	94	94
36253	\$1,761.36	94	94
36261	\$1,709.17	94	94
36570	\$1,244.57	94	94
36835	\$1,501.19	94	94
36836	\$6,734.72	94	94
36837	\$8,590.90	94	94
36903	\$5,298.55	94	94
36906	\$8,149.83	94	94
37183	\$1,970.30	94	94
37184	\$8,036.22	94	94
37187	\$5,801.68	94	94
37188	\$1,308.65	94	94
37191	\$2,091.23	94	94
37211	\$1,938.86	94	94
37221	\$4,190.63	94	94
37224	\$2,158.19	94	94
37225	\$8,823.13	94	94
37226	\$4,998.78	94	94
37227	\$8,921.70	94	94
37228	\$3,463.19	94	94

	OFFSET		
HCPCS	AMOUNT	LO_VERSION	HI_VERSION
37229	\$7,979.41	94	94
37230	\$7,045.47	94	94
37231	\$8,245.06	94	94
37236	\$3,927.53	94	94
37238	\$4,451.62	94	94
37241	\$3,470.53	94	94
37242	\$6,875.06	94	94
41512	\$1,805.04	94	94
42215	\$2,373.05	94	94
42900	\$1,155.17	94	94
43210	\$3,241.46	94	94
43212	\$2,841.08	94	94
43229	\$1,997.08	94	94
43240	\$3,286.89	94	94
43257	\$1,434.04	94	94
43266	\$3,133.76	94	94
43276	\$1,703.99	94	94
43284	\$4,759.71	94	94
43647	\$7,888.61	94	94
43770	\$3,897.60	94	94
44370	\$4,189.93	94	94
44402	\$2,736.27	94	94
45327	\$3,581.21	94	94
45347	\$3,388.98	94	94
45389	\$3,201.64	94	94
46707	\$1,061.80	94	94
47383	\$5,101.02	94	94
47538	\$2,545.93	94	94
47540	\$2,440.93	94	94
47556	\$4,185.95	94	94
50593	\$4,548.84	94	94
51715	\$1,468.80	94	94
51992	\$1,938.45	94	94
52327	\$2,216.56	94	94
53440	\$7,616.14	94	94
53444	\$12,173.63	94	94
53445	\$13,786.15	94	94
53447	\$12,909.74	94	94
53451	\$8,290.06	94	94
53452	\$5,140.05	94	94
54400	\$8,199.55	94	94
54401	\$13,565.12	94	94

	OFFSET		
HCPCS	AMOUNT	LO_VERSION	HI_VERSION
54405	\$13,405.60	94	94
54410	\$12,642.59	94	94
54411	\$12,413.88	94	94
54416	\$12,746.37	94	94
54417	\$7,167.27	94	94
54660	\$2,579.42	94	94
55873	\$4,062.19	94	94
55874	\$2,667.17	94	94
55876	\$443.19	94	94
57288	\$1,444.48	94	94
58580	\$2,231.94	94	94
59072	\$124.22	94	94
61626	\$4,001.96	94	94
61885	\$17,981.12	94	94
61886	\$24,710.47	94	94
61888	\$5,905.42	94	94
61891	\$6,461.28	94	94
62350	\$2,921.51	94	94
62351	\$3,175.73	94	94
62360	\$12,645.73	94	94
62361	\$12,118.97	94	94
62362	\$12,321.17	94	94
63075	\$2,109.65	94	94
63610	\$881.55	94	94
63650	\$3,014.43	94	94
63655	\$14,235.66	94	94
63663	\$3,064.61	94	94
63664	\$5,509.56	94	94
63685	\$23,944.18	94	94
63741	\$3,053.53	94	94
63744	\$2,454.37	94	94
64448	\$417.98	94	94
64553	\$7,849.67	94	94
64555	\$4,540.54	94	94
64561	\$3,063.30	94	94
64568	\$25,737.11	94	94
64569	\$9,564.19	94	94
64575	\$8,819.20	94	94
64580	\$13,841.73	94	94
64581	\$4,079.19	94	94
64582	\$23,674.95	94	94
64583	\$7,061.85	94	94

