

2012 Nephrectomy Reimbursement Fact Sheet

SURGEON CPT CODE ¹	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT ²
Traditional Open Procedure		
50220	Nephrectomy, including partial ureterectomy, any open approach including rib resection	\$1,051
50225	Nephrectomy, including partial ureterectomy, any open approach including rib resection; complicated because of previous surgery on same kidney	1,204
50230	Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical with regional lymphadenectomy and/or vena caval thrombectomy	1,291
50234	Nephrectomy with total ureterectomy and bladder cuff; through same incision	1,310
50236	Nephrectomy with total ureterectomy and bladder cuff; through separate incision	1,478
50240	Nephrectomy, partial	1,334
50300	Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral	Excluded from MFS
50320	Donor nephrectomy (including cold preservation); open, from living donor	1,431
50340	Recipient nephrectomy (separate procedure)	939

Laparoscopic Procedure		
50543	Laparoscopy, surgical; partial nephrectomy	\$1,502
50545	Laparoscopy, radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes and adrenalectomy)	1,354
50546	Laparoscopy, nephrectomy, including partial ureterectomy	1,211
50547	Laparoscopy, donor nephrectomy from living donor (excluding preparation and maintenance of allograft)	1,602
50548	Laparoscopy, nephrectomy with total ureterectomy	1,358
50549	Unlisted laparoscopy procedure, renal	Carrier Priced

OUTPATIENT FACILITY

Hospital Outpatient Department		
APC	APC DESCRIPTION	MEDICARE PAYMENT ³
0130	Level I Laparoscopy (CPT code: 50549)	\$2,720
0131	Level II Laparoscopy (CPT code: 50543)	3,358

INPATIENT FACILITY

ICD-9 CODE ⁴	DESCRIPTION
55.51	Nephroureterectomy
55.52	Nephrectomy of remaining kidney
55.4	Partial nephrectomy
55.5*	Complete nephrectomy
55.54	Bilateral nephrectomy

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.

*Requires 4th digit

DRG	DESCRIPTION	AVERAGE LENGTH OF STAY (DAYS) ⁵	NATIONAL AVERAGE DRG PAYMENT ⁶
656	Kidney & ureter procedures for neoplasm with MCC	9.9	\$20,474
657	Kidney & ureter procedures for neoplasm with CC	5.6	11,334
658	Kidney & ureter procedures for neoplasm without CC/MCC	3.3	8,277
659	Kidney & ureter procedures for non-neoplasm with MCC	10.8	19,503
660	Kidney & ureter procedures for non-neoplasm with CC	5.9	10,615
661	Kidney & ureter procedures for non-neoplasm with CC/MCC	2.8	7,332

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 Physician Reimbursement Conversion Factor = \$34.0376.

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

⁴ Federal Register, Vol. 76, No. 230, Wednesday, November 30, 2011/ Rules and Regulations; Final ASC Reimbursement.

⁵ Hospital ICD-9-CM 2010 Volumes 1, 2 & 3, 9th Revision-Clinical Modification, American Medical Association. Copyright © 2011 Saunders, an imprint of Elsevier, Inc.

⁶ 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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