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BIOFOAM®

Wedge System

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.

For further information, visit www.wmt.com/codeitwright

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. However, regular HCPCS II device codes are generally used for billing non-Medicare payers.

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

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
**Check with private payers regarding reporting for reimbursement. CMS does not currently recognize a specific HCPCS code for Biofoam wedges.*

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
28297	Lapidus-type procedure	16.66	$596	23.35	$835
28300	Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation	18.71	$669	NA	NA
28302	Osteotomy; talus	20.46	$732	NA	NA
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)	11.57	$414	17.68	$632
28306	Osteotomy, with or without lengthening, shortening or angular correction, other than first metatarsal	13.49	$482	20.43	$731
28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	10.79	$386	16.28	$582
28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	26.11	$934	NA	NA

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
28320	Repair, nonunion or malunion; tarsal bones	17.4	$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
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
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	17.85	$639	24.35	$871

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	Average Payment
28300	Osteotomy; calcaneus (eg, 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, other than 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
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
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
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

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
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 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 identifies a device-intensive procedure; paid at an 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.

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
28297	Lapidus-type procedure	A2	Y	33.2875	$1,467
28300	Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation	A2	Y	64.9113	$2,861
28302	Osteotomy; talus	A2	Y	21.6844	$956
28304	Osteotomy, tarsal bones, other than calcaneus or talus;	A2	Y	64.9113	$2,861
28305	Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (eg, Fowler type)	A2	Y	64.9113	$2,861
28306	Osteotomy, with or without lengthening, shortening or angular correction, other than 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
28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	A2	Y	64.9113	$2,861
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
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
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 BIOFOAM® Evans wedge or BIOFOAM® Wedge System though other codes may also be appropriate. The ICD-9-CM book should always be referenced for diagnostic coding.

IDC-9-CM Diagnosis	Description
239.2	Neoplasm of unspecified nature of bone, soft tissue, and skin
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
718.87	Other joint derangement, not elsewhere classified, ankle and foot
719.67	Other symptoms referable to joint, ankle and foot
719.87	Other specified disorders of joint, ankle and foot
726.91	Exostosis of unspecified site
727.1	Bunion
731.3	Major osseous defects
732.5	Juvenile osteochondrosis of foot
733.19	Pathologic fracture of other specified site
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
733.99	Other disorders of bone and cartilage
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
736.70	Unspecified deformity of ankle and foot, acquired

IDC-9-CM Diagnosis	Description
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
754.62	Talipes calcaneovalgus
754.69	Other valgus deformities of feet
754.70	Talipes, unspecified
754.71	Talipes cavus
754.89	Other specified nonteratogenic anomalies
755.38	Longitudinal deficiency, tarsals or metatarsals, complete or partial (with or without incomplete phalangeal deficiency)
755.66	Other specified congenital deformities of toes
755.67	Congenital anomalies of foot, not elsewhere classified
825.0	Fracture of calcaneous, closed
825.1	Fracture of calcaneous, 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
838.02	Closed dislocation of midtarsal (joint)
905.4	Late effect of fracture of lower extremities
996.49	Other mechanical complication of other internal orthopedic device, implant, and graft

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	81.14 81.15 ~with~ 77.77 or 77.79
496	Local Excision and Removal Internal Fixation Devices Except Hip and Femur W CC	1.7289	$10,027	
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 77.78 78.08 78.28 78.38 78.48 78.58 79.37 81.14 81.15
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	77.29
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	

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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