INTUITIVE

Da Vinci Surgical System 2024 U.S. Coding and Reimbursement Guide—Facilities

Medicare national average rates

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How to use this guide: intended use and audience

The intention of this guide is

To provide general coding and reimbursement information based on publicly available Medicare data for educational purposes only.

To provide U.S. national average reimbursement rates based on Medicare publicly available fee schedules.

To provide relevant supporting information about U.S. coding and reimbursement.

The intended audience for this presentation is

Healthcare professionals involved in coding, documentation, claims processing, and/or reimbursement for relevant procedures. This may include hospital and/or physician office billing professionals, coders, financial, and/or revenue integrity teams, and others who act in roles associated with the coding, coverage, and payment of relevant procedures.

It is NOT intended for

Healthcare providers and/or allied health professionals or other hospital and/or office staff who do not act in above roles and capacities.

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Disclaimer

Intuitive is providing this resource for informational purposes only, in support of accurate coding and reimbursement practices based on Medicare coding, coverage, and payment. Intuitive cannot guarantee that this document is complete or without errors, as coding, coverage, and payment are subject to change at any time. HCPCS codes listed in this guide represent no statement, promise, or guarantee that these codes will be appropriate or that reimbursement will be made. This coding and reimbursement guide cannot, under any circumstances, be interpreted as, or used in place of, clinical judgment. Any coding and reimbursement decisions and practices are the sole responsibility of the provider and/or designated party responsible for coding and reimbursement.

The Medicare Physician Fee schedule provides relative value units (RVU's) broken into work, facility, and nonfacility practice expense. To calculate facility and nonfacility payments, RVU's for facility and nonfacility settings were multiplied against the 2024 conversion factor of $32.74.

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Methodology and background

This guide includes Healthcare Common Procedure Coding System (HCPCS) codes used by Medicare and other health insurers to standardize coding in claims and other documentation. It is the responsibility of the provider and/or designated party responsible for coding and reimbursement to determine the appropriate code(s) based on the situation.*

HCPCS codes are comprised of 2 levels, referred to as Level I and Level II of the HCPCS:

Level I includes the Physicians' Current Procedural Terminology Fourth Edition (CPT). CPT is based on a numeric coding system maintained by the American Medical Association (AMA) that describes medical services and procedures provided by physicians and other healthcare professionals.

In 2007, the AMA determined that no new CPT codes or unique identifiers were needed when describing laparoscopic / endoscopic procedures performed with robotic assistance.

Level II codes are used to report durable medical equipment, supplies, nonphysician services, and some drugs. S2900 (Surgical techniques requiring use of robotic surgical system) is a Level II code that was issued by a private insurer in 2005. S2900 is not a code that is processed by Medicare. Note that other Level II codes are not shown in this document.

* This guide is provided for informational purposes, and is not a comprehensive list of procedures. As the AMA publishes CPT codes on an annual basis, and makes decisions regarding the addition, deletion, or revision of CPT codes throughout the year, this guide may not reflect interim updates. Please refer to the most recent AMA publication of CPT® codes for additional information.

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Reimbursement terminology and abbreviations

Reimbursement terminology used in this guide are briefly defined below in support of 2024 Medicare reimbursement information. Unless otherwise noted, all definitions and sources available at the Centers of Medicare and Medicaid Services (CMS) Glossary: www.cms.gov/apps/glossary/

American Medical Association (AMA): Professional organization for physicians that maintains the Current Procedural Terminology (CPT) coding system.

Ambulatory Payment Classification (APC): Developed by CMS as the basis for hospital outpatient reimbursement rates; relevant CPT codes are grouped into APCs based on resource utilization.

Ambulatory Surgery Center (ASC): Site of care for some services and procedures where patients are admitted, treated, and discharged within 24 hours.

Centers for Medicare and Medicaid Services (CMS): Federal government agency within the Department of Health and Human Services that administers public health programs.

Complications / Comorbidities (CC): Complications and diagnoses that determine appropriate diagnosis-related group (DRG) for inpatient admission. (See also "MCC".)

Current Procedural Terminology (CPT): See HCPCS Level I.

Diagnosis-Related Group (DRG): Classification system that groups patients according to diagnosis, treatment type, and other criteria. Under the US Inpatient Prospective Payment System (IPPS), hospitals are paid a set fee per patient based on DRG category, regardless of actual cost of care. Only one DRG is assigned for each inpatient stay, regardless of the number of procedures performed. DRGs shown in this guide are those typically assigned when a patient is admitted specifically for the procedure described. All DRG reimbursement rates shown in this guide reflect estimated Medicare National Average rates for 2024, inclusive of both operating and capital payments. (See also "PPS".)

