

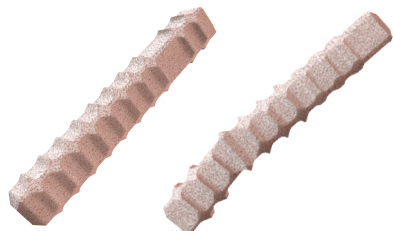


# TENFUSE®

## 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
C1762	Long Description: Connective Tissue, Human (Includes Fascia Lata)
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
28126	Resection, partial or complete, phalangeal base, each toe	7.14	\$256	11.41	\$408
28160	Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each	7.76	\$278	12.18	\$436
28285	Correction, hammertoe (e.g., Interphalangeal fusion, partial or total phalangectomy)	10.84	\$388	15.42	\$552
28286	Correction, cock-up fifth toe, with plastic skin closure (e.g., Ruiz-Mora type procedure)	8.56	\$306	12.97	\$464
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint	15.69	\$562	21.11	\$756
28292	Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride, or Mayo type procedure	17.26	\$618	22.75	\$814

28293	Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant	20.32	\$727	30.07	\$1,077
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 osteotomy (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
28299	Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy	19.44	\$696	25.85	\$925
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	10.79	\$386	16.28	\$583
28310	Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)	10.29	\$368	15.81	\$566
28312	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe	9.30	\$333	14.94	\$535
28322	Repair, nonunion or malunion; metatarsal, with or without bone graft [includes obtaining graft]	16.56	\$593	22.72	\$813
28505	Open treatment of fracture great toe, phalanx or phalanges, with or without internal or external fixation, when performed	14.47	\$518	19.42	\$695
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, with or without internal or external fixation, when performed	11.27	\$403	16.07	\$575
28645	Open treatment of metatarsophalangeal joint dislocation, with or without internal or external fixation, when performed	13.86	\$496	18.83	\$674
28675	Open treatment of interphalangeal joint dislocation, with or without internal or external fixation, when performed	11.92	\$427	17.00	\$609
28755	Arthrodesis, great toe, interphalangeal joint	9.47	\$339	14.64	\$524

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
28126	Resection, partial or complete, phalangeal base, each toe	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	\$1,743
28160	Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	\$1,743
28285	Correction, hammertoe (e.g., Interphalangeal fusion, partial or total phalangectomy)	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	\$1,743
28286	Correction, cock-up fifth toe, with plastic skin closure (e.g., Ruiz-Mora type procedure)	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	\$1,743
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	\$1,743
28292	Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride, or Mayo type procedure	0057	Bunion Procedures	T	36.0840	\$2,675

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Medicare Average Payment
28293	Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant	0057	Bunion Procedures	T	36.0840	\$2,675
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 osteotomy (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
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	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	\$1,743
28310	Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	\$1,743
28312	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	\$1,743
28322	Repair, nonunion or malunion; metatarsal, with or without bone graft [includes obtaining graft]	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	\$1,743
28505	Open treatment of fracture great toe, phalanx or phalanges, with or without internal or external fixation, when performed	0062	Level I Treatment Fracture/Dislocation	T	27.5390	\$2,042
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, with or without internal or external fixation, when performed	0062	Level I Treatment Fracture/Dislocation	T	27.5390	\$2,042
28645	Open treatment of metatarsophalangeal joint dislocation, with or without internal or external fixation, when performed	0062	Level I Treatment Fracture/Dislocation	T	27.5390	\$2,042
28675	Open treatment of interphalangeal joint dislocation, with or without internal or external fixation, when performed	0062	Level I Treatment Fracture/Dislocation	T	27.5390	\$2,042
28755	Arthrodesis, great toe, interphalangeal joint	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	\$1,743

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
28126	Resection, partial or complete, phalangeal base, each toe	A2	Y	21.6844	\$956
28160	Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each	A2	Y	21.6844	\$956
28285	Correction, hammertoe (e.g., Interphalangeal fusion, partial or total phalangectomy)	A2	Y	21.6844	\$956

