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EVOLVE® TRIAD™

Fixation 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.

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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
23585	Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation, when performed	28.00	$1,002	NA	NA
24400	Osteotomy, humerus, with or without internal fixation	23.35	$836	NA	NA
24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure	30.24	$1,083	NA	NA
24430	Repair of nonunion or malunion, humerus; without graft (eg, compression technique)	30.19	$1,081	NA	NA
24435	Repair of nonunion or malunion, humerus; with iliac or other autograft (includes obtaining graft)	30.80	$1,103	NA	NA
24545	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension	26.55	$951	NA	NA
24546	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension	29.69	$1,063	NA	NA

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
24575	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	20.94	$750	NA	NA
24579	Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed	23.83	$853	NA	NA
24665	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed	18.58	$665	NA	NA
24685	Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed	18.64	$667	NA	NA
25355	Osteotomy, radius; middle or proximal third	26.95	$965	NA	NA
25360	Osteotomy; ulna	18.64	$667	NA	NA
25365	Osteotomy; radius AND ulna	26.14	$936	NA	NA
25370	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna	28.77	$1,030	NA	NA
25375	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius AND ulna	27.23	$975	NA	NA
25400	Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique)	22.88	$819	NA	NA
25405	Repair of nonunion or malunion, radius OR ulna; with autograft (includes obtaining graft)	29.50	$1,056	NA	NA
25415	Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)	27.66	$990	NA	NA
25515	Open treatment of radial shaft fracture, includes internal fixation, when performed	19.09	$683	NA	NA
25545	Open treatment of ulnar shaft fracture, includes internal fixation, when performed	17.76	$636	NA	NA
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	20.92	$749	NA	NA
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments	23.49	$841	NA	NA
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 fragments	29.85	$1,069	NA	NA
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	16.39	$587	NA	NA
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each	16.97	$608	NA	NA
26860	Arthrodesis, interphalangeal joint, with or without internal fixation	15.81	$566	NA	NA
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	15.07	$540	NA	NA
28705	Arthrodesis; pantalar	36.02	$1,290	NA	NA
28715	Arthrodesis; triple	26.89	$963	NA	NA
28725	Arthrodesis; subtalar	22.26	$797	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	$802	NA	NA
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	19.85	$711	NA	NA
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	17.85	$639	24.35	$872
28750	Arthrodesis, great toe; metatarsophalangeal joint	16.98	$608	23.48	$841

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. 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.

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
23585	Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation, when performed	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
24400	Osteotomy, humerus, with or without internal fixation	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
24430	"Repair of nonunion or malunion, humerus; without graft (eg, compression technique) "	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
24435	Repair of nonunion or malunion, humerus; with iliac or other autograft (includes obtaining graft)	0425	Level V Musculoskeletal Procedures Except Hand and Foot	J1	137.8399	$10,220
24545	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
24546	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
24575	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
24579	Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
24665	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
24685	Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
25355	Osteotomy, radius; middle or proximal third	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
25360	Osteotomy; ulna	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
25365	Osteotomy; radius AND ulna	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
25370	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
25375	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius AND ulna	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
25400	Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique)	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
25405	Repair of nonunion or malunion, radius OR ulna; with autograft (includes obtaining graft)	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
25415	Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
25515	Open treatment of radial shaft fracture, includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
25545	Open treatment of ulnar shaft fracture, includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 fragments	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each	0062	Level I Treatment Fracture/ Dislocation	T	27.5390	$2,042
26860	Arthrodesis, interphalangeal joint, with or without internal fixation	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	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	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
28750	Arthrodesis, great toe; metatarsophalangeal 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 G2 is a technical variation but also means a surgical procedures 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
23585	Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation, when performed	J8	Y	93.9112	$4,139
24400	Osteotomy, humerus, with or without internal fixation	A2	Y	46.8009	$2,063
24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)	A2	Y	46.8009	$2,063
24430	Repair of nonunion or malunion, humerus; without graft (eg, compression technique)	A2	Y	78.6374	$3,466
24435	Repair of nonunion or malunion, humerus; with iliac or other autograft (includes obtaining graft)	J8	N	177.9456	$7,842
24545	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension	J8	Y	93.9112	$4,139
24546	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension	A2	Y	2.6594	$117
24575	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	J8	Y	93.9112	$4,139
24579	Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed	J8	Y	93.9112	$4,139
24665	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed	A2	Y	52.5892	$2,318
24685	Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed	A2	Y	52.5892	$2,318
25355	Osteotomy, radius; middle or proximal third	A2	Y	46.8009	$2,063
25360	Osteotomy; ulna	A2	Y	46.8009	$2,063
25365	Osteotomy; radius AND ulna	A2	Y	46.8009	$2,063
25370	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna	A2	Y	46.8009	$2,063
25375	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius AND ulna	A2	Y	46.8009	$2,063
25400	Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique)	A2	Y	78.6374	$3,466
25405	Repair of nonunion or malunion, radius OR ulna; with autograft (includes obtaining graft)	A2	Y	78.6374	$3,466
25415	Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)	A2	Y	78.6374	$3,466
25515	Open treatment of radial shaft fracture, includes internal fixation, when performed	A2	Y	52.5892	$2,318
25545	Open treatment of ulnar shaft fracture, includes internal fixation, when performed	A2	Y	52.5892	$2,318
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	J8	Y	93.9112	$4,139
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments	J8	Y	93.9112	$4,139
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 fragments	J8	Y	93.9112	$4,139
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	A2	Y	52.5892	$2,318
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each	A2	Y	25.4047	$1,120