Fee Schedule: List of codes and services with payment amounts (also referred to as reimbursement rates).

Healthcare Common Procedure Coding System (HCPCS) Level I: Numeric coding system used by physicians, other health professionals, hospitals, and ambulatory surgical centers (ASC) to code procedures and services. HCPCS Level I is comprised of the American Medical Association's Physicians' Current Procedural Terminology (CPT) codes.

CPT codes have been adopted by the Secretary of Health and Human Services as a standard to describe medical services and procedures provided by physicians and other health care professionals.

Major Complications / Comorbidities (MCC): Complications and diagnoses indicating highest level of severity; also used to determine diagnosis-related groups (DRG) for inpatient admissions. Complete Medicare MCC list published annually, available at https://www.cms.gov/medicare/coding-billing/icd-10-codes/2024-icd-10-pcs .

Post-Acute Care Transfer (PACT) DRG: For some DRGs, Medicare may reduce payments when a patient's length of stay is 1 or more days less than the geometric mean LOS for that DRG, or if the patient is transferred to another Medicare-covered acute care facility or post-acute setting. FY2024 Final DRG PACT designation available in Table 5. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page .

Prospective Payment System (PPS): A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (e.g., DRGs for inpatient hospital services).

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2024 Medicare reimbursement

All rates shown reflect 2024 Medicare national average rates, unadjusted by geography or other factors.

Medicare Hospital Inpatient data files available at https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page.

Medicare Hospital Outpatient data files, including Ambulatory Surgical Center (ASC) information, available at https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps.

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Appendectomy and other bowel procedures

DRG	DRG description	2024 facility national average	PACT DRG applicable
Appendectomy			
397	Appendix procedures with MCC	$15,730	No
398	Appendix procedures with CC	$10,596	No
399	Appendix procedures without CC/MCC	$7,793	No
Adrenalectomy			
614	Adrenal and pituitary procedures with CC/MCC	$15,770	No
615	Adrenal and pituitary procedures without CC/MCC	$10,300	No
Splenectomy			
799	Splenectomy with MCC	$34,690	No
800	Splenectomy with CC	$19,728	No
801	Splenectomy without CC/MCC	$12,531	No

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Appendectomy and other bowel procedures

CPT	CPT description	APC	APC description	2024 Medicare national average APC rate	2024 ASC national average rate
Laparoscopic procedures					
38120	Laparoscopy, surgical, splenectomy	5362	Level 2 Laparoscopy and related services	$9,818	N/A
49320	Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	5361	Level 1 Laparoscopy and related services	$5,503	$2,706
44970	Laparoscopy, surgical, appendectomy				
60650	Laparoscopy, surgical, with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal		Not applicable (Inpatient only)		
Open procedures					
38100	Splenectomy; total (separate procedure)		Not applicable (Inpatient only)		
38101	Splenectomy; partial (separate procedure)				
38102	Splenectomy; total, en bloc for extensive disease, in conjunction with other procedure (List in addition to code for primary procedure)				
38115	Repair of ruptured spleen (splenorrhaphy) with or without partial splenectomy				
44950	Appendectomy	5342	Level 2 Peritoneal and abdominal procedures	$7,216	N/A
44955	Appendectomy; when done for indicated purpose at time of other major procedure (not separate procedure) (List separately in addition to primary procedure)		Not applicable (Inpatient only)		
44960	Appendectomy; for ruptured appendix with abscess or generalized peritonitis				
60540	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure)				
60545	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure); with excision of adjacent retroperitoneal tumor				

Bariatric procedures

DRG	DRG description	2024 facility national average	PACT DRG applicable
619	OR procedures for obesity with MCC	$18,222	No
620	OR procedures for obesity with CC	$11,358	No
621	OR procedures for obesity without CC/MCC	$10,624	No

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Bariatric procedures

CPT	CPT description	APC
Laparoscopic procedures		
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	Not applicable (Inpatient only)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (e.g., sleeve gastrectomy)	
Open procedures		
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	Not applicable (Inpatient only)
43845	Gastric restrictive procedure, with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common chanel) to limit absorption (biliopancreatic diversion with duodenal switch)	
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	

Colorectal procedures

DRG	DRG description	2024 facility national average	PACT DRG applicable
329	Major small and large bowel procedures with MCC	$31,625	Yes
330	Major small and large bowel procedures with CC	$16,608	Yes
331	Major small and large bowel procedures without CC/MCC	$11,707	Yes
332	Rectal resection with MCC	$27,586	Yes
333	Rectal resection with CC	$14,560	Yes
334	Rectal resection without CC/MCC	$11,238	Yes

