

2012 Appendectomy Reimbursement Fact Sheet

SURGEON CPT CODE ¹	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT ²
Traditional Open Procedure		
44950	Appendectomy (incidental during intra-abdominal surgery)	\$638
44955	Appendectomy when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure)	84
44960	Appendectomy for ruptured appendix, with abscess or generalized peritonitis	868
Laparoscopic Procedure		
44970	Laparoscopy, surgical; appendectomy	\$595
44979	Unlisted laparoscopy procedure, appendix	Carrier Priced

OUTPATIENT FACILITY 2008

Hospital Outpatient Department

APC	APC DESCRIPTION	MEDICARE PAYMENT ³
0130	Level I Laparoscopy (CPT code: 44979)	\$2,720
0131	Level II Laparoscopy (CPT code: 44970)	3,358
0153	Peritoneal and Abdominal Procedures (CPT code: 44950, 44955)	1,918

INPATIENT FACILITY

ICD-9 CODE ⁴	DESCRIPTION
47.01	Laparoscopic appendectomy
47.09	Other appendectomy
47.11	Laparoscopic incidental appendectomy
47.19	Other incidental appendectomy

NOTE: 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) ⁵	NATIONAL AVERAGE DRG PAYMENT ⁵
338	Appendectomy with complicated principal diagnosis with MCC	10.1	\$18,380
339	Appendectomy with complicated principal diagnosis with CC	6.3	10,409
340	Appendectomy with complicated principal diagnosis without CC/MCC	3.7	6,931
341	Appendectomy without complicated principal diagnosis with MCC	6.8	13,273
342	Appendectomy without complicated principal diagnosis with CC	3.7	7,589
343	Appendectomy without complicated principal diagnosis without CC/MCC	1.9	5,399

¹ 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.

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

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

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

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

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

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