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
26860	Arthrodesis, interphalangeal joint, with or without internal fixation	A2	Y	27.4875	$1,211
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	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
28750	Arthrodesis, great toe; metatarsophalangeal 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 EVOLVE® TRIAD™ Fixation System , though other codes may also be appropriate. This list includes common codes assigned for ankle and foot disorders. The ICD-9-CM book should always be referenced for diagnostic coding.

IDC-9-CM Diagnosis	Description
713.5	Arthropathy associated with neurological disorders
714.0	Rheumatoid arthritis
715.04	Osteoarthrosis, generalized, hand
715.11	Osteoarthrosis, localized, primary, shoulder region
715.13	Osteoarthrosis, localized, primary, forearm
715.14	Osteoarthrosis, localized, primary, hand
715.17	Osteoarthrosis, localized, primary, ankle and foot
715.27	Osteoarthrosis, localized, secondary, ankle and foot
715.34	Osteoarthrosis, localized, not specified whether primary or secondary, hand
715.37	Osteoarthrosis, localized, not specified whether primary or secondary, ankle and foot
715.93	Osteoarthrosis, unspecified whether generalized, forearm
715.94	Osteoarthrosis, unspecified whether generalized, hand
715.97	Osteoarthrosis, unspecified whether generalized, ankle and foot
716.11	Traumatic arthropathy, shoulder region
716.17	Traumatic arthropathy, ankle and foot
718.44	Contracture of joint, hand
718.47	Contracture of joint, ankle and foot
718.81	Other joint derangement, not elsewhere classified, shoulder region
719.41	Pain in joint, shoulder region
726.10	Disorders of bursae and tendons in shoulder region, unspecified
727.61	Complete rupture of rotator cuff
727.81	Contracture of tendon (sheath)
729.6	Residual foreign body in soft tissue
733.19	Pathologic fracture of other specified site
733.81	Malunion of fracture

IDC-9-CM Diagnosis	Description
733.82	Nonunion of fracture
733.99	Other disorder of bone and cartilage
734	Flat foot
735.0	Hallux valgus (acquired)
735.2	Hallux rigidus
735.4	Other hammer toe (acquired)
735.5	Claw toe (acquired)
735.8	Other acquired deformities of toe
736.72	Equinus deformity of foot, acquired
736.79	Other deformity of foot
754.59	Other varus deformities of feet
810.00	Fracture of clavicle, closed, unspecified part
811.01	Fracture of scapula, closed, acromial process
811.03	Fracture of scapula, closed, glenoid cavity and neck of scapula
811.09	Fracture of scapula, closed, other
812.00	Fracture of humerus, upper end, closed, unspecified part
812.03	Fracture of humerus, closed, greater tuberosity
812.20	Fracture of humerus, shaft or unspecified part, closed unspecified part
812.21	Fracture of humerus, closed, shaft of humerus
812.4	Fracture of humerus, lower end, closed, unspecified part
812.41	Fracture of humerus, closed, supracondylar
812.42	Fracture of humerus, closed, lateral condyle
812.43	Fracture of humerus, closed, medial condyle
812.44	Fracture of humerus, closed, condyle(s), unspecified
812.49	Fracture of humerus, closed, other
812.50	Fracture of humerus, lower end, open, unspecified part