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Colorectal procedures

CPT	CPT description	APC
Laparoscopic procedures		
44187	Laparoscopy, surgical; ileostomy or jejunostomy, non-tube	Not applicable (Inpatient only)
44188	Laparoscopy, surgical, colostomy or skin level cecostomy (Do not report 44188 in conjunction with 44970)	
44204	Laparoscopy, surgical; colectomy, partial, with anastomosis	
44205	Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy	
44206	Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)	
44207	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (lowith pelvic anastomosis)	
44208	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (lowith pelvic anatomosis) with colostomy	
44210	Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy	
44212	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy	
44213	Laparoscopy, surgical; mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy	
45395	Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy	
45397	Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (e.g., colo-anal anastomosis), with creation of colonic reservoir (e.g., J-pouch), with diverting enterostomy, when performed	
45400	Laparoscopy, surgical; proctopexy (for prolapse)	
45402	Laparoscopy, surgical; proctopexy (for prolapse) with sigmoid resection	
Open procedures		
44139	Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)	Not applicable (Inpatient only)
44140	Colectomy, partial; with anastomosis	
44141	Colectomy, partial; with skin level cecostomy or colostomy	
44143	Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)	

Colorectal procedures

CPT	CPT description	APC
Open procedures		
44144	Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula	
44145	Colectomy, partial; with coloproctostomy (lowith pelvic anastomosis)	
44146	Colectomy, partial; with coloproctostomy (lowith pelvic anastomosis), with colostomy	
44150	Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy	
44151	Colectomy, total, abdominal, without proctectomy; with continent ileostomy	
44155	Colectomy, total, abdominal, with proctectomy; with ileostomy	
44156	Colectomy, total, abdominal, with proctectomy; with continent ileostomy	
44157	Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy, when performed	
44158	Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, creation of ileal reservoir (S or J), includes loop ileostomy, and rectal mucosectomy, when performed	
44160	Colectomy, partial, with removal of terminal ileum with ileocolostomy	Not applicable (Inpatient only)
44310	Ileostomy or jejunostomy, non-tube	
45110	Proctectomy; complete, combined abdominoperineal, with colostomy	
45111	Proctectomy; partial resection of rectum, transabdominal approach	
45112	Proctectomy, combined abdominoperineal, pullthrough procedure (e.g., colo-anal anastomosis)	
45119	Proctectomy, combined abdominoperineal pull-through procedure (e.g., colo-anal anastomosis), with creation of colonic reservoir (e.g., J-pouch), with diverting enterostomy when performed	
45120	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull-through procedure and anastomosis (e.g., Swenson, Duhamel, or Soave type operation)	
45123	Proctectomy, partial, without anastomosis, perineal approach	
45540	Proctopexy (for prolapse) abdominal approach	
45550	Proctopexy (for prolapse) abdominal approach, with sigmoid resection	

Esophagectomy and thoracic procedures

DRG	DRG description	2024 facility national average	PACT DRG applicable
Esophagectomy* procedures			
140	Major head and neck procedures with MCC	$26,453	No
141	Major head and neck procedures with CC	$14,505	No
142	Major head and neck procedures without CC/MCC	$10,817	No
143	Other ears, nose, mouth, and throat OR procedures with MCC	$23,285	No
144	Other ears, nose, mouth, and throat OR procedures with CC	$12,116	No
145	Other ears, nose, mouth, and throat OR procedures without CC/MCC	$8,550	No
326	Stomach, esophageal, and duodenal procedures with MCC	$35,561	Yes
327	Stomach, esophageal, and duodenal procedures with CC	$17,486	Yes
328	Stomach, esophageal, and duodenal procedures without CC/MCC	$11,184	Yes
Thoracic procedures			
163	Major chest procedures with MCC	$33,003	Yes
164	Major chest procedures with CC	$17,857	Yes
165	Major chest procedures without CC/MCC	$13,138	Yes

*DRG assignment may vary depending on principal diagnosis

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Esophagectomy and thoracic procedures

CPT	CPT description	APC	APC description	2024 Medicare national average APC rate	2024 ASC national average rate
Laparoscopic procedures					
43124	Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy				
43286	Esophagectomy, total or near total, with laparoscopic mobilization of the abdominal and mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy or esophagogastrostomy (e.g., laparoscopic transhiatal esophagectomy)				
43287	Esophagectomy, distal two-thirds, with laparoscopic mobilization of the abdominal and lower mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with separate thoracoscopic mobilization of the middle and upper mediastinal esophagus and thoracic esophagogastrostomy (e.g., laparoscopic thoracoscopic esophagectomy, Ivor Lewis esophagectomy)		Not applicable (Inpatient only)		
43288	Esophagectomy, total or near total, with thoracoscopic mobilization of the upper, middle, and lower mediastinal esophagus, with separate laparoscopic proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy or esophagogastrostomy (e.g., thoracoscopic, laparoscopic and cervical incision esophagectomy, McKeown esophagectomy, tri-incisional esophagectomy)				
Open procedures					
43107	Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)				
43108	Total or near total esophagectomy, without thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es)				
43112	Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty		Not applicable (Inpatient only)		
43113	Total or near total esophagectomy, with thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)				
43116	Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction				

