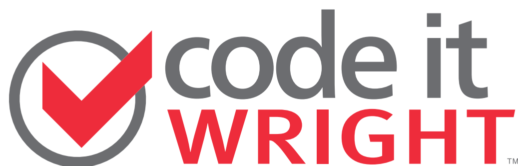

GRAFTJACKET®

2014 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. 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
Q4107	GRAFTJACKET®, per sq cm

R 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
+15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	6.08	$217	6.08	$217
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	23.47	$840	NA	NA
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	24.33	$871	NA	NA
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	27.68	$990	NA	NA
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	34.39	$1,231	NA	NA
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	41.69	$1,492	NA	NA
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	46.55	$1,666	NA	
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	50.36	$1,802	NA	NA

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
23800	Arthrodesis, glenohumeral joint	29.34	$1,050	NA	NA
23929	Unlisted procedure, shoulder	UNL	UNL	UNL	UNL
26476	Lengthening of tendon, extensor, hand or finger, each tendon	16.44	$587	NA	NA
26478	Lengthening of tendon, flexor, hand or finger, each tendon	17.28	$618	NA	NA
26502	Reconstruction of tendon pulley, each tendon; with tendon or fascial graft (includes obtaining graft) (separate procedure)	20.00	$716	NA	NA
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	19.93	$713	NA	NA
27036	Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas)	28.91	$1,035	NA	NA
27422	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)	21.19	$758	NA	NA
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)	31.88	$1,141	NA	NA
27430	Quadricepsplasty (eg, Bennett or Thompson type)	21.02	$752	NA	NA
27599	Unlisted procedure, femur or knee	UNL	UNL	UNL	UNL
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	19.63	$702	NA	NA
27654	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	20.23	$724	NA	NA
27659	Repair, flexor tendon, leg; secondary, with or without graft, each tendon	13.71	$490	NA	NA
27665	Repair, extensor tendon, leg; secondary, with or without graft, each tendon	11.69	$418	NA	NA
27685	Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)	13.25	$474	18.95	$678
27686	Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each	16.10	$576	NA	NA
27899	Unlisted procedure, leg or ankle	UNL	UNL	UNL	UNL
28200	Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon	9.20	$329	14.09	$504
28208	Repair, tendon, extensor, foot; primary or secondary, each tendon	8.96	$320	13.70	$490
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	22.39	$801	NA	NA
28899	Unlisted procedure, foot or toes	UNL	UNL	UNL	UNL
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)	5.05	$180	NA	NA
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	30.13	$1,120	NA	NA

Reference: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2015 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. Status Indicator C indicates an inpatient procedure, Not paid under OPPS. Patient should be admitted and billed as an inpatient. 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 N services are paid under the OPPS, but their payment is packaged into payment for a separately paid service, it is a packaged service/item; no separate payment made. Local carrier determinations may also apply to N when separate payment is allowed. 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
+15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	NA	NA	N	NA	NA
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	0425	Level V Musculoskeletal Procedures Except Hand and Foot	J1	137.8399	$10,220
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	NA	NA	C	NA	NA
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	0047	Arthroplasty	T	45.3575	$3,363
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	NA	NA	C	NA	NA
23800	Arthrodesis, glenohumeral joint	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
23929	Unlisted procedure, shoulder	0129	Level I Closed Treatment Fracture	T	2.2797	$169
26476	Lengthening of tendon, extensor, hand or finger, each tendon	0053	Level I Hand Musculoskeletal Procedures	T	16.5603	$1,228
26478	Lengthening of tendon, flexor, hand or finger, each tendon	0053	Level I Hand Musculoskeletal Procedures	T	16.5603	$1,228
26502	Reconstruction of tendon pulley, each tendon; with tendon or fascial graft (includes obtaining graft) (separate procedure)	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
27036	Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas)	NA	NA	C	NA	NA
27422	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)	0425	Level V Musculoskeletal Procedures Except Hand and Foot	J1	137.8399	$10,220

