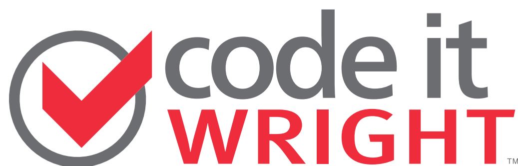

OSTEOSET® XR

Pre-made Pellets

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
C1713	Anchor/screw for opposing bone-to-bone or soft tissue 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
+20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only	UA	UA	UA	UA
20999	Unlisted procedure, musculoskeletal system, general	UA	UA	UA	UA
22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical	51.46	$1,842	NA	NA
22212	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic	42.70	$1,529	NA	NA
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar	28.51	$1,021	NA	NA
22325	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar	41.18	$1,474	NA	NA
22327	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; thoracic	43.26	$1,549	NA	NA
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	49.45	$1,770	NA	NA

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	44.29	$1,586	NA	NA
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	45.73	$1,637	NA	NA
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	45.22	$1,619	NA	NA
22633	L3-L4 combined posterolateral/posterior interbody fusion	53.44	$1,913	NA	NA
22634	L4-L5 combined posterolater/posterior interbody fusion	14.37	$514	NA	NA
+22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)	22.01	$788	NA	NA
+22841	Internal spinal fixation by wiring of spinous processes	UA	UA	UA	UA
23140	Excision or curettage of bone cyst or benign tumor of clavicle or scapula	15.05	$539	NA	NA
23146	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with allograft	17.74	$635	NA	NA
23150	Excision or curettage of bone cyst or benign tumor of proximal humerus	18.90	$677	NA	NA
23180	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), clavicle	19.04	$682	NA	NA
23200	Radical resection of tumor; clavicle	43.47	$1,556	NA	NA
23480	Osteotomy, clavicle, with or without internal fixation	23.48	$841	NA	NA
23490	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; clavicle	24.66	$883	NA	NA
23515	Open treatment of clavicular fracture, includes internal fixation, when performed	20.54	$735	NA	NA
23929	Unlisted procedure, shoulder	UA	UA	UA	UA
24110	Excision or curettage of bone cyst or benign tumor, humerus	16.77	$600	NA	NA
24120	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process	15.02	$538	NA	NA
24999	Unlisted procedure, humerus or elbow	UA	UA	UA	UA
25130	Excision or curettage of bone cyst or benign tumor of carpal bones	12.67	$454	NA	NA
25136	Excision or curettage of bone cyst or benign tumor of carpal bones; with allograft	14.06	$503	NA	NA
25431	Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone	22.32	$799	NA	NA
25440	Repair of nonunion, scaphoid carpal (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)	21.87	$783	NA	NA
25999	Unlisted procedure, forearm or wrist	UA	UA	UA	UA
26200	Excision or curettage of bone cyst or benign tumor of metacarpal	12.73	$456	NA	NA
26210	Excision or curettage of bone cyst or benign tumor of proximal, middle, or distal phalanx of finger	12.54	$449	NA	NA
26250	Radical resection of tumor, metacarpal	30.70	$1,099	NA	NA
26989	Unlisted procedure, hands or fingers	UA	UA	UA	UA
27066	Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; deep (subfascial), includes autograft, when performed	23.21		NA	NA
27071	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); deep (subfascial or intramuscular)	26.12	$935	NA	$0
27161	Osteotomy, femoral neck (separate procedure)	23.21	$831	NA	NA
27202	Open treatment of coccygeal fracture	15.22	$545	NA	NA
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	34.25	$1,226	NA	NA
27248	Open treatment of greater trochanteric fracture, includes internal fixation, when performed	21.25	$761	NA	NA
27254	Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation	36.43	$1,304	NA	NA
27269	Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed	35.63	$1,276	NA	NA