	OFFSET		
HCPCS	AMOUNT	LO_VERSION	HI_VERSION
64590	\$16,834.76	94	94
64596	\$4,023.47	94	94
64628	\$6,341.39	94	94
64716	\$583.90	94	94
64858	\$1,466.55	94	94
64890	\$2,171.30	94	94
64891	\$2,687.94	94	94
64892	\$2,646.69	94	94
64893	\$2,017.07	94	94
64897	\$4,583.15	94	94
64910	\$2,799.65	94	94
64912	\$3,473.70	94	94
65770	\$5,904.78	94	94
65781	\$2,498.37	94	94
66175	\$1,809.66	94	94
66179	\$1,528.80	94	94
66180	\$1,278.77	94	94
66183	\$1,968.33	94	94
66225	\$2,640.79	94	94
66989	\$2,432.63	94	94
66991	\$2,493.39	94	94
67440	\$1,474.65	94	94
69705	\$2,355.20	94	94
69706	\$2,366.91	94	94
69714	\$7,806.04	94	94
69716	\$7,892.56	94	94
69717	\$3,941.20	94	94
69719	\$7,325.76	94	94
69729	\$3,887.34	94	94
69730	\$3,887.34	94	94
69930	\$24,723.99	94	94
75746	\$997.96	94	94
75831	\$1,247.30	94	94
75870	\$1,086.34	94	94
75898	\$1,342.97	94	94
91040	\$226.69	94	94
92920	\$1,662.61	94	94
92924	\$5,396.04	94	94
92928	\$3,701.13	94	94
92933	\$8,719.55	94	94
92937	\$3,299.67	94	94
92943	\$4,413.89	94	94

	OFFSET		
HCPCS	AMOUNT	LO_VERSION	HI_VERSION
92986	\$1,772.62	94	94
92987	\$3,884.56	94	94
92990	\$4,092.10	94	94
93580	\$11,142.11	94	94
93581	\$9,621.74	94	94
93582	\$9,060.37	94	94
93590	\$6,823.27	94	94
93591	\$5,439.90	94	94
93600	\$2,740.94	94	94
93602	\$2,323.96	94	94
93603	\$371.94	94	94
93618	\$539.31	94	94
93619	\$2,668.36	94	94
93650	\$3,493.06	94	94
93653	\$9,753.18	94	94
93654	\$10,436.58	94	94
93656	\$11,251.23	94	94
95938	\$174.45	94	94
95961	\$362.01	94	94
C9600	\$3,814.33	94	94
C9602	\$9,382.83	94	94
C9604	\$3,728.38	94	94
C9607	\$8,524.07	94	94
C9739	\$3,014.25	94	94
C9740	\$6,366.26	94	94
C9764	\$5,739.84	94	94
C9765	\$8,744.61	94	94
C9766	\$9,655.15	94	94
C9767	\$9,641.79	94	94
C9769	\$4,751.21	94	94
C9772	\$4,516.61	94	94
C9773	\$7,598.48	94	94
C9774	\$8,637.68	94	94
C9775	\$9,087.11	94	94
C9778	\$1,455.85	94	94
C9780	\$2,557.66	85	94
C9781	\$7,106.32	94	94
C9782	\$5,425.16	90	94
C9783	\$3,636.14	94	94