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
27430	Quadricepsplasty (eg, Bennett or Thompson type)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
27599	Unlisted procedure, femur or knee	0129	Level I Closed Treatment Fracture	T	2.2797	$169
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
27654	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
27659	Repair, flexor tendon, leg; secondary, with or without graft, each tendon	0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	22.3913	$1,660
27665	Repair, extensor tendon, leg; secondary, with or without graft, each tendon	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27685	Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27686	Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27899	Unlisted procedure, leg or ankle	0129	Level I Closed Treatment Fracture	T	2.2797	$169
28200	Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28208	Repair, tendon, extensor, foot; primary or secondary, each tendon	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	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
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)	NA	NA	N	NA	NA
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	0042	Level II Arthroscopy	T	58.5867	$4,344

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. Payment indicator N1 indicates a packaged procedure/item; no separate payment made. 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
+15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	N1	NA	0.0000	NA
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	A2	Y	46.8009	$2,063
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	A2	Y	46.8009	$2,063

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	A2	Y	46.8009	$2,063
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	NA	NA	NA	NA
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	NA	NA	NA	NA
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	NA	NA	NA	NA
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	NA	NA	NA	NA
23800	Arthrodesis, glenohumeral joint	A2	Y	78.6374	$3,466
23929	Unlisted procedure, shoulder	NA	NA	NA	NA
26476	Lengthening of tendon, extensor, hand or finger, each tendon	A2	Y	15.2769	$673
26478	Lengthening of tendon, flexor, hand or finger, each tendon	A2	Y	15.2769	$673
26502	Reconstruction of tendon pulley, each tendon; with tendon or fascial graft (includes obtaining graft) (separate procedure)	A2	Y	27.4875	$1,211
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	A2	Y	27.4875	$1,211
27036	Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas)	NA	NA	NA	NA
27422	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)	A2	Y	46.8009	$2,063
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)	J8	N	177.9456	$7,842
27430	Quadricepsplasty (eg, Bennett or Thompson type)	A2	Y	46.8009	$2,063
27599	Unlisted procedure, femur or knee	NA	NA	NA	NA
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	A2	Y	46.8009	$2,063
27654	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	A2	Y	46.8009	$2,063
27659	Repair, flexor tendon, leg; secondary, with or without graft, each tendon	A2	Y	20.6560	$910
27665	Repair, extensor tendon, leg; secondary, with or without graft, each tendon	A2	Y	32.3631	$1,426
27685	Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)	A2	Y	32.3631	$1,426
27686	Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each	A2	Y	32.3631	$1,426
27899	Unlisted procedure, leg or ankle	NA	NA	NA	NA
28200	Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon	A2	Y	21.6844	$956
28208	Repair, tendon, extensor, foot; primary or secondary, each tendon	A2	Y	21.6844	$956
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	A2	Y	64.9113	$2,861
28899	Unlisted procedure, foot or toes	NA	NA	NA	NA
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)	N1	NA	0.0000	NA
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	A2	Y	54.0462	$2,382

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 GRAFTJACKET® Regenerative Tissue Matrix though other codes may also be appropriate. The ICD-9-CM book should always be referenced for diagnostic coding.