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
27299	Unlisted procedure, pelvis or hip joint	UA	UA	UA	UA
27355	Excision or curettage of bone cyst or benign tumor of femur	17.22	$616	NA	NA
27358	Excision or curettage of bone cyst or benign tumor of femur; with internal fixation (List in addition to code for primary procedure	8.01	$287	NA	NA
27360	Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess)	24.30	$870	NA	NA
27364	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; 5 cm or greater	44.73	$1,601	NA	NA
27365	Radical resection of tumor, femur or knee	59.19	$2,119	NA	NA
27470	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)	33.63	$1,204	NA	NA
27507	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage	27.82	$996	NA	NA
27511	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed	28.52	$1,021	NA	NA
27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed	35.52	$1,272	NA	NA
27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed	27.68	$991	NA	NA
27535	Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed	25.66	$919	NA	NA
27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula	16.79	$601	NA	NA
27638	Excision or curettage of bone cyst or benign tumor, tibia or fibula; with allograft	22.18	$794	NA	NA
27640	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia	23.92	$856	NA	NA
27641	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula	19.12	$685	NA	NA
27645	Radical resection of tumor; tibia	51.10	$1,829	NA	NA
27700	Arthroplasty, ankle	16.71	$598	NA	NA
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
27758	Open treatment of tibial shaft fracture (with or without fibular fracture), with plate/screws, with or without cerclage	25.49	$913	NA	NA
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	17.48	$626	NA	NA
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	20.72	$742	NA	NA
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	18.68	$669	NA	NA
27814	Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed	22.09	$791	NA	NA
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	24.03	$860	NA	NA
27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	27.36	$980	NA	NA
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	23.80	$852	NA	NA
27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula	37.06	$1,327	NA	NA
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	19.56	$700	NA	NA
27870	Arthrodesis, ankle, open	29.53	$1,057	NA	NA
27871	Arthrodesis, tibiofibular joint, proximal or distal	19.58	$701	NA	NA
27899	Unlisted procedure, leg or ankle	UA	UA	UA	UA
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus	11.89	$426	17.59	$36

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
28104	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus	10.20	$365	15.34	$36
28171	Radical resection of tumor; tarsal (except talus or calcaneus)	24.33	$871	NA	
28445	Open treatment of talus fracture, includes internal fixation, when performed	30.57	$1,094	NA	NA
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	17.66	$632	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
28750	Arthrodesis, great toe; metatarsophalangeal joint	16.98	$608	23.48	$841
28899	Unlisted procedure, foot or toes	UA	UA	UA	UA
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)	19.01	$681	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. 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
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only			N		
20999	Unlisted procedure, musculoskeletal system, general	0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	22.3913	$1,660
22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical			C		
22212	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic			C		
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar			C		
22325	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar			C		
22327	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; thoracic			C		
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	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
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar			C		
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	0425	Level V Musculoskeletal Procedures Except Hand and Foot	J1	137.8399	$10,220
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar			C		
22633	L3-L4 combined posterolateral/posterior interbody fusion			C		
22634	L4-L5 combined posterolateral/posterior interbody fusion			C		
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)			C		
22841	Internal spinal fixation by wiring of spinous processes			C		
23140	Excision or curettage of bone cyst or benign tumor of clavicle or scapula	0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	22.3913	$1,660
23146	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with allograft	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
23150	Excision or curettage of bone cyst or benign tumor of proximal humerus	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
23180	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), clavicle	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
23200	Radical resection of tumor; clavicle			C		
23480	Osteotomy, clavicle, with or without internal fixation	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
23490	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; clavicle	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
23515	Open treatment of clavicular fracture, includes internal fixation, when performed	0064	Level III Treatment Fracture/Dislocation	T	75.0875	$5,567
23929	Unlisted procedure, shoulder	0129	Level I Closed Treatment Fracture	T	2.2797	$169
24110	Excision or curettage of bone cyst or benign tumor, humerus	0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	22.3913	$1,660
24120	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process	0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	22.3913	$1,660
24999	Unlisted procedure, humerus or elbow	0129	Level I Closed Treatment Fracture	T	2.2797	$169
25130	Excision or curettage of bone cyst or benign tumor of carpal bones	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
25136	Excision or curettage of bone cyst or benign tumor of carpal bones; with allograft	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
25431	Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
25440	Repair of nonunion, scaphoid carpal (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
25999	Unlisted procedure, forearm or wrist	0129	Level I Closed Treatment Fracture	T	2.2797	$169
26200	Excision or curettage of bone cyst or benign tumor of metacarpal	0053	Level I Hand Musculoskeletal Procedures	T	16.5603	$1,228
26210	Excision or curettage of bone cyst or benign tumor of proximal, middle, or distal phalanx of finger	0053	Level I Hand Musculoskeletal Procedures	T	16.5603	$1,228
26250	Radical resection of tumor, metacarpal	0053	Level I Hand Musculoskeletal Procedures	T	16.5603	$1,228
26989	Unlisted procedure, hands or fingers	0129	Level I Closed Treatment Fracture	T	2.2797	$169
27066	Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; deep (subfascial), includes autograft, when performed	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27071	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); deep (subfascial or intramuscular)			C		
27161	Osteotomy, femoral neck (separate procedure)			C		
27202	Open treatment of coccygeal fracture	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement			C		
27248	Open treatment of greater trochanteric fracture, includes internal fixation, when performed			C		
27254	Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation			C		
27269	Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed			C		
27299	Unlisted procedure, pelvis or hip joint	0129	Level I Closed Treatment Fracture	T	2.2797	$169
27355	Excision or curettage of bone cyst or benign tumor of femur	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27358	Excision or curettage of bone cyst or benign tumor of femur; with internal fixation (List in addition to code for primary procedure)			N		
27360	Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess)	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27364	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; 5 cm or greater	0022	Level IV Excision/ Biopsy	T	24.5953	$1,824
27365	Radical resection of tumor, femur or knee			C		
27470	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)			N		
27507	Open treatment of femoral shaft fracture with plate/ screws, with or without cerclage			C		
27511	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed			C		
27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed			C		
27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed			C		
27535	Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed			C		
27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
27638	Excision or curettage of bone cyst or benign tumor, tibia or fibula; with allograft	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27640	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27641	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27645	Radical resection of tumor; tibia			C		
27700	Arthroplasty, ankle	0047	Arthroplasty	T	45.3575	$3,363
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
27758	Open treatment of tibial shaft fracture (with or without fibular fracture), with plate/screws, with or without cerclage	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
27814	Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
27870	Arthrodesis, ankle, open	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
27871	Arthrodesis, tibiofibular joint, proximal or distal	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
27899	Unlisted procedure, leg or ankle	0129	Level I Closed Treatment Fracture	T	2.2797	$169
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28104	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
28171	Radical resection of tumor; tarsal (except talus or calcaneus)	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28445	Open treatment of talus fracture, includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), 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
28750	Arthrodesis, great toe; metatarsophalangeal joint	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
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)	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
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only	N1	N	N1	N1
20999	Unlisted procedure, musculoskeletal system, general	NA	NA	NA	NA
22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical	NA	NA	NA	NA
22212	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic	NA	NA	NA	NA
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar	NA	NA	NA	NA
22325	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar	NA	NA	NA	NA
22327	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; thoracic	NA	NA	NA	NA
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	J8	N	177.9456	$7,842
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	NA	NA	NA	NA
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	J8	N	177.9456	$7,842