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	94
0441T	Abltj perc lxtr/perph nrv	1	94	94
0627T	Perq njx algc fluor lmb1 1st	1	90	94
0629T	Perq njx algc ct lmb1 1st	1	90	94
10035	Plmt sft tiss loclzj dev 1st	1	94	94
19281	Perq device breast 1st imag	1	90	94
19283	Perq dev breast 1st strtctc	1	82	94
19285	Perq dev breast 1st us imag	1	82	94
19287	Perq dev breast 1st mr guide	1	90	94
20900	Removal of bone for graft	1	86	94
21121	Reconstruction of chin	1	94	94
21125	Augmentation lower jaw bone	1	94	94
21150	Lefort ii anterior intrusion	1	90	94
21195	Reconst lwr jaw w/o fixation	1	86	94
21215	Lower jaw bone graft	1	94	94
21246	Reconstruction of jaw	1	94	94
21256	Reconstruction of orbit	1	86	94
21346	Opn tx nasomax fx w/fixj	1	90	94
21347	Opn tx nasomax fx multiple	1	90	94
21395	Opn tx orbit periorbt w/grft	1	94	94
21422	Treat mouth roof fracture	1	90	94
21452	Treat lower jaw fracture	1	86	94
21461	Treat lower jaw fracture	1	74	94
21742	Repair stern/nuss w/o scope	1	90	94
21743	Repair sternum/nuss w/scope	1	94	94
22551	Arthrd ant ntrbdy cervical	1	86	94
22612	Arthrd pst tq 1ntrspc lumbar	1	90	94
22630	Arthrd pst tq 1ntrspc lum	1	86	94
22633	Arthrd cmbn 1ntrspc lumbar	1	90	94
22899	Unlisted procedure spine	1	90	94
23195	Removal of head of humerus	1	94	94
23460	Repair shoulder capsule	1	94	94
23473	Revis reconst shoulder joint	1	74	94
23485	Revision of collar bone	1	86	94
23491	Reinforce shoulder bones	1	94	94
23515	Optx clavicular fx w/int fix	1	90	94
23550	Optx acromclv dislc aqt/chrn	1	94	94
23552	Optx acrclv dscl aq/chrn grf	1	90	94
23585	Optx scapular fx w/int fixj	1	90	94
23615	Optx prox humrl fx w/int fix	1	90	94
23616	Optx prx hmrl fx fix rpr rpl	1	90	94
23680	Optx sho dislc neck fx fixj	1	90	94
24116	Exc/crtg b1 cst/tum hum algr	1	94	94

Procedures that Bypass Edit 92 when Reported with Modifier -CG

(Data_HCPCS, Column DC "BYPASS_E92_MODIFIER")

24126	Exc/crtg b1 cst/tum rds algr	1	90	94
24370	Revise reconst elbow joint	1	74	94
24371	Revise reconst elbow joint	1	74	94
24430	Repair of humerus	1	86	94
24435	Repair humerus with graft	1	86	94
24545	Treat humerus fracture	1	74	94
24546	Treat humerus fracture	1	90	94
24575	Treat humerus fracture	1	78	94
24579	Treat humerus fracture	1	74	94
24586	Treat elbow fracture	1	86	94
24615	Treat elbow dislocation	1	86	94
24635	Treat elbow fracture	1	74	94
24666	Treat radius fracture	1	74	94
24685	Treat ulnar fracture	1	74	94
25350	Revision of radius	1	86	94
25390	Shorten radius or ulna	1	86	94
25391	Lengthen radius or ulna	1	86	94
25400	Repair radius or ulna	1	86	94
25405	Repair/graft radius or ulna	1	86	94
25415	Repair radius & ulna	1	86	94
25420	Repair/graft radius & ulna	1	86	94
25426	Repair/graft radius & ulna	1	86	94
25431	Repair nonunion carpal bone	1	94	94
25515	Treat fracture of radius	1	74	94
25525	Treat fracture of radius	1	94	94
25545	Treat fracture of ulna	1	78	94
25574	Treat fracture radius & ulna	1	74	94
25575	Treat fracture radius/ulna	1	74	94
25652	Treat fracture ulnar styloid	1	86	94
25800	Fusion of wrist joint	1	86	94
25805	Fusion/graft of wrist joint	1	86	94
25810	Fusion/graft of wrist joint	1	86	94
25820	Fusion of hand bones	1	86	94
25825	Fuse hand bones with graft	1	86	94
26530	Revise knuckle joint	1	94	94
26541	Repair hand joint with graft	1	90	94
26568	Lengthen metacarpal/finger	1	86	94
27278	Arthr d si jt prq wo txfj dev	1	94	94
27381	Repair/graft kneecap tendon	1	82	94
27485	Surgery to stop leg growth	1	94	94
27654	Repair of achilles tendon	1	82	94
27656	Repair leg fascia defect	1	86	94
27665	Repair of leg tendon each	1	94	94
27695	Repair of ankle ligament	1	90	94
27696	Repair of ankle ligaments	1	82	94