IDC-9-CM Diagnosis	Description
812.51	Fracture of humerus, lower end, open, supracondylar
812.52	Fracture of humerus, lower end, open, lateral condyle
812.53	Fracture of humerus, lower end, open, medial condyle
813.00	Fracture, upper end of forearm, closed, unspecified
813.01	Fracture, olecranon process of ulna, closed
813.01	Fracture, olecranon process of ulna, closed
813.03	Monteggia's fracture, closed
813.05	Fracture, head of radius, closed
813.06	Fracture, neck of radius, closed
813.11	Fracture, olecranon process of ulna, open
813.21	Fracture, radius (alone), closed
813.22	Fracture, ulna (alone), closed
813.23	Fracture, radius with ulna, closed
813.31	Fracture, radius (alone), open
813.32	Fracture, ulna (alone), open
813.41	Colles' fracture, closed
813.42	Other fractures of distal end of radius (alone), closed
813.44	Fracture, radius with ulna, lower end, closed
813.82	Fracture, ulna unspecified (alone), closed
815.00	Fracture of metacarpal bone(s), closed, metacarpal bone(s), site unspecified
815.02	Fracture of metacarpal bone(s), closed, base of other metacarpal bone(s)
815.03	Fracture of metacarpal bone(s), closed, shaft of metacarpal bone(s)
815.04	Fracture of metacarpal bone(s), closed, neck of metacarpal bone(s)
815.1	Fracture of metacarpal bone(s), open, metacarpal bone(s), site unspecified
815.12	Fracture of metacarpal bone(s), open, base of other metacarpal bone(s)

IDC-9-CM Diagnosis	Description
815.13	Fracture of metacarpal bone(s), open, shaft of metacarpal bone(s)
815.14	Fracture of metacarpal bone(s), open, neck of metacarpal bone(s)
816.00	Fracture of one or more phalanges of hand, closed, phalanx or phalanges, unspecified
816.01	Fracture of one or more phalanges of hand, closed, middle or proximal phalanx or phalanges
816.02	Fracture of one or more phalanges of hand, closed, distal phalanx or phalanges
816.11	Fracture of one or more phalanges of hand, open, middle or proximal phalanx or phalanges
825.25	Fracture of one or more tarsal and metatarsal bones, metatarsal bone(s), closed
825.35	Fracture of other tarsal and metatarsal bones, open, metatarsal bone(s)
831.00	Dislocation of shoulder, closed, shoulder, unspecified
841.00	Sprains and strains of radial collateral ligament
841.1	Sprains and strains of ulnar collateral ligament
841.9	Sprains and strains of unspecified site of elbow and forearm
842.00	Sprains and strains of wrist and hand, unspecified site
905.2	Late effect of fracture of upper extremities
996.40	Unspecified mechanical complication of internal orthopedic device, implant, and graft
996.43	Broken prosthetic joint implant
996.49	Failed Fusion / Other mechanical complication of other internal orthopedic device, implant, and graft
996.77	Other complications due to internal joint prosthesis
996.78	Other complications due to other internal orthopedic device, implant, and graft
V54.01	Encounter for removal of internal fixation device
E878.1	Surgical operation with implant of artificial internal device as the cause of abnormal reaction or later complication

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
492	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with MCC	3.1873	$18,695	77.22 77.32 78.02 78.42 78.52 79.31 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	77.79 ~with~ 77.22 77.23 77.32 77.33 81.13 81.14 81.15 81.16 81.28
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	79.37 81.13 81.14 81.15 or 81.16
504	Foot Procedures W CC	1.5691	$9,203	
505	Foot Procedures WO CC/MCC	1.2474	$7,316	
510	Shoulder, Elbow or Forearm Procedure except Major Joint Procedure W MCC	2.2857	$13,407	77.23 77.33 78.03 78.53 79.32
511	Shoulder, Elbow or Forearm Procedure except Major Joint Procedure W CC	1.6509	$9,683	
512	Shoulder, Elbow or Forearm Procedure except Major Joint Procedure without CC/MCC	1.2963	$7,603	
513	Hand or Wrist Procedure, except Major Thumb or Joint Procedure Hand or Wrist Procedure, except Major Thumb or Joint Procedure with CC/MCC"	1.4462	$8,483	79.33 79.34 81.28
514	Hand or Wrist Procedure, except Major Thumb or Joint Procedure without CC/MCC	0.8996	$5,277	
515	Other Musculoskeletal System and Connective Tissue OR Procedures with MCC	3.2235	$18,907	79.39
516	Other Musculoskeletal System and Connective Tissue OR Procedures with CC	2.0434	$11,985	
517	Other Musculoskeletal System and Connective Tissue OR Procedures with 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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