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	NA	NA	NA	NA
22633	L3-L4 combined posterolateral/posterior interbody fusion	NA	NA	NA	NA
22634	L4-L5 combined posterolater/posterior interbody fusion	NA	NA	NA	NA
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)	NA	NA	NA	NA
22841	Internal spinal fixation by wiring of spinous processes	NA	NA	NA	NA
23140	Excision or curettage of bone cyst or benign tumor of clavicle or scapula	A2	Y	20.6560	$910
23146	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with allograft	A2	Y	32.3631	$1,426
23150	Excision or curettage of bone cyst or benign tumor of proximal humerus	A2	Y	32.3631	$1,426
23180	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), clavicle	A2	Y	32.3631	$1,426
23200	Radical resection of tumor; clavicle	NA	NA		
23480	Osteotomy, clavicle, with or without internal fixation	A2	Y	46.8009	$2,063
23490	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; clavicle	A2	Y	78.6374	$3,466
23515	Open treatment of clavicular fracture, includes internal fixation, when performed	J8	Y	93.9112	$4,139
23929	Unlisted procedure, shoulder	NA	NA	NA	NA
24110	Excision or curettage of bone cyst or benign tumor, humerus	A2	Y	20.6560	$910
24120	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process	A2	Y	20.6560	$910
24999	Unlisted procedure, humerus or elbow	NA	NA	NA	NA
25130	Excision or curettage of bone cyst or benign tumor of carpal bones	A2	Y	32.3631	$1,426
25136	Excision or curettage of bone cyst or benign tumor of carpal bones; with allograft	A2	Y	32.3631	$1,426
25431	Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone	G2	Y	46.8009	$2,063
25440	Repair of nonunion, scaphoid carpal (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)	A2	Y	46.8009	$2,063
25999	Unlisted procedure, forearm or wrist	NA	NA	NA	NA
26200	Excision or curettage of bone cyst or benign tumor of metacarpal	A2	Y	15.2769	$673
26210	Excision or curettage of bone cyst or benign tumor of proximal, middle, or distal phalanx of finger	A2	Y	15.2769	$673
26250	Radical resection of tumor, metacarpal	A2	Y	15.2769	$673
26989	Unlisted procedure, hands or fingers	NA	NA	NA	NA
27066	Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; deep (subfascial), includes autograft, when performed	A2	Y	32.3631	$1,426
27071	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); deep (subfascial or intramuscular)	NA	NA	NA	NA
27161	Osteotomy, femoral neck (separate procedure)	NA	NA	NA	NA
27202	Open treatment of coccygeal fracture	A2	Y	52.5892	$2,318
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	NA	NA	NA	NA
27248	Open treatment of greater trochanteric fracture, includes internal fixation, when performed	NA	NA	NA	NA
27254	Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation	NA	NA	NA	NA
27269	Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed	NA	NA	NA	NA
27299	Unlisted procedure, pelvis or hip joint	NA	NA	NA	NA
27355	Excision or curettage of bone cyst or benign tumor of femur	A2	Y	32.3631	$1,426