Procedures that Bypass Edit 92 when Reported with Modifier -CG

(Data_HCPCS, Column DC "BYPASS_E92_MODIFIER")

27698	Repair of ankle ligament	1	90	94
27700	Revision of ankle joint	1	82	94
27705	Incision of tibia	1	78	94
27730	Repair of tibia epiphysis	1	94	94
27792	Treatment of ankle fracture	1	74	94
27814	Treatment of ankle fracture	1	74	94
27822	Treatment of ankle fracture	1	74	94
27823	Treatment of ankle fracture	1	74	94
27826	Treat lower leg fracture	1	78	94
27827	Treat lower leg fracture	1	74	94
27828	Treat lower leg fracture	1	74	94
27829	Treat lower leg joint	1	86	94
27832	Treat lower leg dislocation	1	86	94
28202	Repair/graft of foot tendon	1	90	94
28210	Repair/graft of foot tendon	1	86	94
28261	Revision of foot tendon	1	90	94
28299	Cor hlx vlg double osteot	1	94	94
28300	Incision of heel bone	1	74	94
28310	Revision of big toe	1	90	94
28360	Reconstruct cleft foot	1	94	94
28415	Treat heel fracture	1	74	94
28420	Treat/graft heel fracture	1	74	94
28465	Treat midfoot fracture each	1	94	94
28485	Treat metatarsal fracture	1	74	94
28555	Repair foot dislocation	1	74	94
28585	Repair foot dislocation	1	74	94
28615	Repair foot dislocation	1	74	94
29855	Tibial arthroscopy/surgery	1	74	94
29856	Tibial arthroscopy/surgery	1	74	94
29885	Knee arthroscopy/surgery	1	86	94
30469	Rpr nsl vlv collapse w/rmdlg	1	90	94
31242	Nsl/sinus ndsc rf abltj pnn	1	94	94
31243	Nsl/sinus ndsc cryoabltj pnn	1	94	94
33220	Repair lead pace-defib dual	1	78	94
33226	Reposition l ventric lead	1	90	94
33233	Removal of pm generator	1	78	94
33279	Rmvl phrnc nrv stim transvns	1	94	94
36261	Revision of infusion pump	1	94	94
37241	Vasc embolize/occlude venous	1	86	94
42215	Reconstruct cleft palate	1	94	94
43210	Egd esophagogastrc fndoplsty	1	90	94
43257	Egd w/thrml txmnt gerd	1	94	94
45327	Proctosigmoidoscopy w/stent	1	78	94
57288	Repair bladder defect	1	74	94
59072	Umbilical cord occlud w/us	1	78	94

Procedures that Bypass Edit 92 when Reported with Modifier -CG

(Data_HCPCS, Column DC "BYPASS_E92_MODIFIER")