*DRG assignment may vary depending on principal diagnosis

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Esophagectomy and thoracic procedures

CPT	CPT description	APC	APC description	2024 Medicare national average APC rate	2024 ASC national average rate
Open procedures					
43117	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)				
43118	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)				
43121	Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty		Not applicable (Inpatient only)		
43122	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty				
43123	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)				

*DRG assignment may vary depending on principal diagnosis

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Esophagectomy and thoracic procedures

CPT	CPT description	APC	APC description	2024 Medicare national average APC rate	2024 ASC national average rate
Laparoscopic procedures					
32601	Thoracoscopy, diagnostic (separate procedure); lungs, pericardial sac, mediastinal or pleural space, without biopsy	5361	Level 1 Laparoscopy and related services	$5,503	N/A
32607	Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (e.g., wedge, incisional), unilateral	5362	Level 2 Laparoscopy and related services	$9,818	N/A
32608	Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (e.g., wedge, incisional), unilateral				
32655	Thoracoscopy, surgical; with resection-plication of bullae, includes any pleural procedure when performed				
32656	Thorascopy, surgical; with parietal pleurectomy				
32658	Thoracoscopy, surgical; with removal of clot or foreign body from pericardial sac				
32661	Thoracoscopy, surgical; with excision of pericardial cyst, tumor, or mass				
32662	Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass				
32663	Thoracoscopy, surgical; with lobectomy (single lobe)				
32666	Thoracoscopy, surgical; with therapeutic wedge resection (e.g., mass, nodule), initial unilateral		Not applicable (Inpatient only)		
32667	Thoracoscopy, surgical; with therapeutic wedge resection (e.g., mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)				
32668	Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)				
32669	Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)				
32670	Thoracoscopy, surgical; with removal of two lobes (bilobectomy)				
32672	Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed				

*DRG assignment may vary depending on principal diagnosis

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Esophagectomy and thoracic procedures

CPT	CPT description	APC	APC description	2024 Medicare national average APC rate	2024 ASC national average rate
Open procedures					
32140	Thoracotomy; with cyst(s) removal, includes pleural procedure when performed				
32141	Thoracotomy; with resection-plication of bullae, includes any pleural procedure when performed				
32160	Thoracotomy; with cardiac massage				
32480	Removal of lung, other than pneumonectomy; single lobe (lobectomy)				
32482	Removal of lung, other than pneumonectomy; 2 lobes (bilobectomy)				
32484	Removal of lung, other than pneumonectomy; single segment (segmentectomy)		Not applicable (Inpatient only)		
32505	Thoracotomy; with therapeutic wedge resection (e.g., mass, nodule), initial				
32506	Thoracotomy; with therapeutic wedge resection (e.g., mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)				
32507	Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)				
33020	Pericardiotomy for removal of clot or foreign body (primary procedure)				

*DRG assignment may vary depending on principal diagnosis

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Gastrectomy, Nissen fundoplication, and Heller myotomy procedures

DRG	DRG description	2024 facility national average	PACT DRG applicable
326	Stomach, esophageal, and duodenal proc with MCC	$35,561	Yes
327	Stomach, esophageal, and duodenal proc with CC	$17,486	Yes
328	Stomach, esophageal, and duodenal proc without CC/MCC	$11,184	Yes

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Gastrectomy, Nissen fundoplication, and Heller myotomy procedures

CPT	CPT description	APC	APC description	2024 Medicare national average APC rate	2024 ASC national average rate
Laparoscopic procedures					
32665	Thoracoscopy, surgical; with esophagomyotomy (Heller type)		Not applicable (Inpatient only)		
43279	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed				
43280	Laparoscopy, surgical,esophagogastric fundoplasty (e.g., Nissen, Toupet procedures)	5362	Level 2 Laparoscopy and related services	$9,818	N/A
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh				
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh				
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and roux-en-y gastroenterostomy (roux limb 150 cm or less)		Not applicable (Inpatient only)		
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption				
Open procedures					
43325	Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)		Not applicable (Inpatient only)		
43327	Esophagogastric fundoplasty partial or complete; laparotomy				
43328	Esophagogastric fundoplasty partial or complete; thoracotomy				
43330	Esophagomyotomy (Heller type); abdominal approach				
43331	Esophagogastric fundoplasty partial or complete; thoracotomy				
43621	Gastrectomy, total; with Roux-en-Y reconstruction				
43622	Gastrectomy, total; with formation of intestinal pouch, any type				
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction				
43634	Gastrectomy, partial, distal; with formation of intestinal pouch				

