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SIDEKICK®

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-to-bone (implantable)

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
20690	Application of a uniplane (pins or wires in 1 plane), unilateral, external fixation system	17.00	$608	NA	NA
20692	Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)	31.96	$1,144	NA	NA
20693	Adjustment or revision of external fixation system requiring anesthesia (eg, new pin[s] or wire[s] and/or new ring[s] or bar[s])	12.78	$457	NA	NA
20694	Removal, under anesthesia, of external fixation system	9.63	$344	12.06	$431
28705	Arthrodesis; pantalar	36.02	$1,289	NA	NA
28715	Arthrodesis; triple	26.89	$962	NA	NA
28725	Arthrodesis; subtalar	22.26	$796	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	$801	NA	NA

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	19.85	$710	NA	NA
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	17.85	$639	24.35	$871
28750	Arthrodesis, great toe; metatarsophalangeal joint	16.98	$607	23.48	$840
28755	Arthrodesis, great toe; interphalangeal joint	9.47	$339	14.64	$524
28760	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure)	16.59	$593	22.78	$815
28899	Unlisted procedure, foot or toes	UNL	UNL	UNL	UNL

Reference: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2014 Final Rule, Adendum 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. Status indicator J1 will trigger a comprehensive APC payment for the claim, meaning a single APC will be paid while all other items and services on the same date of service will no longer generate separate payment. Status indicator Q1 is packaged when billed on the same date of service with any other code with a status indicator of S, T, V, or X. If not, they are separately payable under a separate APC.

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	Average Payment
20690	Application of a uniplane (pins or wires in 1 plane), unilateral, external fixation system	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
20692	Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
20693	Adjustment or revision of external fixation system requiring anesthesia (eg, new pin[s] or wire[s] and/or new ring[s] or bar[s])	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
20694	Removal, under anesthesia, of external fixation system	0049	Level I Musculoskeletal Procedures Except Hand and Foot	Q2	22.3913	$1,660
28705	Arthrodesis; pantalar	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
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

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
28750	Arthrodesis, great toe; metatarsophalangeal joint	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28755	Arthrodesis, great toe; interphalangeal joint	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28760	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure)	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28899	Unlisted procedure, foot or toes	0129	Level I Closed Treatment Fracture	T	2.2797	$169

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 J8 indicates Device-intensive procedure; paid at adjusted 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. NA indicates surgical procedures excluded from payment in ASCs for CY 2015. 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
20690	Application of a uniplane (pins or wires in 1 plane), unilateral, external fixation system	A2	Y	32.3631	$1,426
20692	Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)	A2	Y	32.3631	$1,426
20693	Adjustment or revision of external fixation system requiring anesthesia (eg, new pin[s] or wire[s] and/or new ring[s] or bar[s])	A2	Y	32.3631	$1,426
20694	Removal, under anesthesia, of external fixation system	A2	N	20.6560	$910
28705	Arthrodesis; pantalar	A2	Y	64.9113	$2,861
28715	Arthrodesis; triple	J8	N	177.9456	$7,842
28725	Arthrodesis; subtalar	A2	Y	64.9113	$2,861
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse	A2	Y	64.9113	$2,861
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	A2	Y	64.9113	$2,861
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	A2	Y	64.9113	$2,861
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	A2	Y	64.9113	$2,861
28750	Arthrodesis, great toe; metatarsophalangeal joint	A2	Y	64.9113	$2,861
28755	Arthrodesis, great toe; interphalangeal joint	A2	Y	21.6844	$956
28760	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure)	A2	Y	64.9113	$2,861
28899	Unlisted procedure, foot or toes	NA	NA	NA	NA

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 the SIDEKICK® Coretrak Tube Fixator, SIDEKICK® TOMAHAWK® Mini Fixator, SIDEKICK® STEALTH™ Rearfoot Fixator or SIDEKICK® FREEDOM™ Circular Fixator, though other codes may also be appropriate. The ICD-9-CM book should always be referenced for diagnostic coding.

IDC-9-CM Diagnosis	Description
250.60	Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled
250.61	Diabetes with neurological manifestations, type I [juvenile type], not stated as uncontrolled
250.62	Diabetes with neurological manifestations, type II or unspecified type, uncontrolled
250.63	Diabetes with neurological manifestations, type I [juvenile type], uncontrolled
713.5	Arthropathy associated with neurological disorders
714.0	Rheumatoid arthritis
714.1	Felty's syndrome
714.30	Polyarticular juvenile rheumatoid arthritis, chronic or unspecified
714.32	Osteoarthrosis, localized, not specified whether primary or secondary, upper arm
715.17	Osteoarthrosis, localized, primary, ankle and foot
715.27	Osteoarthrosis, localized, secondary, 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
719.47	Pain in joint, ankle and foot
719.67	Other symptoms referable to joint, ankle and foot
719.87	Other specified disorders of joint, ankle and foot
727.1	Bunion
731.3	Major osseous defects
733.19	Pathologic fracture of other specified site
733.44	Aseptic necrosis of talus
733.49	Aseptic necrosis of bone, other
733.81	Malunion of fracture
733.82	Nonunion of fracture
733.94	Stress fracture of metatarsals
733.95	Stress fracture of other bone
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)
735.8	Other acquired deformities of toe