61888	Revise/remove neuroreceiver	1	82	94
61891	Rev/rplcmt sk-mnt crnl nstm	1	94	94
62350	Implant spinal canal cath	1	74	94
62351	Implant spinal canal cath	1	94	94
63650	Implant neuroelectrodes	1	94	94
63655	Implant neuroelectrodes	1	94	94
63663	Revise spine eltrd perq aray	1	74	94
63664	Revise spine eltrd plate	1	74	94
64448	Njx aa&/strd fem nrv nfs img	1	90	94
64569	Revise/repl vagus n eltrd	1	82	94
64583	Rev/rplct hpglsl nstm ary pg	1	90	94
64891	Nrv grf 1strnd hnd/foot >4cm	1	94	94
64892	Nrv grf 1strnd arm/leg <4cm	1	94	94
64893	Nrv grf 1strnd arm/leg >4 cm	1	94	94
64897	Nrv grf mltst arm/leg <4 cm	1	94	94
64910	Nerve repair w/allograft	1	78	94
64912	Nrv rpr w/nrv algrft 1st	1	78	94
66175	Trluml dil aq o/f can w/st	1	94	94
66225	Repair/graft eye lesion	1	94	94
66989	Xcpl ctrc rmvl cplx insj 1+	1	94	94
67440	Explore/drain eye socket	1	94	94
69719	Rplcm oi implt sk tc esp<100	1	90	94
75746	Artery x-rays lung	1	94	94
93602	Intra-atrial recording	1	90	94
93619	Electrophysiology evaluation	1	90	94
95938	Somatosensory testing	1	90	94
C9782	Blind myocar trpl bon marrow	1	87	94
C9783	Blind cor sinus reducer impl	1	87	94

TABLE 84: DEVICES WITH PASS-THROUGH STATUS EXPIRING IN 2023, IN 2024, OR IN 2025

HCPCS Code	Long Descriptor	Effective Date	Pass-Through Expiration Date
C1824*	Generator, cardiac contractility modulation (implantable)	1/1/2020	12/31/2023
C1982*	Catheter, pressure-generating, one-way valve, intermittently occlusive	1/1/2020	12/31/2023
C1839*	Iris prosthesis	1/1/2020	12/31/2023
C1734*	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	1/1/2020	12/31/2023
C2596*	Probe, image-guided, robotic, waterjet ablation	1/1/2020	12/31/2023
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
C1831	Personalized, anterior and lateral interbody cage (implantable)	10/1/2021	9/30/2024
C1832	Autograft suspension, including cell processing and application, and all system components	1/1/2022	12/31/2024
C1833	Monitor, cardiac, including intracardiac lead and all system components (implantable)	1/1/2022	12/31/2024
C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system	1/1/2023	12/31/2025
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	1/1/2023	12/31/2025
C1747	Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)	1/1/2023	12/31/2025

*Device for which pass-through status was extended for a 1-year period by section (a)(2) of the Consolidated Appropriations Act, 2023 (CAA, 2023) (Pub. L. 117-328), titled "Extension of Pass-Through Status Under the Medicare Program for Certain Devices Impacted by COVID-19."

Pass-through Devices, Associated Procedure Codes, and Offset Amounts
(Offset_Codepair)

