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CONICAL SUBTALAR SPACER(CSTS) 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
S2117	Arthroereisis, subtalar

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
0335T	Extra-osseous subtalar joint implant for talotarsal stabilization	UA	UA	UA	UA
*20680	Removal of implant; deep (eg buried wire, pin, screw, metal band, nail, rod or plate)	12.09	$433	17.58	$629
*27605	Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia	5.27	$189	9.70	$347
*27606	Tenotomy, percutaneous, Achilles tendon (separate procedure); general anesthesia	8.16	$292	NA	NA
*27612	Arthrotomy, posterior capsular release, ankle, with or without Achilles tendon lengthening	16.16	$579	NA	NA
*27650	Repair, primary, open or percutaneous, ruptured Achilles tendon;	18.83	$674	NA	NA
*27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	19.63	$703	NA	NA
*27654	Repair, secondary, Achilles tendon, with or without graft, each tendon	20.23	$724	NA	NA
*27658	Repair, flexor tendon, leg; primary, without graft each tendon	10.69	$383	NA	NA
*27675	Repair, dislocating peroneal tendons; without fibular osteotomy	13.78	$493	NA	NA
*27676	Repair, dislocating peroneal tendons; with fibular osteotomy	16.94	$606	NA	NA

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
*27680	Tenolysis, flexor or extensor tendon, leg and/or ankle, single, each tendon	12.31	$441	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
*27687	Gastrocnemius recession (eg, Strayer procedure)	13.02	$466	NA	NA
*27691	Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)	21.46	$768	NA	NA
*28238	Reconstruction, (advancement) posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)	14.08	$504	19.50	$698
*28292	Correction, hallux valgus (bunion) with or without sesamoidectomy; Keller, McBride or Mayo type procedure	17.26	$618	22.75	$814
*28293	Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant	20.32	$727	30.07	$1,077
*28294	Correction, hallux valgus (bunion) with or without sesamoidectomy; with tendon transplants (eg Joplin type procedure)	15.48	$554	22.04	$789
*28296	Correction, hallux valgus (bunion) with or without sesamoidectomy; with metatarsal ostectomy (eg, Mitchell, Chevron, or concentric type procedures)	14.94	$535	20.53	$735
*28297	Correction, hallux valgus (bunion) with or without sesamoidectomy; Lapidus-type procedure	16.66	$596	23.35	$836
*28298	Correction, hallux valgus (bunion) with or without sesamoidectomy; by phalanx osteotomy	14.47	$518	20.73	$742
*28299	Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy	19.44	$696	25.85	$925
*28304	Osteotomy, tarsal bones, other than calcaneus or talus	17.43	$624	23.86	$854
*28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	11.57	$414	17.68	$633

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. 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
0335T	Extra-osseous subtalar joint implant for talotarsal stabilization	UA	UA	UA	UA	UA
20680	Removal of implant; deep (eg buried wire, pin, screw, metal band, nail, rod or plate)	0022	Level IV Excision/ Biopsy	Q2	24.5953	$1,824
27605	Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia	0055	Level II Musculoskeletal Procedures Except Hand and Foot	T	23.5061	$1,743
27606	Tenotomy, percutaneous, Achilles tendon (separate procedure); general anesthesia	0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	22.3913	$1,660

