

# 2012 Adrenalectomy Reimbursement Fact Sheet

SURGEON CPT CODE <sup>1</sup>	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT <sup>2</sup>	
<b>Traditional Open Procedure</b>			
60540	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedures);	\$1,057	
60545	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedures); with excision of adjacent retroperitoneal tumor	1,213	
<b>Laparoscopic Procedure</b>			
60650	Laparoscopy, surgical, with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal	\$1,191	
60659	Unlisted laparoscopy procedure, endocrine system	Carrier Priced	
<b>OUTPATIENT FACILITY</b>			
<b>Hospital Outpatient Department</b>			
APC	APC DESCRIPTION	MEDICARE PAYMENT <sup>3</sup>	
0130	Level I Laparoscopy (CPT code: 60659)	\$2,720	
<b>INPATIENT FACILITY</b>			
ICD-9 CODE <sup>4</sup>	DESCRIPTION		
07.22	Unilateral adrenalectomy		
07.29	Other partial adrenalectomy		
07.3	Bilateral adrenalectomy		
<b>NOTE:</b> ICD-9 codes are grouped into Diagnoses Related Groups (DRGs) for Medicare reimbursement using a patient's diagnoses, procedures performed, age, sex and discharge status. One DRG is assigned to each inpatient stay.			
DRG	DESCRIPTION	AVERAGE LENGTH OF STAY (DAYS) <sup>5</sup>	NATIONAL AVERAGE DRG PAYMENT <sup>5</sup>
579	Other skin, subcutaneous tissue & breast procedures with MCC	9.7	\$15,168
580	Other skin, subcutaneous tissue & breast procedures with CC	5.1	8,335
581	Other skin, subcutaneous tissue & breast procedures without CC/MCC	2.4	5,348
614	Adrenal & pituitary procedures with CC/MCC	6.1	13,841
615	Adrenal & pituitary procedures without CC/MCC	2.8	8,063

<sup>1</sup> All Current Procedural Terminology (CPT) five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines, and other material are copyright 2011 American Medical Association. All Rights Reserved.

<sup>2</sup> Federal Register, Vol. 76, No. 228, Monday, November 28, 2011/ Rules and Regulations. The 2012 Physician Reimbursement Conversion Factor = \$34.0376.; Federal Register.

<sup>3</sup> Federal Register, Vol. 76, No. 230, Wednesday, November 30, 2011/ Rules and Regulations; Final Hospital Outpatient Payment.

<sup>4</sup> Hospital ICD-9-CM 2010 Volumes 1, 2 & 3, 9th Revision-Clinical Modification, American Medical Association. Copyright © 2011 Saunders, an imprint of Elsevier, Inc.

<sup>5</sup> Federal Register, Vol. 76, No. 160, Thursday, August 18, 2011/ Rules and Regulations; Final National Average DRG Payment.

Physicians should refer to their provider Carrier Manual for their geographic payments.

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