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FUSEFORCE®

2015 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. CPT® codes and descriptors are copyrighted by the American Medical Association (AMA). CPT® is a registered trademark of the American Medical Association.

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HCPCS Device Codes

HCPCS codes are developed and maintained by CMS and are used to report items such as medical devices, implants, drugs and supplies. C-codes are a special type of HCPCS code designed specifically for hospital use in billing Medicare for certain outpatient items and procedures. Other payers may also accept C-codes. S codes are used by private insurers to report drugs, services, and supplies for which there are no national codes but for which codes are needed by the private sector to implement policies, programs, or claims processing. They are for the purpose of meeting the particular needs of the private sector.

Not all implanted items have a specific HCPCS code. If desired, a miscellaneous HCPCS code can be used.

HCPCS Code	Description
C1713	Anchor/screw for opposing bone-to-bone or soft tissue bone (implantable)
L8699	Prosthetic implant, not otherwise specified

Reference: "List of Device Category Codes for Present or Previous Pass-Through Payment and Related Definitions", January 2015

CPT® Codes

Codes for internal or external fixation are to be used only when internal or external fixation is not already listed as part of the basic procedure.

Physician Coding

Resource based relative value scale (RBRVS) is the prospective payment system Medicare uses to reimburse physicians. Each service has relative value units (RVUs) that indicate its rank compared to all other services in terms of the relative costs of the resources required, including physician work, practice expenses, and malpractice insurance. The RVU is converted to a flat payment amount using a standardized conversion factor.

Different sites of services have different RVUs and payment:

- Facility RVUs represent surgical services provided in hospitals, ambulatory surgical centers, or skilled nursing facilities.
- Non-Facility RVUs represent surgical services provided in physician's offices.
- RVUs and payments are usually lower in the Facility setting because the facility is incurring some of the costs. RVUs and payments are usually higher in the Non-Facility setting because the physician incurs all costs there and the physician must be reimbursed for those costs.

"NA" indicates that the Non-Facility RVUs do not exist because the service is expected to be performed in a facility.
"UNL" indicates the CPT code as unlisted, and therefore Non-Facility or Facility RVUs cannot be calculated.

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
25628	Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed	20.51	$734	NA	NA
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	16.39	$587	NA	NA
28294	Correction, hallux valgus (bunion) with or without sesamoidectomy; with tendon transplants (eg Joplin type procedure)	15.48	$554	22.04	$789
28296	Correction, hallux valgus (bunion) with or without sesamoidectomy; with metatarsal ostectomy (eg, Mitchell, Chevron, or concentric type procedures)	14.94	$535	20.53	$735
28297	Correction, hallux valgus (bunion) with or without sesamoidectomy; Lapidus-type procedure	16.66	$596	23.35	$836
28298	Correction, hallux valgus (bunion) with or without sesamoidectomy; by phalanx osteotomy	14.47	$518	20.73	$742

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
28299	Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy	19.44	$696	25.85	$925
28300	Osteotomy; calcaneus (Dwyer or Chambers type procedure), with or without internal fixation	18.71	$670	NA	$36
28302	Osteotomy; talus	20.46	$732	NA	$36
28304	Osteotomy, tarsal bones, other than calcaneus or talus	17.43	$624	23.86	$854
28305	Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft)(eg, Fowler type)	18.71	$670	NA	NA
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	11.57	$414	17.68	$633
28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	13.49	$483	20.43	$731
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	10.79	$386	16.28	$583
28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	26.11	$935	NA	$36
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed;	9.36	$335	13.93	$499
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	17.40	$623	NA	$36
28445	Open treatment of talus fracture, includes internal fixation, when performed	10.47	$375	15.06	$539
28446	Open osteochondral autograft, talus (includes obtaining graft[s])	35.10	$1,257	NA	NA
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	17.66	$632	NA	NA
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	15.07	$540	NA	NA
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	14.47	$518	19.42	$695
28715	Arthrodesis, triple	26.89	$963	NA	NA
28725	Arthrodesis, subtalar	22.26	$797	NA	NA
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse	20.93	$749	NA	NA
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse with osteotomy (eg, flatfoot correction)	22.39	$802	NA	NA
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	19.85	$711	NA	NA
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	17.85	$639	24.35	$872
28750	Arthrodesis, great toe; metatarsophalangeal joint	16.98	$608	23.48	$841

Reference: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2015 Final Rule, Addendum B: CY 2015 Relative Value Units (RVUs) and related information used in determining final Medicare payments.

