



SALVATION™

BEAMS AND BOLTS

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 2014

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
28320	Repair, nonunion or malunion; tarsal bones	17.40	\$622	NA	NA
28322	Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)	16.56	\$592	22.72	\$813
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed	31.69	\$1,134	NA	NA
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	35.94	\$1,286	NA	NA
28445	Open treatment of talus fracture, includes internal fixation, when performed	30.57	\$1,094	NA	NA
28446	Open osteochondral autograft, talus (includes obtaining graft[s])	35.10	\$1,256	NA	NA
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	17.66	\$632	NA	
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	15.07	\$539	NA	NA
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	19.18	\$686	25.35	\$907

28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed	19.18	\$686	24.53	\$871
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	22.57	\$808	NA	NA
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
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	NA

Reference: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2015 Final Rule,

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	Average Payment
28320	Repair, nonunion or malunion; tarsal bones	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	\$5,217
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
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
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	0063	Level II Treatment Fracture/Dislocation	T	57.0073	\$4,227
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed	0062	Level I Treatment Fracture/Dislocation	T	27.5390	\$2,042
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	0063	Level II Treatment Fracture/Dislocation	T	57.0073	\$4,227
28705	Arthrodesis; pantalar	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	\$5,217
28715	Arthrodesis; triple	0425		J1	137.8399	\$10,220

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
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

Reference: Medicare Program: Hospital Outpatient Prospective Payment System Final Rule Addendum C - Final HCPCS Codes Payable Under the 2015 OPFS 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
28320	Repair, nonunion or malunion; tarsal bones	A2	Y	64.9113	\$2,861
28322	Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)	A2	Y	21.6844	\$956
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed	J8	Y	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	Y	52.5892	\$2,318
28445	Open treatment of talus fracture, includes internal fixation, when performed	A2	Y	52.5892	\$2,318
28446	Open osteochondral autograft, talus (includes obtaining graft[s])	G2	Y	64.9113	\$2,861
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	A2	Y	52.5892	\$2,318
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	A2	Y	52.5892	\$2,318
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	A2	Y	52.5892	\$2,318
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed	A2	Y	25.4047	\$1,120
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	A2	Y	52.5892	\$2,318
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

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 SALVATION™ Fusion Beams and Bolts System though other codes may also be appropriate. The ICD-9-CM book should always be referenced for diagnostic coding.

ICD-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
715.17	Osteoarthritis, localized, primary, ankle and foot
715.27	Osteoarthritis, localized, secondary, ankle and foot
715.37	Osteoarthritis, localized, not specified whether primary or secondary, ankle and foot
715.89	Osteoarthritis involving, or with mention of more than one site, but not specified as generalized, multiple sites
715.97	Osteoarthritis, unspecified whether generalized or localized, ankle and foot
716.17	Traumatic arthropathy, ankle and foot
718.27	Pathological dislocation of joint, ankle and foot
718.28	Pathological dislocation of joint, other specified sites
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
731.3	Major osseous defects
732.7	Osteochondritis dissecans
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
733.91	Arrest of bone development or growth
733.94	Stress fracture of metatarsals
733.95	Stress fracture of other bone
734	Flat foot
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

ICD-9-CM Diagnosis	Description
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
755.67	Congenital anomalies of foot, not elsewhere classified
814.01	Closed fracture, navicular bone
823.80	Closed fracture of unspecified part of tibia alone
824.0	Fracture of medial malleolus, closed
825.0	Fracture of calcaneus, closed
825.1	Fracture of calcaneus, open
825.20	Closed fracture of unspecified bone(s) of foot [except toes]
825.21	Closed fracture of astragalus
825.22	Closed fracture of navicular [scaphoid], foot
825.23	Closed fracture of cuboid
825.24	Closed fracture of cuneiform, foot
825.25	Closed fracture of metatarsal bone(s)
825.29	Other closed fracture of tarsal and metatarsal bones
825.31	Open fracture of astragalus
825.32	Open fracture of navicular [scaphoid], foot
825.33	Open fracture of cuboid
825.34	Open fracture of cuneiform, foot
825.35	Open fracture of metatarsal bone(s)
825.39	Other open fracture of tarsal and metatarsal bones
837.0	Closed dislocation of ankle
837.1	Open dislocation of ankle
838.01	Closed dislocation of tarsal (bone), joint unspecified
838.02	Closed dislocation of midtarsal (joint)
838.03	Closed dislocation of tarsometatarsal (joint)
838.05	Closed dislocation of metatarsophalangeal (joint)
838.11	Open dislocation of tarsal (bone), joint unspecified
838.12	Open dislocation of midtarsal (joint)
838.15	Open dislocation of metatarsophalangeal (joint)
905.4	Late effect of fracture of lower extremities
928.20	Crushing injury of foot
928.21	Crushing injury of ankle
v54.9	Aftercare following joint replacement

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	3.1873	\$18,695	78.57 79.26 81.11 81.12
493	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with CC	2.0354	\$11,938	
494	Lower Extremity and Humerus Procedures WO CC/MCC	1.5397	\$9,031	
495	Local Excision and Removal Internal Fixation Devices Except Hip and Femur W MCC	3.0476	\$17,875	81.13 81.14 81.15 81.16 ~with~ 77.78 or 77.79"
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	
504	Foot Procedures W CC	1.5691	\$9,203	77.38 78.08 78.48 78.58 79.27 79.37 79.88 81.13 81.14 81.15
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	80.90 alone
516	Other Musculoskeletal System and Connective Tissue OR Procedures W CC	2.0434	\$11,985	
517	Other Musculoskeletal System and Connective Tissue OR Procedures WO CC/MCC	1.7251	\$10,118	
981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	4.9968	\$29,306	DRGs 981-983 are resultant if principal diagnosis of 250.60-250.63 is paired with 77.38 78.08 78.48 78.57 78.58 79.26 79.27 79.37 79.88 80.90 81.11 81.12 81.13 81.14 81.15
982	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.8150	\$16,509	
983	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.8039	\$10,738	

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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