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
27612	Arthrotomy, posterior capsular release, ankle, with or without Achilles tendon lengthening	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon;	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
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, secondary, Achilles tendon, with or without graft, each tendon	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
27658	Repair, flexor tendon, leg; primary, without graft each tendon	0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	22.3913	$1,660
27675	Repair, dislocating peroneal tendons; without fibular osteotomy	0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	22.3913	$1,660
27676	Repair, dislocating peroneal tendons; with fibular osteotomy	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle, single, 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
27687	Gastrocnemius recession (eg, Strayer procedure)	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27691	Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
28238	Reconstruction, posterior tibial tendon with excision of accessory tarsal navicular bone	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28292	Correction, hallux valgus (bunion) with or without sesamoidectomy; Keller, McBride or Mayo type procedure	0057	Bunion Procedures	T	36.0840	$2,675
28293	Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant	0057	Bunion Procedures	T	36.0840	$2,675
28294	Correction, hallux valgus (bunion) with or without sesamoidectomy; with tendon transplants (eg Joplin type procedure)	0057	Bunion Procedures	T	36.0840	$2,675
28296	Correction, hallux valgus (bunion) with or without sesamoidectomy; with metatarsal ostectomy (eg, Mitchell, Chevron, or concentric type procedures)	0057	Bunion Procedures	T	36.0840	$2,675
28297	Correction, hallux valgus (bunion) with or without sesamoidectomy; Lapidus-type procedure	0057	Bunion Procedures	T	36.0840	$2,675
28298	Correction, hallux valgus (bunion) with or without sesamoidectomy; by phalanx osteotomy	0057	Bunion Procedures	T	36.0840	$2,675
28299	Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy	0057	Bunion Procedures	T	36.0840	$2,675
28304	Osteotomy, tarsal bones, other than calcaneus or talus	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743

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
0335T	Extra-osseous subtalar joint implant for talotarsal stabilization	G2	Y	25.4047	$1,120
20680	Removal of implant; deep (eg buried wire, pin, screw, metal band, nail, rod or plate)	A2	N	22.6892	$1,000
27605	Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia	A2	Y	21.6844	$956
27606	Tenotomy, percutaneous, Achilles tendon (separate procedure); general anesthesia	A2	Y	20.6560	$910
27612	Arthrotomy, posterior capsular release, ankle, with or without Achilles tendon lengthening	A2	Y	32.3631	$1,426
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon;	A2	Y	46.8009	$2,063
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	A2	Y	46.8009	$2,063
27654	Repair, secondary, Achilles tendon, with or without graft, each tendon	A2	Y	46.8009	$2,063
27658	Repair, flexor tendon, leg; primary, without graft each tendon	A2	Y	20.6560	$910
27675	Repair, dislocating peroneal tendons; without fibular osteotomy	A2	Y	20.6560	$910
27676	Repair, dislocating peroneal tendons; with fibular osteotomy	A2	Y	32.3631	$1,426
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle, single, 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
27687	Gastrocnemius recession (eg, Strayer procedure)	A2	Y	32.3631	$1,426
27691	Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)	A2	Y	46.8009	$2,063
28238	Reconstruction, posterior tibial tendon with excision of accessory tarsal navicular bone	A2	Y	64.9113	$2,861
28292	Correction, hallux valgus (bunion) with or without sesamoidectomy; Keller, McBride or Mayo type procedure	A2	Y	33.2875	$1,467
28293	Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant	A2	Y	33.2875	$1,467
28294	Correction, hallux valgus (bunion) with or without sesamoidectomy; with tendon transplants (eg Joplin type procedure)	A2	Y	33.2875	$1,467
28296	Correction, hallux valgus (bunion) with or without sesamoidectomy; with metatarsal ostectomy (eg, Mitchell, Chevron, or concentric type procedures)	A2	Y	33.2875	$1,467
28297	Correction, hallux valgus (bunion) with or without sesamoidectomy; Lapidus-type procedure	A2	Y	33.2875	$1,467
28298	Correction, hallux valgus (bunion) with or without sesamoidectomy; by phalanx osteotomy	A2	Y	33.2875	$1,467
28299	Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy	A2	Y	33.2875	$1,467
28304	Osteotomy, tarsal bones, other than calcaneus or talus	A2	Y	64.9113	$2,861
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	A2	Y	21.6844	$956

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 CSTS implant, though other codes may also be appropriate. This list includes common codes assigned for ankle and foot disorders. Also listed are several diagnostic codes reported for hand disorders where CSTS implant may support surgical technique. The ICD-9-CM book should always be referenced for diagnostic coding.