See also: http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

2015 Medicare Physician Fee Schedule (MPFS) Conversion Factor: The CY 2015 MPFS conversion factor is $35.8013 for January 1, 2015 through March 31, 2015--as a result of Congress passing a "fix" to the sustainable growth rate (SGR) in April 2014. The "fix" provided for a zero percent update for services furnished between January 1 and March 31, 2015.

Hospital Outpatient Coding (APCs)

Ambulatory payment classifications (APCs) is the prospective payment system Medicare uses to reimburse hospitals for outpatient services. Each CPT® code for a significant procedure is assigned to a specific APC class based on clinical and resource similarities. Each APC has a relative weight that indicates its rank compared to all other procedures in terms of the relative costs. The relative weight is then converted to a flat payment amount using a standardized conversion factor.

Multiple APCs can be assigned for the same case if multiple procedures are performed. The status indicator (SI) signifies how a code is handled for payment. Specifically, status indicator T means that the code pays at 100% of the rate when it is the only procedure or is the highest-weighted procedure, but pays at 50% of the rate when it is submitted with another higher-weighted procedure.

For Medicare, with a few exceptions, the APC payment for the procedure code is considered complete. In general, separate payment is not made for implanted devices. Instead, payment for implants used in the procedure is included in the payment for the procedure. However, private payers may have carve-outs for implants.

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Medicare Average Payment
25628	Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
28294	Correction, hallux valgus (bunion) with or without sesamoidectomy; with tendon transplants (eg Joplin type procedure)	0057	Bunion Procedures	T	36.0840	$2,675
28296	Correction, hallux valgus (bunion) with or without sesamoidectomy; with metatarsal ostectomy (eg, Mitchell, Chevron, or concentric type procedures)	0057	Bunion Procedures	T	36.0840	$2,675
28297	Correction, hallux valgus (bunion) with or without sesamoidectomy; Lapidus-type procedure	0057	Bunion Procedures	T	36.0840	$2,675
28298	Correction, hallux valgus (bunion) with or without sesamoidectomy; by phalanx osteotomy	0057	Bunion Procedures	T	36.0840	$2,675
28299	Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy	0057	Bunion Procedures	T	36.0840	$2,675
28300	Osteotomy; calcaneus (Dwyer or Chambers type procedure), with or without internal fixation	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28302	Osteotomy; talus	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28304	Osteotomy, tarsal bones, other than calcaneus or talus	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28305	Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft)(eg, Fowler type)	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed;	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
28445	Open treatment of talus fracture, includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
28446	Open osteochondral autograft, talus (includes obtaining graft[s])	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	0062	Level I Treatment Fracture/ Dislocation	T	27.5390	$2,042

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Medicare Average Payment
28715	Arthrodesis, triple	0425	Level V Musculoskeletal Procedures Except Hand and Foot	J1	137.8399	$10,220
28725	Arthrodesis, subtalar	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse with osteotomy (eg, flatfoot correction)	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28750	Arthrodesis, great toe; metatarsophalangeal joint	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217

Reference: Medicare Program: Hospital Outpatient Prospective Payment System Final Rule Addendum C - Final HCPCS Codes Payable Under the 2015 OPPS by APC

Ambulatory Surgery Center (ASC) Coding

Medicare's prospective payment system for ASCs is based on the systems used for hospital outpatient services and physician office-based procedures. Each CPT® code for an ASC-covered procedure is assigned a relative weight and flat payment amount which is then adjusted for the ASC setting.

Multiple procedures can be paid for the same case if multiple codes are submitted. The payment indicator (PI) signifies how a code is handled for payment. Specifically, payment indicator A2 means a surgical procedure whose payment is based on the hospital outpatient rate. Payment indicator G2 is a technical variation but also means a surgical procedure whose payment is based on the hospital outpatient rate. When the Multiple Procedure Discount is Yes, it indicates that the code pays at 100% of the rate when it is the only procedure or is the highest-weighted procedure, but pays at 50% of the rate when it is submitted with another higher-weighted procedure.

