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SWANSON Finger Joint

2014 Reimbursement Codes*

The following codes contained within this document are representative of possible services or diagnoses that may be associated with use of Wright products. This is not a complete listing of possible codes. Not all of the codes are necessarily to be used together. Some codes may be considered a component of another ('bundled'). Final determination of the correct or appropriate coding for services performed are made by the claims submitter/provider and should be consistent with the billing policies of the patient's health insurance program.

HCPCS Level II Code

Code	Description
L8630	Metacarpophalangeal Joint Implant

CPT® Codes

The reimbursement for implants or internal fixation is frequently included in the CPT code.

Codes for implanted devices or internal fixation are to be used only when these devices are not already listed as part of the basic procedure. In cases where the CPT does not contain inclusion of the device, it is appropriate to list the procedure for application of the device(s) separately, utilizing an Unlisted Procedure code from the appropriate musculoskeletal system.

26989 Unlisted procedure, hands or fingers

When reporting an unlisted code to describe a procedure or service, it will be necessary to submit supporting documentation (e.g., procedure report) along with the claim to provide an adequate description of the nature, extent, need for the procedure; and the time, effort, and equipment necessary to provide the service.

CPT® Code	Description	RVU Fac	RVU Phys Ofc	APC Pymt	ASC Pymt
26531	Arthroplasty, metacarpophalangeal joint; with prosthetic implant, each joint	$17.65	N/A	$4638.89	$2562.62
26535	Arthroplasty, interphalangeal joint; with prosthetic implant, each joint	$11.85	N/A	$3122.45	$1724.90

ICD-9 Diagnostic Codes

Swanson Finger Joints are designed to restore function to hands disabled by rheumatoid, degenerative or traumatic arthritis. Select the appropriate diagnosis that represents the patient's arthritic condition. Code also any underlying cause where indicated.

Code	Description
715.04	Osteoarthritis, generalized, hand

Inpatient Hospital Data

MS-DRG Code	Description	National Unadjusted Pymt
506	Major thumb or joint procedures	$6983.29

* Medicare Physician Fee Schedule facility and non-facility (office) relative value amounts published in the 2014 Medicare Physician Fee Schedule Final Rule Addendum B, linked at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html?DLPage=1&DLSort=3&DLSortDir=descending. Hospital Outpatient Prospective Payment System payment rates published in the 2014 Hospital Outpatient Prospective Payment System Final Rule Addendum B, linked at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1601-FC-.html?DLPage=1&DLSort=2&DLSortDir=descending. Ambulatory Surgical Center payment rates published in the 2014 Ambulatory Surgical Center Final Rule Addendum AA, linked at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1601-FC.html?DLPage=1&DLSort=2&DLSortDir=descending. In-patient payment rates calculated using the MS-DRG relative weights published in Table 5 to the 2014 Medicare Hospital Inpatient Prospective Payment System for Acute Care Hospitals final rule, linked at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Tables.html?DLPage=1&DLSort=0&DLSortDir=ascending, multiplied by the 2014 final rule standardized amount of $5,799.59.

Disclaimer

The information and data provided by Wright Medical Technology is presented for informational purposes only and is accurate as of its date of publication. It is the provider's responsibility to report the codes that accurately describe the products and services furnished to individual patients. Reimbursement is dynamic. Laws and regulations regarding reimbursement change frequently and providers are solely responsible for all decisions related to coding and billing including determining, if and under what circumstances, it is appropriate to seek reimbursement for products and services and obtaining pre-authorization, if necessary. For these reasons, providers are advised to, and should contact Medicare and/or specific payers if the provider has any questions regarding billing, coverage and payment. Likewise, providers should contact a medical specialty society or the AMA for coding clarification. Providers should check the complete and current CPT manual to see and consider all possible CPT codes. Wright Medical Technology makes no representation or warranty regarding this information or its completeness or accuracy and will bear no responsibility for the results or consequences of the use of this information.

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Wright Medical Technology, Inc.
1023 Cherry Road
Memphis, TN 38117
800 238 7117
901 867 9971
www.wmt.com

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