CODE1		CODE2		AMOUNT	LO_ VERS	HI_ VERS
C1600	Cath, bladed, vasc prep	36902	Intro cath dialysis circuit	\$1,451.86	94	94
C1600	Cath, bladed, vasc prep	36903	Intro cath dialysis circuit	\$5,298.55	94	94
C1600	Cath, bladed, vasc prep	36905	Thrmbc/nfs dialysis circuit	\$3,010.38	94	94
C1600	Cath, bladed, vasc prep	36906	Thrmbc/nfs dialysis circuit	\$8,149.83	94	94
C1601	Endo, single, pulmonary	31615	Visualization of windpipe	\$0.16	94	94
C1601	Endo, single, pulmonary	31622	Dx bronchoscope/wash	\$8.57	94	94
C1601	Endo, single, pulmonary	31623	Dx bronchoscope/brush	\$6.47	94	94
C1601	Endo, single, pulmonary	31624	Dx bronchoscope/lavage	\$2.91	94	94
C1601	Endo, single, pulmonary	31625	Bronchoscopy w/biopsy(s)	\$14.88	94	94
C1601	Endo, single, pulmonary	31626	Bronchoscopy w/markers	\$652.77	94	94
C1601	Endo, single, pulmonary	31627	Navigational Bronchoscopy	\$0.00	94	94
C1601	Endo, single, pulmonary	31628	Bronchoscopy/lung bx each	\$36.04	94	94
C1601	Endo, single, pulmonary	31629	Bronchoscopy/needle bx each	\$44.96	94	94
C1601	Endo, single, pulmonary	31630	Bronchoscopy dilate/fx repr	\$421.03	94	94
C1601	Endo, single, pulmonary	31631	Bronchoscopy dilate w/stent	\$1,688.99	94	94
C1601	Endo, single, pulmonary	31632	Bronchoscopy/lung bx addl	\$0.00	94	94
C1601	Endo, single, pulmonary	31633	Bronchoscopy/needle bx addl	\$0.00	94	94
C1601	Endo, single, pulmonary	31634	Bronch w/balloon occlusion	\$1,161.42	94	94
C1601	Endo, single, pulmonary	31635	Bronchoscopy w/fb removal	\$14.39	94	94
C1601	Endo, single, pulmonary	31636	Bronchoscopy bronch stents	\$2,808.68	94	94
C1601	Endo, single, pulmonary	31637	Bronchoscopy stent add-on	\$0.00	94	94
C1601	Endo, single, pulmonary	31638	Bronchoscopy revise stent	\$907.75	94	94
C1601	Endo, single, pulmonary	31640	Bronchoscopy w/tumor excise	\$132.02	94	94
C1601	Endo, single, pulmonary	31641	Bronchoscopy treat blockage	\$251.90	94	94
C1601	Endo, single, pulmonary	31643	Diag bronchoscope/catheter	\$10.51	94	94
C1601	Endo, single, pulmonary	31645	Brnchsc w/ther aspir 1st	\$12.61	94	94
C1601	Endo, single, pulmonary	31646	Brnchsc w/ther aspir sbsq	\$0.00	94	94
C1601	Endo, single, pulmonary	31647	Bronchial valve init insert	\$3,704.69	94	94
C1601	Endo, single, pulmonary	31648	Bronchial valve remov init	\$87.77	94	94
C1601	Endo, single, pulmonary	31649	Bronchial valve remov addl	\$0.00	94	94
C1601	Endo, single, pulmonary	31651	Bronchial valve addl insert	\$0.00	94	94
C1601	Endo, single, pulmonary	31652	Bronch ebus samplng 1/2 node	\$27.12	94	94
C1601	Endo, single, pulmonary	31653	Bronch ebus samplng 3/> node	\$27.83	94	94
C1601	Endo, single, pulmonary	31654	Bronch ebus ivntj perph les	\$0.00	94	94
C1601	Endo, single, pulmonary	31660	Bronch thermoplasty 1 lobe	\$3,220.16	94	94
C1601	Endo, single, pulmonary	31661	Bronch thermoplasty 2/> lobes	\$3,055.83	94	94
C1601	Endo, single, pulmonary	31785	Remove windpipe lesion	\$83.14	94	94
C1602	Orth/matrix/bn fill drug-elut	23035	Drain shoulder bone lesion	\$0.00	94	94
C1602	Orth/matrix/bn fill drug-elut	23170	Remove collar bone lesion	\$779.03	94	94
C1602	Orth/matrix/bn fill drug-elut	23172	Remove shoulder blade lesion	\$0.00	94	94
C1602	Orth/matrix/bn fill drug-elut	23174	Remove humerus lesion	\$0.00	94	94
C1602	Orth/matrix/bn fill drug-elut	23180	Remove collar bone lesion	\$0.00	94	94
C1602	Orth/matrix/bn fill drug-elut	23182	Remove shoulder blade lesion	\$411.71	94	94