Gynecology procedures

DRG	DRG description	2024 facility national average	PACT DRG applicable
739	Uterine, adnexa proc for non-ovarian/adnexal malignancy with MCC	$25,320	No
740	Uterine, adnexa proc for non-ovarian/adnexal malignancy with CC	$12,512	No
741	Uterine, adnexa proc for non-ovarian/adnexal malignancy without CC/MCC	$9,097	No
742	Uterine and adnexa proc for non-malignancy with CC/MCC	$12,476	No
743	Uterine and adnexa proc for non-malignancy without CC/MCC	$8,136	No

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Gynecology procedures

CPT	CPT description	APC	APC description	2024 national average APC payment	2024 national average ASC payment
Laparoscopic procedures					
38571*	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy	5362	Level 2 Laparoscopy and related services	$9,818	$4,541
49322	Laparoscopy, surgical, abdomen, peritoneum, and omentum; with aspiration of cavity or cyst (e.g., ovarian cyst) (single or multiple)	5361	Level 1 Laparoscopy and related services	$5,503	$2,706
57425	Laparoscopy, surgical, sacrocolpopexy	5362	Level 2 Laparoscopy and related services	$9,818	$4,541
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less				
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)				
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g				
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)				
58545	Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 g or less and/or removal of surface myomas	5361	Level 1 Laparoscopy and related services	$5,503	$2,706
58546	Laparoscopy, surgical, myomectomy, excision; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g	5362	Level 2 Laparoscopy and related services	$9,818	$4,541
58548	Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed	Not applicable (Inpatient only)			
58550	Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 g or less	5361	Level 1 Laparoscopy and related services	$5,503	$2,706
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	5362	Level 2 Laparoscopy and related services	$9,818	$4,541
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g				
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)				
*C9756	Intraoperative near-infrared fluorescence lymphatic mapping of lymph node(s) (sentinel or tumor draining) with administration of indocyanine green (ICG) (list separately in addition to primary procedure). May only be reported with CPT 38571.			Packaged	

Gynecology procedures

CPT	CPT description	APC	APC description	2024 national average APC payment	2024 national average ASC payment
Laparoscopic procedures					
58561	Hysteroscopy, surgical; with removal of leiomyomata	5415	Level 5 Gynecologic procedures	$4,744	$2,136
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less	5362	Level 2 Laparoscopy and related services	$9,818	$4,541
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)				
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g				
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)				
58575	Laparoscopy, surgical, total hysterectomy for resection of malignancy (tumor debulking), with omentectomy including salpingooophorectomy, unilateral or bilateral, when performed	Not applicable (Inpatient only)			
58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)	5361	Level 1 Laparoscopy and related services	$5,503	$2,706
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)				
58662	Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method				
58673	Laparoscopy, surgical with lysis of adhesions, with salpingostomy	5362	Level 2 Laparoscopy and related services	$9,818	$4,541
Open procedures					
38770	Pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)	Not applicable (Inpatient only)			
57268	Repair of enterocele, vaginal approach (separate procedure)	5415	Level 5 Gynecologic procedures	$4,744	$2,136
58140	Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; abdominal approach	Not applicable (Inpatient only)			
58145	Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; vaginal approach	5414	Level 4 Gynecologic procedures	$2,982	$1,586
58146	Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g, abdominal approach	Not applicable (Inpatient only)			

Gynecology procedures

CPT	CPT description	APC	APC description	2024 national average APC payment	2024 national average ASC payment
Open procedures					
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);				
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)				
58200	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s				
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)		Not applicable (Inpatient only)		
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)				
58740	Lysis of adhesions (salpingolysis, ovariolysis)				
58760	Fimbrioplasty				
58770	Salpingostomy (salpingoneostomy)	5414	Level 4 Gynecologic procedures	$2,982	N/A
58805	Drainage of ovarian cyst(s), unilateral or bilateral (separate procedure); abdominal approach	5414	Level 4 Gynecologic procedures	$2,982	$1,586
58920	Wedge resection or bisection of ovary, unilateral or bilateral	5416	Level 6 Gynecologic procedures	$7,207	N/A
58925	Ovarian cystectomy, unilateral or bilateral	5415	Level 5 Gynecologic procedures	$4,744	N/A
58940	Oophorectomy, partial or total, unilateral or bilateral		Not applicable (Inpatient only)		

