

# Appendectomy Reimbursement Fact Sheet – 2008

## Surgeon

CPT-4 Code <sup>1</sup>	Procedure	National Average Medicare Payment <sup>2</sup>
44950	Appendectomy (incidental during intra-abdominal surgery)	\$561.78
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)	\$76.94
44960	Appendectomy for ruptured appendix, with abscess or generalized peritonitis	\$749.17
44970	Laparoscopy, surgical; appendectomy	\$514.56
44979	Unlisted laparoscopy procedure, appendix	Carrier Priced

## Outpatient Facility

Hospital Outpatient Department		
APC	APC Description	Medicare Payment <sup>3</sup>
130	Level I Laparoscopy (CPT Code: 44979)	\$2,190.81
131	Level II Laparoscopy (CPT Code: 44970)	\$2,900.10

## Inpatient Facility

ICD-9 Code <sup>4</sup>	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) <sup>5</sup>	National Average DRG Payment <sup>5</sup>
338	Appendectomy w complicated principal diag w MCC	10.9	\$14,672.93
339	Appendectomy w complicated principal diag w CC	7.1	\$10,662.56
340	Appendectomy w complicated principal diag w/o CC/MCC	4.3	\$7,455.98
341	Appendectomy w/o complicated principal diag w MCC	7.3	\$10,134.41
342	Appendectomy w/o complicated principal diag w CC	4.3	\$7,301.47
343	Appendectomy w/o complicated principal diag w/o CC/MCC	2.3	\$5,322.93

<sup>1</sup> All Current Procedural Terminology (CPT) five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines, and other material are Copyright 2006 American Medical Association. All Rights Reserved.

<sup>2</sup> Federal Register, Vol. 72, No. 227, Tuesday, November 27, 2007, and reflects the legislation passed by Congress on December 19, 2007, 2008 Physician Reimbursement Conversion Factor = \$38.087. 2008 conversion factor, Work, PE & MP GPCI geographical averages used (CY 2008 Physician Fee Schedule 11/01/07 RVU values), please see your specific geographical GPCI for more accurate amounts. (Medicare pays 80%; the remaining 20% is the patient's responsibility. Many patients have supplemental insurance).

<sup>3</sup> Federal Register, Vol. 72, No. 227, Tuesday, November 27, 2007, 2008 Hospital Outpatient Payment

<sup>4</sup> 2007 Encoder Pro Professional Hospital & Payor ICD-9-CM Volumes 1, 2 & 3.

<sup>5</sup> Federal Register, Vol. 72, No. 162, August 22, 2007; 2008 National Average DRG Payment

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

NOTE: 2008 Reimbursement and Billing Codes for these procedures have been validated by Princeton Reimbursement Group.

The information contained in this document is provided to help you understand the reimbursement process. It is not intended to increase or maximize reimbursement by any payor. We strongly recommend that providers consult their Payor organization with regard to local reimbursement policies.

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