For Medicare, with a few exceptions, the ASC payment for the procedure code is considered complete. In general, separate payment is not made for implanted devices. Instead, payment for implants used in the procedure is included in the payment for the procedure. However, private payers may have carve-outs for implants.

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
25628	Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed	A2	Yes	52.5892	$2,318
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	A2	Yes	52.5892	$2,318
28294	Correction, hallux valgus (bunion) with or without sesamoidectomy; with tendon transplants (eg Joplin type procedure)	A2	Yes	33.2875	$1,467
28296	Correction, hallux valgus (bunion) with or without sesamoidectomy; with metatarsal ostectomy (eg, Mitchell, Chevron, or concentric type procedures)	A2	Yes	33.2875	$1,467
28297	Correction, hallux valgus (bunion) with or without sesamoidectomy; Lapidus-type procedure	A2	Yes	33.2875	$1,467
28298	Correction, hallux valgus (bunion) with or without sesamoidectomy; by phalanx osteotomy	A2	Yes	33.2875	$1,467
28299	Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy	A2	Yes	33.2875	$1,467
28300	Osteotomy; calcaneus (Dwyer or Chambers type procedure), with or without internal fixation	A2	Yes	64.9113	$2,861
28302	Osteotomy; talus	A2	Yes	21.6844	$956
28304	Osteotomy, tarsal bones, other than calcaneus or talus	A2	Yes	64.9113	$2,861
28305	Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (eg, Fowler type)	A2	Yes	64.9113	$2,861
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	A2	Yes	21.6844	$956
28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	A2	Yes	21.6844	$956

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	A2	Yes	21.6844	$956
28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	A2	Yes	64.9113	$2,861
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed;	A2	Yes	93.9112	$4,139
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	A2	Yes	52.5892	$2,318
28445	Open treatment of talus fracture, includes internal fixation, when performed	A2	Yes	52.5892	$2,318
28446	Open osteochondral autograft, talus (includes obtaining graft[s])	G2	Yes	64.9113	$2,861
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	A2	Yes	52.5892	$2,318
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	A2	Yes	52.5892	$2,318
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	A2	Yes	25.4047	$1,120
28715	Arthrodesis, triple	A2	Yes	177.9456	$7,842
28725	Arthrodesis, subtalar	A2	Yes	64.9113	$2,861
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse	A2	Yes	64.9113	$2,861
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse with osteotomy (eg, flatfoot correction)	A2	Yes	64.9113	$2,861
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	A2	Yes	64.9113	$2,861
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	A2	Yes	64.9113	$2,861
28750	Arthrodesis, great toe; metatarsophalangeal joint	A2	Yes	64.9113	$2,861

Reference: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Final Rule, Addendum AA -- Final ASC Covered Surgical Procedures for CY 2015 (Including Surgical Procedures for Which Payment is Packaged), Addendum EE -- Surgical Procedures Proposed to be Excluded from Payment in ASCs for CY 2015

ICD-9-CM Diagnosis Codes

ICD-9-CM diagnosis codes are used by all providers, including physicians, hospitals and ASCs, and in all settings, including inpatient and outpatient. Diagnosis codes indicate the reason for the procedure and are mandatory for reimbursement. The codes shown below are those that are common with procedures using FUSEFORCE®, though other codes may also be appropriate. This list includes common codes assigned for ankle and foot disorders. Also listed are several diagnostic codes reported for hand disorders where FUSEFORCE® may support surgical technique. The ICD-9-CM book should always be referenced for diagnostic coding.

IDC-9-CM Diagnosis	Description
714.0	Rheumatoid arthritis
715.17	Osteoarthrosis, localized, primary, ankle and foot
715.37	Osteoarthrosis, localized, not specified whether primary or secondary, ankle and foot
715.97	Osteoarthrosis, unspecified whether generalized or localized, ankle and foot
716.17	Traumatic arthropathy, ankle and foot
718.47	Contracture of joint, ankle and foot
718.77	Developmental dislocation of joint, ankle and foot
718.87	Other joint derangement, not elsewhere classified, ankle and foot
726.91	Exostosis of unspecified site
727.1	Bunion
731.3	Major osseous defects