IDC-9-CM Diagnosis	Description
170.4	Malignant neoplasm of scapula and long bones of upper limb [resection of tumor] [resection of tumor]
171.2	Malignant neoplasm of connective and other soft tissue of upper limb, including shoulder [resection of tumor] [resection of tumor]
337.20	Reflex sympathetic dystrophy, unspecified
337.21	Reflex sympathetic dystrophy of the upper limb
337.22	Reflex sympathetic dystrophy of the lower limb
353.0	Brachial plexus [with flail shoulder]
714.0	Rheumatoid arthritis
715.11	Primary localized osteoarthrosis, shoulder region
715.15	Osteoarthrosis, localized, primary, pelvic region and thigh
715.21	Secondary localized osteoarthrosis, shoulder region
715.25	Osteoarthrosis, localized, secondary, pelvic region and thigh
715.31	Localized osteoarthrosis not specified whether primary or secondary,shoulder region
715.35	Osteoarthrosis, localized, not specified whether primary or secondary, pelvic region and thigh
715.91	Osteoarthrosis, unspecified whether generalized or localized, shoulder region
715.95	Osteoarthrosis, unspecified whether generalized or localized, pelvic region and thigh
716.11	Traumatic arthropathy, shoulder region
716.51	Unspecified polyarthropathy or polyarthritis, shoulder region
716.61	Unspecified monoarthritis, shoulder region
716.81	Other specified arthropathy, shoulder region
716.91	Unspecified arthropathy, shoulder region
717.0	Old bucket handle tear of medial meniscus
717.1	Derangement of anterior horn of medial meniscus
717.2	Derangement of posterior horn of medial meniscus
717.3	Other and unspecified derangement of medial meniscus
717.40	Derangement of lateral meniscus, unspecified
717.41	Bucket handle tear of lateral meniscus
717.42	Derangement of anterior horn of lateral meniscus
717.43	Derangement of posterior horn of lateral meniscus
717.49	Other derangement of lateral meniscus
717.81	Old disruption of lateral collateral ligament
717.82	Old disruption of medial collateral ligament
717.83	Old disruption of anterior cruciate ligament
717.84	Old disruption of posterior cruciate ligament
717.89	Other internal derangement of knee
718.65	Unspecified intrapelvic protrusion of acetabulum, pelvic region and thigh
718.90	Unspecified derangement of joint, site unspecified
718.91	Unspecified derangement of joint, shoulder region

IDC-9-CM Diagnosis	Description
718.95	Unspecified derangement of joint, pelvic region and thigh
718.97	Unspecified derangement of joint, ankle and foot
719.61	Other symptoms referable to joint of shoulder region [crepitus]
726.19	Other specified disorders of shoulder [Rotator cuff tear arthropathy with severe rotator cuff tearing]
726.2	Other affections of shoulder region, not elsewhere classified
726.39	Other enthesopathy of elbow region
726.4	Enthesopathy of wrist and carpus
726.5	Enthesopathy of hip region
726.63	Fibular collateral ligament bursitis
726.64	Patellar tendinitis
726.71	Achilles bursitis or tendinitis
726.72	Tibialis tendinitis
726.79	Other enthesopathy of ankle and tarsus
726.8	Other peripheral enthesopathies
727.61	Complete rupture of rotator cuff
728.4	Laxity of ligament
728.6	Contracture of palmar fascia
732.7	Osteochondritis dissecans
726.0	Adhesive capsulitis of shoulder
733.41	Aseptic necrosis of head of humerus [without glenoid involvement]
733.42	Aseptic necrosis of head and neck of femur
733.81	Malunion of fracture
733.82	Nonunion of fracture
767.7	Other cranial and peripheral nerve injuries due to birth trauma [paralytic disorders of infancy]
812.12	Fracture of anatomical neck of humerus, open
812.20	Fracture of unspecified part of humerus, closed
831.00	Closed dislocation of shoulder, unspecified
831.01	Closed anterior dislocation of humerus
831.02	Closed posterior dislocation of humerus
831.03	Closed inferior dislocation of humerus
831.04	Closed dislocation of acromioclavicular (joint)
831.10	Open dislocation of shoulder, unspecified
831.11	Open anterior dislocation of humerus
831.12	Open posterior dislocation of humerus
831.13	Open inferior dislocation of humerus
831.14	Open dislocation of acromioclavicular (joint)
844.0	Sprain of lateral collateral ligament of knee
844.1	Sprain of medial collateral ligament of knee
844.2	Sprain of cruciate ligament of knee

IDC-9-CM Diagnosis	Description
844.3	Sprain of tibiofibular (joint) (ligament) superior, of knee
840.4	Rotator cuff (capsule) sprain and strain
844.8	Sprains and strains of other specified sites of knee and leg
845.0	Sprain of ankle, unspecified site
845.01	Sprain of deltoid (ligament), ankle
845.02	Sprain of calcaneofibular (ligament) of ankle
845.03	Sprain of tibiofibular (ligament), distal of ankle
845.09	Other sprains and strains of ankle
905.2	Late effect of fracture of upper extremities
905.3	Late effect of fracture of neck of femur
905.4	Late effect of fracture of lower extremities
905.8	Late effect of tendon injury
V43.61	Shoulder joint replacement status [failed total shoulder arthroplasty]
V43.62	Elbow joint replacement status [failed total shoulder arthroplasty]
V43.63	Wrist joint replacement [failed total shoulder arthroplasty]
V43.64	Hip joint replacement [failed total shoulder arthroplasty]
V43.65	Knee joint replacement [failed total shoulder arthroplasty]
V43.66	Ankle joint replacement [failed total shoulder arthroplasty]