Hepatobiliary and pancreatic procedures

DRG	DRG description	2024 facility national average	PACT DRG applicable
Hepatobiliary procedures			
408	Biliary tract procedures except only cholecystectomy with or without C.D.E. with MCC	$26,061	No
409	Biliary tract procedures except only cholecystectomy with or without C.D.E. with CC	$13,704	No
410	Biliary tract procedures except only cholecystectomy with or without C.D.E. without CC/MCC	$10,959	No
411	Cholecystectomy with C.D.E. with MCC	$21,288	No
412	Cholecystectomy with C.D.E. with CC	$14,466	No
413	Cholecystectomy with C.D.E. without CC/MCC	$10,570	No
414	Cholecystectomy except by laparoscope without C.D.E. with MCC	$24,682	Yes
415	Cholecystectomy except by laparoscope without C.D.E. with CC	$13,834	Yes
416	Cholecystectomy except by laparoscope without C.D.E. without CC/MCC	$9,377	Yes
417	Laparoscope cholecystectomy without C.D.E. with MCC	$16,228	No
418	Laparoscope cholecystectomy without C.D.E. with CC	$11,446	No
419	Laparoscope cholecystectomy without C.D.E. without CC/MCC	$9,195	No
Pancreatic procedures			
326	Stomach, esophageal, and duodenal procedures with MCC	$35,561	Yes
327	Stomach, esophageal, and duodenal procedures with CC	$17,486	Yes
328	Stomach, esophageal, and duodenal proc without CC/MCC	$11,184	Yes
405	Pancreas, liver, and shunt procedures with MCC	$38,545	Yes
406	Pancreas, liver, and shunt procedures with CC	$20,216	Yes
407	Pancreas, liver, and shunt procedures without CC/MCC	$15,060	Yes
628	Other endocrine, nutrit, and metab OR procedures with MCC	$28,108	Yes
629	Other endocrine, nutrit, and metab OR procedures with CC	$15,843	Yes
630	Other endocrine, nutrit, and metab OR procedures without CC/MCC	$9,776	Yes

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Hepatobiliary and pancreatic procedures

CPT	CPT description	APC	APC description	2024 Medicare national average APC rate	2024 ASC national average rate
Laparoscopic procedures					
47562	Laparoscopy, surgical; cholecystectomy	5361	Level 1 Laparoscopy and related services	$5,503	$2,706
47563*	Laparoscopy, surgical; cholecystectomy with cholangiography				
47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct	5362	Level 2 Laparoscopy and related services	$9,818	$4,541
Open procedures					
47600	Cholecystectomy;	Not applicable (Inpatient only)			
47605	Cholecystectomy; with cholangiography				
47610	Cholecystectomy with exploration of common duct				
48140	Pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostomy				
48145	Pancreatectomy, distal subtotal, with or without splenectomy; with pancreaticojejunostomy				
48150	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple- type procedure); with pancreatojejunostomy				
48152	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple- type procedure); without pancreatojejunostomy				
48153	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy				
48154	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus- sparing, Whipple-type procedure); without pancreatojejunostomy				
48155	Pancreatectomy, total				
*C9776	Fluorescence bile duct imaging with ICG (list separately when used in conjunction with CPT 47563)			Packaged	

Hernia: inguinal, ventral, and incisional procedures

DRG	DRG description	2024 facility national average	PACT DRG applicable
350	Inguinal and femoral hernia procedures with MCC	$16,804	No
351	Inguinal and femoral hernia procedures with CC	$10,192	No
352	Inguinal and femoral hernia procedures without CC/MCC	$7,765	No
353	Hernia procedures except inguinal and femoral with MCC	$20,475	No
354	Hernia procedures except inguinal and femoral with CC	$12,027	No
355	Hernia procedures except inguinal and femoral without CC/MCC	$9,540	No

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Hernia: inguinal procedures

CPT	CPT description	APC	APC description	2024 Medicare national average APC rate	2024 ASC national average rate
Laparoscopic procedures					
49650	Laparoscopy, surgical; repair initial inguinal hernia	5361	Level 1 Laparoscopy and related services	$5,503	$2,706
49651	Laparoscopy, surgical; repair recurrent inguinal hernia				
Open procedures					
49505	Repair initial inguinal hernia, age 5 years or older; reducible	5341	Peritoneal and abdominal procedures	$3,300	$1,622
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated				
49520	Repair recurrent inguinal hernia, any age; reducible				
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	5342	Level 2 Peritoneal and abdominal procedures	$7,216	$3,722
49525	Repair inguinal hernia, sliding, any age	5341	Peritoneal and abdominal procedures	$3,300	$1,622