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
28286	Correction, cock-up fifth toe, with plastic skin closure (e.g., Ruiz-Mora type procedure)	A2	Y	21.6844	\$956
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint	A2	Y	21.6844	\$956
28292	Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride, or Mayo type procedure	A2	Y	33.2875	\$1,467
28293	Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant	A2	Y	33.2875	\$1,467
28294	Correction, hallux valgus (bunion), with or without sesamoidectomy; with tendon transplants (eg, Joplin type procedure)	A2	Y	33.2875	\$1,467
28296	Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)	A2	Y	33.2875	\$1,467
28297	Correction, hallux valgus (bunion), with or without sesamoidectomy; Lapidus-type procedure	A2	Y	33.2875	\$1,467
28298	Correction, hallux valgus (bunion), with or without sesamoidectomy; by phalanx osteotomy	A2	Y	33.2875	\$1,467
28299	Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy	A2	Y	33.2875	\$1,467
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	A2	Y	21.6844	\$956
28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	A2	Y	21.6844	\$956
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal	A2	Y	21.6844	\$956
28310	Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)	A2	Y	21.6844	\$956
28312	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe	A2	Y	21.6844	\$956
28322	Repair, nonunion or malunion; metatarsal, with or without bone graft [includes obtaining graft]	A2	Y	21.6844	\$956
28505	Open treatment of fracture great toe, phalanx or phalanges, with or without internal or external fixation, when performed	A2	Y	25.4047	\$1,120
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, with or without internal or external fixation, when performed	A2	Y	25.4047	\$1,120
28645	Open treatment of metatarsophalangeal joint dislocation, with or without internal or external fixation, when performed	A2	Y	25.4047	\$1,120
28675	Open treatment of interphalangeal joint dislocation, with or without internal or external fixation, when performed	A2	Y	25.4047	\$1,120
28755	Arthrodesis, great toe, interphalangeal joint	A2	Y	21.6844	\$956

Reference: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Final Rule, Addendum AA -- Final ASC Covered Surgical Procedures for CY 2014 (Including Surgical Procedures for Which Payment is Packaged)

## 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 TENFUSE®, 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 TENFUSE® may support surgical technique. The ICD-9-CM book should always be referenced for diagnostic coding.

ICD-9-CM Diagnosis	Description
714.0	Rheumatoid arthritis
715.17	Primary localized osteoarthritis, ankle/foot
715.97	Osteoarthritis unspecified whether generalized or localized, ankle and foot
718.47	Contracture of ankle and foot joint
719.47	Pain in joint, ankle and foot
726.91	Exostosis of unspecified site
727.1	Bunion
733.81	Malunion of fracture
733.82	Nonunion of fracture
733.91	Arrest of bone development or growth
733.99	Other disorders of bone and cartilage
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)
735.8	Other acquired deformities of toe
736.70	Unspecified deformity of ankle and foot, acquired
736.79	Other acquired deformity of ankle and foot
754.50	Congenital talipes varus
754.52	Metatarsus primus varus
754.53	Congenital metatarsus varus
754.60	Congenital talipes valgus
755.66	Other congenital anomaly of toes
754.71	Talipes cavus
755.38	Longitudinal deficiency, tarsals or metatarsals, complete or partial (with or without incomplete phalangeal deficiency)
755.66	Congenital anomaly of toe
755.67	Congenital anomalies of foot, not elsewhere classified
826.0	Closed fracture of one or more phalanges of foot
826.1	Open fracture of one or more phalanges of foot
838.09	Closed dislocation of foot, other
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
495	Local Excision and Removal Internal Fixation Devices Except Hip and Femur W MCC	3.0476	\$17,875	77.79 alone or with (any listed procedure code from DRGs 503-505 and 515-517) 77.28 77.29 77.38 77.51 77.52 77.53 77.56 77.58 77.59 77.78 77.89 78.08 77.89 78.48 79.28 79.38 79.88
496	Local Excision and Removal Internal Fixation Devices Except Hip and Femur W CC	1.7289	\$10,140	
497	Local Excision and Removal Internal Fixation Devices Except Hip and Femur WO CC/MCC	1.2230	\$7,173	
503	Foot Procedures W CC	2.3338	\$13,688	77.28 77.38 77.51 77.52 77.53 77.56 77.58 77.59 77.78 78.08 78.48 79.28 79.38 79.88
504	Foot Procedures W CC	1.5691	\$9,203	
505	Foot Procedures WO CC/MCC	1.2474	\$7,316	
515	Other Musculoskeletal System and Connective Tissue OR Procedures W MCC	3.2235	\$18,907	
516	Other Musculoskeletal System and Connective Tissue OR Procedures W CC	2.0434	\$11,985	77.29 77.89
517	Other Musculoskeletal System and Connective Tissue OR Procedures WO 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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