Pass-through Devices, Associated Procedure Codes, and Offset Amounts
(Offset_Codepair)

C1602	Orth/matrix/bn fill drug-elut	23184	Remove humerus lesion	\$0.00	94	94
C1602	Orth/matrix/bn fill drug-elut	23935	Inc dp opn b1 crtx hum/elbw	\$97.15	94	94
C1602	Orth/matrix/bn fill drug-elut	24134	Sequestrectomy shft/dstl hum	\$647.55	94	94
C1602	Orth/matrix/bn fill drug-elut	24136	Sequestrectomy radial h/n	\$0.00	94	94
C1602	Orth/matrix/bn fill drug-elut	24138	Sequestrectomy olecrn proces	\$165.64	94	94
C1602	Orth/matrix/bn fill drug-elut	24140	Partial exc bone humerus	\$143.72	94	94
C1602	Orth/matrix/bn fill drug-elut	24145	Prtl exc bone radial h/n	\$0.00	94	94
C1602	Orth/matrix/bn fill drug-elut	24147	Prtl exc bone olecrn proces	\$66.31	94	94
C1602	Orth/matrix/bn fill drug-elut	25035	Treat forearm bone lesion	\$805.01	94	94
C1602	Orth/matrix/bn fill drug-elut	25150	Partial removal of ulna	\$18.20	94	94
C1602	Orth/matrix/bn fill drug-elut	25151	Partial removal of radius	\$101.46	94	94
C1602	Orth/matrix/bn fill drug-elut	26230	Partial removal of hand bone	\$64.76	94	94
C1602	Orth/matrix/bn fill drug-elut	27360	Partial removal leg bone(s)	\$169.00	94	94
C1602	Orth/matrix/bn fill drug-elut	27607	Treat lower leg bone lesion	\$557.28	94	94
C1602	Orth/matrix/bn fill drug-elut	27640	Partial removal of tibia	\$329.37	94	94
C1602	Orth/matrix/bn fill drug-elut	27641	Partial removal of fibula	\$72.78	94	94
C1602	Orth/matrix/bn fill drug-elut	28005	Treat foot bone lesion	\$214.65	94	94
C1602	Orth/matrix/bn fill drug-elut	28120	Part removal of ankle/heel	\$218.35	94	94
C1602	Orth/matrix/bn fill drug-elut	28122	Partial removal of foot bone	\$104.86	94	94
C1603	Ret dev, laser, ivc filter	37193	Rem endovas vena cava filter	\$782.64	94	94
C1604	Grft, trnsmurl/trnsvens byps	0505T	Ev fempop artl revsc	\$4,947.41	94	94
C1747	Endo, single, urinary tract	50080	Perq nl/pl lithotr p smpl<2cm	\$1,018.18	94	94
C1747	Endo, single, urinary tract	50081	Perq nl/pl lithotr p cplx>2cm	\$1,091.03	94	94
C1747	Endo, single, urinary tract	50575	Kidney endoscopy	\$682.32	94	94
C1747	Endo, single, urinary tract	50951	Endoscopy of ureter	\$178.70	94	94
C1747	Endo, single, urinary tract	50953	Endoscopy of ureter	\$328.84	94	94
C1747	Endo, single, urinary tract	50955	Ureter endoscopy & biopsy	\$355.95	94	94
C1747	Endo, single, urinary tract	50957	Ureter endoscopy & treatment	\$441.24	94	94
C1747	Endo, single, urinary tract	50961	Ureter endoscopy & treatment	\$330.81	94	94
C1747	Endo, single, urinary tract	50970	Ureter endoscopy	\$0.00	94	94
C1747	Endo, single, urinary tract	50972	Ureter endoscopy & catheter	\$33.22	94	94
C1747	Endo, single, urinary tract	50974	Ureter endoscopy & biopsy	\$828.75	94	94
C1747	Endo, single, urinary tract	50976	Ureter endoscopy & treatment	\$688.24	94	94
C1747	Endo, single, urinary tract	50980	Ureter endoscopy & treatment	\$717.82	94	94
C1747	Endo, single, urinary tract	52344	Cysto/uretero stricture tx	\$500.23	94	94
C1747	Endo, single, urinary tract	52345	Cysto/uretero w/up stricture	\$516.51	94	94
C1747	Endo, single, urinary tract	52346	Cystouretero w/renal strict	\$455.54	94	94
C1747	Endo, single, urinary tract	52351	Cystouretero & or pyeloscope	\$196.97	94	94
C1747	Endo, single, urinary tract	52352	Cystouretero w/stone remove	\$310.24	94	94
C1747	Endo, single, urinary tract	52353	Cystouretero w/lithotripsy	\$315.53	94	94
C1747	Endo, single, urinary tract	52354	Cystouretero w/biopsy	\$436.31	94	94
C1747	Endo, single, urinary tract	52355	Cystouretero w/excise tumor	\$360.88	94	94
C1747	Endo, single, urinary tract	52356	Cysto/uretero w/lithotripsy	\$514.21	94	94
C1747	Endo, single, urinary tract	C9761	Cysto, litho, vacuum kidney	\$1,399.12	94	94
C1761	Cath, trans intra litho/coro	92928	Prq card stent w/angio 1 vsl	\$0.00	84	94