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Hernia: ventral procedures

CPT	CPT description	APC	APC description	2024 Medicare national average APC rate	2024 ASC national average rate
Initial procedures	Repair of anterior abdominal hernia(s) (epigastric, incisional, ventral, umbilical, spigelian) any approach (open, lap, robotic) initial, including placement of mesh or other prosthesis, when performed, total length of defect(s);				
49591	Less than 3 cm, reducible	5341	Peritoneal and abdominal procedures	$3,300	$1,622
49592	Less than 3 cm, incarcerated or strangulated	5361	Level 1 Laparoscopy and related services	$5,503	$2,706
49593	3-10 cm, reducible	5341	Peritoneal and abdominal procedures	$3,300	$1,622
49594	3-10 cm, incarcerated or strangulated	5361	Level 1 Laparoscopy and related services	$5,503	$2,706
49595	Greater than 10 cm, reducible	5341	Peritoneal and abdominal procedures	$3,300	$1,622
49596	Greater than 10 cm, incarcerated or strangulated	Not applicable (Inpatient only)			
Recurrent procedures	Repair of anterior abdominal hernia(s) (epigastric, incisional, ventral, umbilical, spigelian) any approach (open, lap, robotic) recurrent, including placement of mesh or other prosthesis, when performed, total length of defect(s);				
49613	Less than 3 cm, reducible	5341	Peritoneal and abdominal procedures	$3,300	$1,622
49614	Less than 3 cm, incarcerated or strangulated	5361	Level 1 Laparoscopy and related services	$5,503	$2,706
49615	3-10 cm, reducible	5341	Peritoneal and abdominal procedures	$3,300	$1,622
49616	3-10 cm, incarcerated or strangulated				
49617	Greater than 10 cm, reducible	Not applicable (Inpatient only)			
49618	Greater than 10 cm, incarcerated or strangulated				

Liver resection/hepatectomy procedures

DRG	DRG description	2024 facility national average	PACT DRG applicable
405	Pancreas, liver, and shunt procedures with MCC	$38,545	Yes
406	Pancreas, liver, and shunt procedures with CC	$20,216	Yes
407	Pancreas, liver, and shunt procedures without CC/MCC	$15,060	Yes

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Liver resection/hepatectomy procedures

CPT	CPT description	APC	APC description
Open procedures			
47120	Hepatectomy, resection of liver; partial lobectomy	Not applicable (Inpatient only)	
47122	Hepatectomy, resection of liver; trisegmentectomy		
47125	Hepatectomy, resection of liver; total left lobectomy		
47130	Hepatectomy, resection of liver; total right lobectomy		

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Otolaryngology procedures

DRG	DRG description	2024 facility national average	PACT DRG applicable
140	Major head and neck procedures with MCC	$26,453	No
141	Major head and neck procedures with CC	$14,505	No
142	Major head and neck procedures without CC/MCC	$10,817	No
143	Other ears, nose, mouth, and throat OR procedures with MCC	$23,285	No
144	Other ears, nose, mouth, and throat OR procedures with CC	$12,116	No
145	Other ears, nose, mouth, and throat OR procedures without CC/MCC	$8,550	No

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Otolaryngology procedures

CPT	CPT description	APC	APC description	2024 Medicare national average APC rate	2024 ASC national average rate
Any method					
31420	Epiglodecttomy	5165	Level 5 ENT Procedures	$5,586	$2,761
42808	Excision or destruction of lesion of pharynx, any method	5164	Level 4 ENT procedures	$3,071	$1,319
42870	Excision or destruction lingual tonsil, any method (separate procedure)	5165	Level 5 ENT Procedures	$5,586	$2,761
Open procedures					
41120	Glossectomy; less than one-half tongue	5165	Level 5 ENT procedures	$5,586	$2,761
41130	Glossectomy; hemiglossectomy		Not applicable (Inpatient only)		
42842	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure	5165	Level 5 ENT procedures	$5,586	$2,761
42844	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with local flap (e.g., tongue, buccal)				
42845	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap		Not applicable (Inpatient only)		
42890	Limited pharyngectomy	5165	Level 5 ENT procedures	$5,586	$2,761