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
480	Hip & Femur Procedures Except Major Joint with Mcc	3.0052	$17,262	80.45
481	Hip & Femur Procedures Except Major Joint with CC	1.9776	$11,599	
482	Hip & Femur Procedures Except Major Joint without CC/MCC	1.6243	$9,527	
483	Major Joint/Limb Reattachment Procedure Of Upper Extremities	2.4205	$14,197	81.80 81.81
487	Knee Procedures with Pdx Of Infection without CC/MCC	1.5630	$9,167	81.44 81.46
488	Knee Procedures without Pdx Of Infection with CC/MCC	1.7225	$10,103	
489	Knee Procedures without Pdx Of Infection without CC/MCC	1.3186	$7,734	

DRG	DRG Title	Relative Weight	Medicare National Unadjusted Payment	ICD-9-CM Procedure Codes and Descriptions
492	Lower Extrem & Humer Proc Except Hip,Foot,Femur with MCC	3.1873	$18,695	81.49
493	Lower Extrem & Humer Proc Except Hip,Foot,Femur with CC	2.0354	$11,938	
494	Lower Extrem & Humer Proc Except Hip,Foot,Femur without CC/MCC	1.5397	$9,031	
495	Local Excision & Removal Int Fix Devices Exc Hip & Femur with MCC	3.0476	$17,875	77.69
496	Local Excision & Removal Int Fix Devices Exc Hip & Femur with CC	1.7289	$10,140	
497	Local Excision & Removal Int Fix Devices Exc Hip & Femur without CC/MCC	1.2230	$7,173	
500	Soft Tissue Procedures with MCC	3.2420	$19,015	83.62 83.75 83.81 83.85 83.86 83.88 83.89
501	Soft Tissue Procedures with CC	1.6474	$9,662	
502	Soft Tissue Procedures without CC/MCC	1.1597	$6,802	
503	Foot Procedures with MCC	2.3338	$13,688	77.38 81.14
504	Foot Procedures with CC	1.5691	$9,203	
505	Foot Procedures without CC/MCC	1.2474	$7,316	
506	Major Thumb Or Joint Procedures	1.2881	$7,555	81.72
507	Major Shoulder Or Elbow Joint Procedures with CC/MCC	1.9154	$11,234	81.23
508	Major Shoulder Or Elbow Joint Procedures without CC/MCC	1.5198	$8,914	
510	Shoulder,Elbow Or Forearm Proc,Exc Major Joint Proc with MCC	2.2857	$13,406	83.63
511	Shoulder,Elbow Or Forearm Proc,Exc Major Joint Proc with CC	1.6509	$9,683	
512	Shoulder,Elbow Or Forearm Proc,Exc Major Joint Proc without CC/Mcc	1.2963	$7,603	
513	Hand Or Wrist Proc, Except Major Thumb Or Joint Proc with CC/MCC	1.4462	$8,482	82.55 82.71
514	Hand Or Wrist Proc, Except Major Thumb Or Joint Proc without CC/MCC	0.8996	$5,276	
515	Other Musculoskelet Sys & Conn Tiss O.r. Proc with MCC	3.2235	$18,907	81.97
516	Other Musculoskelet Sys & Conn Tiss O.r. Proc with CC	2.0434	$11,930	
517	Other Musculoskelet Sys & Conn Tiss O.r. Proc 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 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.

Wright Medical Technology, Inc.
1023 Cherry Road
Memphis, TN 38117
800 238 7117
901 867 9971
www.wmt.com

™Trademarks and ®Registered marks of Wright Medical Technology, Inc.
©2014 Wright Medical Technology, Inc. All Rights Reserved.

011252A_10-Nov-2014