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
27358	Excision or curettage of bone cyst or benign tumor of femur; with internal fixation (List in addition to code for primary procedure)	N1	N	N1	N1
27360	Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess)	A2	Y	32.3631	$1,426
27364	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; 5 cm or greater	G2	Y	22.6892	$1,000
27365	Radical resection of tumor, femur or knee	NA	NA	NA	NA
27470	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)	NA	NA	NA	NA
27507	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage	NA	NA	NA	NA
27511	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed	NA	NA	NA	NA
27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed	NA	NA	NA	NA
27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed	NA	NA	NA	NA
27535	Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed	NA	NA	NA	NA
27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula	A2	Y	32.3631	$1,426
27638	Excision or curettage of bone cyst or benign tumor, tibia or fibula; with allograft	A2	Y	32.3631	$1,426
27640	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia	A2	Y	32.3631	$1,426
27641	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula	A2	Y	32.3631	$1,426
27645	Radical resection of tumor; tibia	NA	NA	NA	NA
27700	Arthroplasty, ankle	A2	Y	41.8423	$1,844
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
27758	Open treatment of tibial shaft fracture (with or without fibular fracture), with plate/screws, with or without cerclage	A2	Y	52.5892	$2,318
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	A2	Y	52.5892	$2,318
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	G2	Y	52.5892	$2,318
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	A2	Y	52.5892	$2,318
27814	Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed	A2	Y	52.5892	$2,318
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	A2	Y	52.5892	$2,318
27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	J8	Y	93.9112	$4,139
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	A2	Y	52.5892	$2,318
27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula	J8	Y	93.9112	$4,139
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	A2	Y	52.5892	$2,318
27870	Arthrodesis, ankle, open	A2	Y	78.6374	$3,466
27871	Arthrodesis, tibiofibular joint, proximal or distal	A2	Y	78.6374	$3,466
27899	Unlisted procedure, leg or ankle	NA	NA	NA	NA

