code it WRIGHT™

INBONE® II

Total Ankle 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. 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
C1776	Joint device, implantable
L8699	Prosthetic implant, not otherwise specified

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
20900	Bone graft, any donor area; minor or small (eg, dowel or button)	5.45	$195	11.94	$427
27702	Arthroplasty, ankle; with implant (total ankle)	27.76	$994	NA	NA
27703	Arthroplasty, ankle; revision, total ankle	27.76	$994	NA	NA
27704	Removal of ankle implant	16.46	$589	NA	NA
27712	Osteotomy; multiple, with realignment on intramedullary rod (eg, Sofield type procedure)	31.66	$1,133	NA	NA

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 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 Q2 are packaged only if they are billed on the same date of service with any other codes with a T status indicator. If not, they are separately payable under a separate APC. 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.

"UA" indicates unassigned as Medicare has not valued this procedure. Reimbursement policy and pricing will vary among non-Medicare payers.

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
20900	Bone graft, any donor area; minor or small (eg, dowel or button)	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601.11
27702	Arthroplasty, ankle; with implant (total ankle)			C		
27703	Arthroplasty, ankle; revision, total ankle			C		
27704	Removal of ankle implant	0049	Level I Musculoskeletal Procedures Except Hand and Foot	Q2	22.3913	$1,660.18
27712	Osteotomy; multiple, with realignment on intramedullary rod (eg, Sofield type procedure)			C		

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. NA indicates surgical procedures excluded from payment in ASCs for CY 2015.

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
20900	Bone graft, any donor area; minor or small (eg, dowel or button)	A2	Y	32.3631	$1,426.27
27702	Arthroplasty, ankle; with implant (total ankle)	NA	NA	NA	NA
27703	Arthroplasty, ankle; revision, total ankle	NA	NA	NA	NA
27704	Removal of ankle implant	A2	N	20.6560	$910.33
27712	Osteotomy; multiple, with realignment on intramedullary rod (eg, Sofield type procedure)	NA	NA	NA	NA

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 INBONE® II Total Ankle 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
711.07	Pyogenic arthritis, ankle and foot
711.17	Arthropathy associated with Reiter's disease and nonspecific urethrits, ankle and foot
711.27	Arthropathy in Behcet's syndrome, ankle and foot
711.37	Postdysenteric arthropathy, ankle and foot
711.47	Arthropathy associated with other bacterial diseases, ankle and foot
711.57	Arthropathy associated with other viral diseases, ankle and foot
711.67	Arthropathy associated with mycoses, ankle and foot
711.77	Arthropathy associated with helminthes, ankle and foot
711.87	Arthropathy associated with other infectious and parasitic diseases, ankle and foot
711.97	Unspecified infective arthritis, ankle and foot
712.17	Chondrocalcinosis due to dicalcium phosphate crystals, ankle and foot
712.27	Chondrocalcinosis due to pyrophosphate crystals, ankle and foot
712.37	Chondrocalcinosis, unspecified, ankle and foot
712.87	Other specified crystal arthropathies, ankle and foot
712.97	Unspecified crystal arthropathy, ankle and foot
713.5	Arthropathy associated with neurological disorders
713.7	Arthropathy associated with articular involvement
714.0	Rheumatoid arthritis
714.1	Felty's syndrome
714.30	Polyarticular juvenile rheumatoid arthritis, chronic or unspecified
714.31	Polyarticular juvenile rheumatoid arthritis, acute
714.32	Pauciarticular juvenile rheumatoid arthritis
714.33	Monoarticular juvenile rheumatoid arthritis
715.17	Osteoarthrosis, localized, primary, ankle and foot
715.27	Osteoarthrosis, localized, secondary, ankle and foot

IDC-9-CM Diagnosis	Description
715.37	Osteoarthrosis, localized, not specified whether primary or secondary, ankle and foot
715.87	Osteoarthrosis involving, or with mention of more than one site, but not specified as generalized, ankle and foot
715.97	Osteoarthrosis, unspecified whether generalized or localized, ankle and foot
716.17	Traumatic arthropathy, ankle and foot
716.57	Unspecified polyarthropathy or polyarthritis, ankle and foot
719.47	Pain in joint, ankle and foot
726.91	Exostosis of unspecified site
733.81	Malunion of fracture
733.82	Nonunion of fracture
736.79	Other acquired deformities of ankle and foot
824.8	Fracture of ankle, unspecified, closed
905.4	Late effect of fracture of lower extremities
909.3	Late effect of complications of surgical and medical care
996.41	Mechanical loosening of prosthetic joint
996.43	Broken prosthetic joint implant
996.45	Peri-prosthetic osteolysis
996.49	Other mechanical complication of other internal orthopedic device, implant, and graft
996.66	Infection and inflammatory reaction due to internal joint prosthesis
996.67	Infection and inflammatory reaction due to other internal orthopedic device, implant and graft
996.78	Other complications due to other internal orthopedic device, implant, and graft
V45.4	Arthrodesis status
V43.66	Organ or tissue replaced by other means, ankle
V54.82	Aftercare following explantation of joint prosthesis
V88.29	Acquired absence of other joint

Hospital Inpatient Diagnosis Related Group (MS-DRGs) and ICD-9-CM Procedure Codes

Diagnosis Related Groups (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. W CC and W 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 DRG payment for the procedure code is considered complete and payment for implants is included in the 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
469	Major Joint Replacement or Reattachment of Lower Extremity W MCC	3.3905	$19,937	81.56 alone or with 77.27 77.79 as secondary code
470	Major Joint Replacement or Reattachment of Lower Extremity WO MCC	2.1137	$12,397	
492	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with MCC	3.1873	$18,695	81.59 with 77.27 77.79 as secondary code
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	80.07
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	
515	Other Musculoskeletal System and Connective Tissue OR Procedures W MCC	3.2235	$18,907	81.59
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.

WRIGHT™
FOCUSED EXCELLENCE

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

012021A_27-Mar-2015