

2012 Thoracotomy Reimbursement Fact Sheet

SURGEON CPT-CODE ¹	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT ²
32096	Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral	\$825
32097	Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral	825
32098	Thoracotomy, with biopsy(ies) of pleura	776
32110	Thoracotomy; with control of traumatic hemorrhage and/or repair of lung tear	1,496
32120	Thoracotomy; for postoperative complications	897
32124	Thoracotomy; with open intrapleural pneumolysis	954
32140	Thoracotomy; with cyst(s) removal, includes pleural procedure when performed	1,018
32141	Thoracotomy; with resection-plication of bullae, includes any pleural procedure when performed	1,564
32150	Thoracotomy; with removal of intrapleural foreign body or fibrin deposit	1,028
32151	Thoracotomy, with removal of intrapulmonary foreign body	1,035
32160	Thoracotomy, with cardiac massage	799

INPATIENT FACILITY

ICD-9 CODE ³	DESCRIPTION
32.21	Plication of emphysematous bleb
32.23	Open ablation of lung lesion or tissue
32.26	Other and unspecified ablation of lung lesion or tissue
32.29	Other local excision or destruction of lesion or tissue of lung
33.1	Incision of lung
33.39	Other surgical collapse of lung
33.43	Closure of laceration of lung
33.49	Other repair and plastic operations on lung
33.99	Other operations on lung
34.02	Exploratory thoracotomy
34.03	Reopening of recent thoracotomy site
34.09	Other incision of pleura
34.59	Other excision of pleura

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) ⁴	NATIONAL AVERAGE DRG PAYMENT ⁴
163	Major chest procedures with MCC	13.9	\$28,668
164	Major chest procedures without CC	7.1	14,657
165	Major chest procedures without CC/MCC	4.3	10,054

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

⁴ 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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