IDC-9-CM Diagnosis	Description
732.5	Juvenile osteochondrosis of foot
733.81	Malunion of fracture
733.82	Nonunion of fracture
733.91	Arrest of bone development or growth
733.94	Stress fracture of the metatarsals
734	Flat Foot
735.0	Hallux valgus (acquired)
735.1	Hallux varus (acquired)
735.2	Hallux rigidus
735.3	Hallux malleus
735.4	Other hammer toe (acquired)
735.5	Claw toe (acquired)

IDC-9-CM Diagnosis	Description
735.8	Other acquired deformities of toe
736.70	Unspecified deformity of ankle and foot, acquired
736.71	Acquired equinovarus deformity
736.73	Cavus deformity of foot
736.75	Cavovarus deformity of foot, acquired
736.79	Other acquired deformities of foot and ankle
754.50	Talipes varus
754.51	Talipes equinovarus
754.52	Metatarsus primus varus
754.53	Metatarsus varus
754.59	Other varus deformities of feet
754.60	Talipes valgus
754.61	Congenital pes planus
754.62	Talipes calcaneovalgus
754.69	Other valgus deformities of feet
754.70	Talipes, unspecified
754.71	Talipes cavus
754.79	Other deformities of the feet
755.38	Longitudinal deficiency, tarsals or metatarsals, complete or partial (with or without incomplete phalangeal deficiency)
755.67	Anomalies of foot, not elsewhere classified
814.01	Closed fracture, navicular bone
815.02	Closed fracture, base of metacarpal bone
815.09	Closed fracture, multiple sites of metacarpus
825.21	Fracture of astragalus, closed
825.22	Fracture of navicular [scaphoid], foot, closed
825.24	Fracture of cuneiform, foot, closed
825.25	Closed fracture of metatarsal bone(s)
825.29	Fracture of other tarsal and metatarsal bones, closed
835.23	Fracture of cuboid, closed
838.02	Closed dislocation of midtarsal (joint)
905.4	Late effect of fracture of lower extremities

Hospital Inpatient Diagnosis Related Group (MS-DRGs) and ICD-9-CM Procedure Codes

Diagnosis Related Groups (MS-DRGs) is the prospective payment system Medicare uses to reimburse hospitals for inpatient services. Each inpatient stay is assigned to a specific group based on clinical and resource similarities for its ICD-9-CM diagnosis and procedure codes. Only one DRG is assigned to each inpatient case, regardless of the number of diagnosis and procedure codes. Both CC and MCC refer to secondary diagnoses that are designated as complications/comorbidities (CC) or major complications/comorbidities (MCC). Each DRG has a relative weight which is then converted to a flat payment amount using standard operating and capital amounts.

For Medicare, with a few exceptions, the MS-DRG payment for the procedure is considered complete and payment for implants is included in the MS-DRG payment. However, private payers may have carve-outs for implants.

DRG	DRG Title	Relative Weight	Medicare National Unadjusted Payment	ICD-9-CM Procedure Codes and Descriptions
492	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with MCC	3.1873	$18,695	81.12
493	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with CC	2.0354	$11,938	
494	Lower Extremity and Humerus Procedures without CC/MCC	1.5397	$9,031	
503	Foot Procedures with CC	2.3338	$13,688	77.28 77.38 77.51 77.52 77.53 77.54 77.58 77.88 78.08 79.37 79.38 81.13 81.14 81.15 81.16
504	Foot Procedures with CC	1.5691	$9,203	
505	Foot Procedures without CC/MCC	1.2474	$7,316	
513	Hand or Wrist Procedure, except Major Thumb or Joint Procedure with CC/MCC	1.4462	$8,482	79.33
514	Hand or Wrist Procedure, except Major Thumb or Joint Procedure without CC/MCC	0.8996	$5,276	
515	Other Musculoskeletal System and Connective Tissue OR Procedures with MCC	3.2235	$18,907	77.29
516	Other Musculoskeletal System and Connective Tissue OR Procedures with CC	2.0434	$11,985	
517	Other Musculoskeletal System and Connective Tissue OR Procedures without CC/MCC	1.7251	$10,118	

Reference: Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals Table 5— List of Medicare Severity Diagnosis Related Groups (MS-DRGs) Relative Weighting Factors— FY 2015 Final Rule

Disclaimer

The coding and reimbursement 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 for obtaining pre-authorization, if necessary. For these reasons, providers are advised to contact Medicare and/or specific payers if they have 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 HCPCS and/or CPT manual to see and consider all possible HCPCS and/or 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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