Pass-through Devices, Associated Procedure Codes, and Offset Amounts
(Offset_Codepair)

C1761	Cath, trans intra litho/coro	92933	Prq card stent/ath/angio	\$8,719.55	94	94
C1761	Cath, trans intra litho/coro	92943	Prq card revasc chronic 1vsl	\$4,413.89	94	94
C1761	Cath, trans intra litho/coro	C9600	Perc drug-el cor stent sing	\$0.00	84	94
C1761	Cath, trans intra litho/coro	C9602	Perc d-e cor stent ather s	\$9,382.83	94	94
C1761	Cath, trans intra litho/coro	C9607	Perc d-e cor revasc chro sin	\$8,524.07	94	94
C1826	Gen, neuro, clo loop, rechg	63685	Ins/rplc spi npg/rcvr pocket	\$23,944.18	94	94
C1827	Gen, neuro, imp led, ex cntr	64568	Opn impltj crnl nrv nea&pg	\$25,737.11	94	94
C1831	Personalized interbody cage	22630	Arthrd pst tq 1ntrspc lum	\$0.00	85	94
C1831	Personalized interbody cage	22633	Arthrd cmbn 1ntrspc lumbar	\$0.00	85	94
C1832	Auto cell process sys	15100	Skin splt grft trnk/arm/leg	\$17.38	94	94
C1832	Auto cell process sys	15110	Epidrm autogrft trnk/arm/leg	\$0.00	90	94
C1832	Auto cell process sys	15115	Epidrm a-grft face/nck/hf/g	\$0.00	90	94
C1832	Auto cell process sys	15120	Skn splt a-grft fac/nck/hf/g	\$28.03	94	94
C1833	Cardiac monitor sys	0525T	Insj/rplcmt compl iims	\$795.62	94	94
C1833	Cardiac monitor sys	0526T	Insj/rplcmt iims eltrd only	\$2,509.33	94	94
C1833	Cardiac monitor sys	0527T	Insj/rplcmt iims implt mntr	\$6,218.28	94	94
C1833	Cardiac monitor sys	0528T	Prgrmg dev eval iims ip	\$0.00	86	94

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FY 2024 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	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	275	Cardiac Defibrillator Implant with Cardiac Catheterization and MCC
05	276	Cardiac Defibrillator Implant with MCC
05	277	Cardiac Defibrillator Implant without 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
08	522	Hip Replacement with Principal Diagnosis of Hip Fracture without MCC

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