Prostatectomy, nephrectomy, and cystectomy procedures

DRG	DRG description	2024 facility national average	PACT DRG applicable
656	Kidney and ureter procedures for neoplasm with MCC	$21,968	No
657	Kidney and ureter procedures for neoplasm with CC	$12,912	No
658	Kidney and ureter procedures for neoplasm without CC/MCC	$10,365	No
659	Kidney and ureter procedures for non-neoplasm with MCC	$18,126	Yes
660	Kidney and ureter procedures for non-neoplasm with CC	$9,423	Yes
661	Kidney and ureter procedures for non-neoplasm without CC/MCC	$7,340	Yes
665	Prostatectomy with MCC	$21,629	No
666	Prostatectomy with CC	$12,025	No
667	Prostatectomy without CC/MCC	$7,349	No
707	Major male pelvic procedures with CC/MCC	$13,736	No
708	Major male pelvic procedures without CC/MCC	$10,212	No

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Prostatectomy, nephrectomy, and cystectomy procedures

CPT	CPT description	APC	APC description	2024 Medicare national average APC rate	2024 ASC national average rate
Laparoscopic procedures					
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	5362	Level 2 Laparoscopy and related services	$9,818	N/A
55867	Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed				
Open procedures					
55810	Prostatectomy, perineal radical	Not applicable (Inpatient only)			
55812	Prostatectomy, perineal radical; with lymph node biopsy(s) (limited pelvic lymphadenectomy)				
55815	Prostatectomy, perineal radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes				
55821	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages				
55840	Prostatectomy, retropubic radical, with or without nerve sparing				
55842	Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)				
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes				

Prostatectomy, nephrectomy, and cystectomy procedures

CPT	CPT description	APC	APC description	2024 Medicare national average APC rate	2024 ASC national average rate
Laparoscopic procedures					
38571*	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy	5362	Level 2 Laparoscopy and related services	$9,818	$4,541
50543	Laparoscopy, surgical; partial nephrectomy	5362	Level 2 Laparoscopy and related services	$9,818	N/A
50545	Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)	Not applicable (Inpatient only)			
50546	Laparoscopy, surgical; nephrectomy, including partial ureterectomy				
Open procedures					
50220	Nephrectomy, including partial ureterectomy, any open approach including rib resection	Not applicable (Inpatient only)			
50225	Nephrectomy, including partial ureterectomy, any open approach including rib resection; complicated because of previous surgery on same kidney				
50230	Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy				
50240	Nephrectomy, partial				
*C9756	Intraoperative near-infrared fluorescence lymphatic mapping of lymph node(s) (sentinel or tumor draining) with administration of indocyanine green (ICG) (list separately in addition to primary procedure). May only be reported with CPT 38571.	Packaged			

Prostatectomy, nephrectomy, and cystectomy procedures

CPT	CPT description	APC	APC description	2024 Medicare national average APC rate	2024 ASC national average rate
Open procedures					
51550	Cystectomy, partial; simple				
51555	Cystectomy, partial; complicated (e.g., postradiation, previous surgery, difficult location)				
51565	Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy)				
51570	Cystectomy, complete; (separate procedure)				
51575	Cystectomy, complete; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes				
51580	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations		Not applicable (Inpatient only)		
51585	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes				
51590	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis				
51595	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes				
51596	Cystectomy, complete, with continent diversion, any open technique, using any segment of small and/or large intestine to construct neobladder				

Da Vinci Xi/X surgical system precaution statement
The demonstration of safety and effectiveness for the representative specific procedures did not include evaluation of outcomes related to the treatment of cancer (overall survival, disease-free survival, local recurrence) or treatment of the patient's underlying disease/condition. Device usage in all surgical procedures should be guided by the clinical judgment of an adequately trained surgeon.

Important safety information
Serious complications may occur in any surgery, including surgery with a da Vinci system, up to and including death. Examples of serious or life-threatening complications, which may require prolonged and/or unexpected hospitalization and/or reoperation, include but are not limited to, one or more of the following: injury to tissues/organs, bleeding, infection, and internal scarring that can cause long-lasting dysfunction/pain.

Risks specific to minimally invasive surgery, including surgery with a da Vinci system, include but are not limited to, one or more of the following: temporary pain/nerve injury associated with positioning; a longer operative time, the need to convert to an open approach, or the need for additional or larger incision sites. Converting the procedure could result in a longer operative time, a longer time under anesthesia, and could lead to increased complications.

Contraindications applicable to the use of conventional endoscopic instruments also apply to the use of all da Vinci instruments.

For important safety information, including surgical risks and considerations, please also refer to intuitive.com/safety.
For a product's intended use and/or indications for use, risks, full cautions, and warnings, please refer to the associated user manual(s).

Individual outcomes may depend on a number of factors, including but not limited to patient characteristics, disease characteristics, and/or surgeon experience.

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