IDC-9-CM Diagnosis	Description
735.9	Unspecified acquired deformity of toe
736.70	Unspecified deformity of ankle and foot, acquired
736.71	Acquired equinovarus deformity
736.72	Equinus deformity of foot, acquired
736.73	Cavus deformity of foot, acquired
736.74	Claw foot, acquired
736.75	Cavovarus deformity of foot, acquired
736.76	Other acquired calcaneus deformity
736.79	Other acquired deformities of ankle and foot
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
754.89	Other specified nonteratogenic anomalies
755.66	Other specified congenital deformities of toes
755.67	Congenital anomalies of foot, not elsewhere classified
824.0	Fracture of medial malleolus, closed
824.1	Fracture of medial malleolus, open
824.2	Fracture of lateral malleolus, closed
824.3	Fracture of lateral malleolus, open
824.4	Bimalleolar fracture, closed
824.5	Bimalleolar fracture, open
824.6	Trimalleolar fracture, closed
824.7	Trimalleolar fracture, open
824.8	Unspecified fracture of ankle, closed
824.9	Unspecified fracture of ankle, open
825.0	Fracture of calcaneus, closed
825.1	Fracture of calcaneus, open
825.20	Closed fracture of unspecified bone(s) of foot [except toes]
825.22	Closed fracture of navicular [scaphoid], foot
825.25	Closed fracture of metatarsal bone(s)
825.29	Other closed fracture of tarsal and metatarsal bones
825.35	Open fracture of metatarsal bone(s)
825.39	Other open fracture of tarsal and metatarsal bones
826.0	Closed fracture of one or more phalanges of foot
826.1	Open fracture of one or more phalanges of foot
827.0	Other, multiple and ill-defined fractures of lower limb, closed
827.1	Other, multiple and ill-defined fractures of lower limb, open
828.0	Closed multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum

IDC-9-CM Diagnosis	Description
828.1	Open multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum
838.02	Closed dislocation of midtarsal (joint)
838.05	Closed dislocation of metatarsophalangeal (joint)
905.4	Late effect of fracture of lower extremities
928.20	Crushing injury of foot
928.3	Crushing injury of toes
996.40	Unspecified mechanical complication of internal orthopedic device, implant, and graft
996.49	Other mechanical complication of other internal orthopedic device, implant, and graft
996.67	Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft
996.78	Other complications due to other internal orthopedic device, implant, and graft
V53.7	Fitting and adjustment of orthopedic devices
V54.01	Other aftercare involving internal fixation device
V54.16	Aftercare for healing traumatic fracture of lower leg
V54.26	Aftercare for healing pathologic fracture of lower leg
V54.89	Aftercare for healing pathologic fracture of lower leg

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. With CC and with MCC refers 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	3.1831	$18,048	78.17 81.11 81.12
493	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with CC	1.9971	$11,583	
494	Lower Extremity and Humerus Procedures without CC/MCC	1.5073	$8,742	
495	Local Excision and Removal Internal Fixation Devices Except Hip and Femur with MCC	2.9110	$16,882	78.67 78.68 78.69
496	Local Excision and Removal Internal Fixation Devices Except Hip and Femur with CC	1.7290	$10,027	
497	Local Excision and Removal Internal Fixation Devices Except Hip and Femur without CC/MCC	1.1731	$6,803	
503	Foot Procedures with CC	2.2584	$13,097	77.38 77.57 77.58 78.10 78.18 81.13 81.14 81.15 81.16
504	Foot Procedures with CC	1.6133	$9,356	
505	Foot Procedures without CC/MCC	1.2072	$7,001	
515	Other Musculoskeletal System and Connective Tissue OR Procedures with MCC	3.3340	$19,335	78.19
516	Other Musculoskeletal System and Connective Tissue OR Procedures with CC	2.0160	$11,691	
517	Other Musculoskeletal System and Connective Tissue OR Procedures without CC/MCC	1.6777	$9,729	
981	Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC	4.9319	$28,600	DRGs 981-3 are resultant if principal diagnosis of 250.60-250.63 is paired with 78.17 77.38 77.57 77.58 78.10 78.18 78.19 81.11 81.12 81.13 81.14 81.15 81.16
982	Extensive O.R. Procedure Unrelated to Principal Diagnosis with CC	2.8504	$16,529	
983	Extensive O.R. Procedure Unrelated to Principal Diagnosis without CC/MCC	1.7462	$10,126	

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 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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