IDC-9-CM Diagnosis	Description
716.17	Traumatic arthropathy, ankle and foot
734	Flat foot
754.61	Congenital pes planus
714.0	Rheumatoid arthritis
714.89	Other specified inflammatory polyarthropathies
715.09	Osteoarthrosis, generalized, multiple sites
715.17	Primary localized osteoarthrosis, ankle/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
718.37	Recurrent dislocation of joint, ankle and foot
718.47	Contracture of ankle and foot joint
718.57	Ankylosis of joint, ankle and foot
718.77	Developmental dislocation of joint, ankle and foot
718.87	Other joint derangement, not elsewhere classified, ankle and foot
719.57	Stiffness of joint, not elsewhere classified, ankle and foot
726.71	Achilles bursitis or tendinitis
726.79	Other enthesopathy of ankle and talus
726.91	Exostosis of unspecified site
727.00	Synovitis and tenosynovitis, unspecified
727.06	Tenosynovitis of foot and ankle
727.1	Bunion
727.67	Nontraumatic rupture of Achilles tendon
727.68	Nontraumatic rupture of other tendons of foot and ankle
727.81	Contracture of tendon (sheath)
727.89	Other disorders of synovium, tendon, and bursa

IDC-9-CM Diagnosis	Description
733.99	Other disorders of bone and cartilage
735.0	Hallux valgus (acquired)
735.1	Hallux varus (acquired)
735.2	Hallux rigidus
735.3	Hallux malleus
735.8	Other acquired deformities of toe
736.70	Unspecified deformity of ankle and foot, acquired
736.71	Acquired equinovarus deformity
754.50	Talipes varus
754.51	Talipes equinovarus
754.52	Metatarsus primus varus
754.53	Metatarsus varus
754.59	Other congenital varus deformities of feet
754.69	Other valgus deformities of feet
754.79	Other congenital deformities of feet
755.66	Other anomalies of toes not elsewhere classified
837.0	Closed dislocation of ankle
845.00	Sprain of ankle, unspecified site
845.01	Sprain of deltoid (ligament), ankle
845.09	Other sprains and strains of ankle
891.2	Open wound of knee, leg [except thigh], and ankle, with tendon involvement
959.7	Knee, leg, ankle, and foot injury
996.49	Other mechanical complication of other internal orthopedic device, implant, and graft
996.78	Other complications due to 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
492	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with MCC	3.1873	18,695	81.18 with 80.47
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	17,876	81.18 ~with~ 77.17 77.77 77.79 78.67 78.68 78.69 ~or~ 83.11
496	Local Excision and Removal Internal Fixation Devices Except Hip and Femur W CC	1.7289	10,141	
497	Local Excision and Removal Internal Fixation Devices Except Hip and Femur WO CC/MCC	1.2230	7,173	
500	Soft Tissue Procedures W MCC	3.2420	19,016	81.18 ~with~ 83.41 83.62 83.64 83.71 83.72 83.75 83.76 83.79 83.81 83.83 83.85 ~or~ 83.91
501	Soft Tissue Procedures W CC	1.6474	9,663	
502	Soft Tissue Procedures W/O CC/MCC	1.1597	6,802	
503	Foot Procedures W CC	2.3338	13,689	81.18 ~with~ 77.28 77.38 77.51 77.53 77.59 77.68 78.08 78.28 ~or~ 78.38
504	Foot Procedures W CC	1.5691	9,204	
505	Foot Procedures WO CC/MCC	1.2474	7,317	
515	Other Musculoskeletal System and Connective Tissue OR Procedures W MCC	3.2235	18,907	81.18 alone
516	Other Musculoskeletal System and Connective Tissue OR Procedures W CC	2.0434	11,986	
517	Other Musculoskeletal System and Connective Tissue OR Procedures WO CC/MCC	1.7251	10,119	

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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012019A_27-Mar-2015