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus	A2	Y	21.6844	$956
28104	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus	A2	Y	21.6844	$956
28171	Radical resection of tumor; tarsal (except talus or calcaneus)	A2	Y	21.6844	$956
28445	Open treatment of talus fracture, includes internal fixation, when performed	A2	Y	52.5892	$2,318
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), 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
28750	Arthrodesis, great toe; metatarsophalangeal joint	A2	Y	64.9113	$2,861
28899	Unlisted procedure, foot or toes	NA	NA	NA	NA
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)	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 OSTEOSET® XR bone void filler, 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
213.4	Benign neoplasm of scapula and long bones of upper limb
213.5	Benign neoplasm of short bones of upper limb
714.4	Chronic postrheumatic arthropathy
715.17	Osteoarthrosis, localized, primary, ankle and foot
715.27	Osteoarthrosis, localized, secondary, ankle and foot
715.97	Osteoarthrosis, unspecified whether generalized or localized, ankle and foot
716.17	Traumatic arthropathy, ankle and foot
718.87	Other joint derangement, not elsewhere classified, ankle and foot
730.32	Periostitis, without mention of osteomyelitis, upper arm
731.3	Chronic osteomyelitis
733.20	Cyst of bone (localized), unspecified
733.21	Solitary bone cyst
733.22	Aneurysmal bone cyst
733.29	Other bone cyst
733.40	Aseptic necrosis of bone, site unspecified
733.41	Aseptic necrosis of head of humerus
733.42	Aseptic necrosis of head and neck of femur
733.43	Aseptic necrosis of medial femoral condyle
733.44	Aseptic necrosis of talus
733.49	Aseptic necrosis of bone, other
733.81	Malunion of fracture
733.82	Nonunion of fracture
733.93	Stress fracture of tibia or fibula
733.94	Stress fracture of the metatarsals
733.95	Stress fracture of other bone
733.96	Stress fracture of femoral neck
733.97	Stress fracture of shaft of femur
736.70	Unspecified deformity of ankle and foot, acquired
805.0X	Closed fracture of cervical vertebra without mention of spinal cord injury

IDC-9-CM Diagnosis	Description
805.4	Closed fracture of lumbar vertebra without mention of spinal cord injury
805.6	Closed fracture of sacrum or coccyx vertebra without mention of spinal cord injury
808.0	Closed fracture of acetabulum
808.4X	Closed fracture of other specified part of pelvis
811.XX	Fracture of scapula
812.XX	Fracture of humerus
813.XX	Fracture of radius and ulna
814.0X	Closed fractures of carpal bones
815.XX	Closed fractures of metacarpal bones
817.0	Multiple closed fractures of hand bones
820.XX	Fracture of intracapsular section of neck of femur, unspecified
821.XX	Fracture of unspecified part of femur
821.XX	Fracture of shaft of femur
822.0	Closed fracture of patella
822.1	Open fracture of patella
823.XX	Fracture of tibia and fibula
824.0	Fracture of medial malleolus, closed
824.1	Fracture of medial malleolus, open
824.2	Fracture of lateral malleolus, closed
824.3	Fracture of lateral malleolus, open
824.4	Bimalleolar fracture, closed
824.5	Bimalleolar fracture, open
824.6	Trimalleolar fracture, closed
824.7	Trimalleolar fracture, open
824.8	Unspecified fracture of ankle, closed
825.XX	Fracture of one or more tarsal and metarsal bones
905.4	Late effect of fracture of lower extremities

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
459	Spinal Fusion except Cervical W MCC	6.6686	$39,115	81.06 81.07 81.08 with 84.55
460	Spinal Fusion except Cervical WO MCC	3.9998	$23,461	
469	Major joint replacement or reattachment of lower extremity W MCC	3.3905	$19,887	81.56 with 84.55
470	Major joint replacement or reattachment of lower extremity WO MCC	2.1137	$12,398	
471	Cervical Spinal Fusion W MCC	4.8737	$28,587	81.02 with 84.55
472	Cervical Spinal Fusion W CC	2.9166	$17,107	
473	Cervical Spinal Fusion W/O CC/MCC	2.2655	$13,288	
480	Hip & Femur Procedures except major joint W MCC	3.0052	$17,627	77.05 77.85 78.55 79.35 79.36
481	Hip & Femur Procedures except major joint W CC	1.9776	$11,600	
482	Hip & Femur Procedures except major joint WO CC/MCC	1.6243	$9,527	
488	Knee Procedures WO Principal Diagnosis of Infection W CC/MCC	1.7225	$10,103	77.86 with 84.55
489	Knee Procedures WO Principal Diagnosis of InfectionWO CC/MCC	1.3186	$7,734	
492	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur W MCC	3.1873	$18,695	79.26 81.11 81.12 81.49 with 84.55
493	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur W 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	$17,876	77.61 77.62 77.63 77.67 77.69 80.07 with 84.55
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	
498	Local excision and removal internal fixation devices hip and femur W CC/MCC	2.1416	$12,562	77.65 with 84.55
499	Local excision and removal internal fixation devices hip and femur WO CC/MCC	1.0753	$6,307	

DRG	DRG Title	Relative Weight	Medicare National Unadjusted Payment	ICD-9-CM Procedure Codes and Descriptions
503	Foot Procedures W CC	2.3338	$13,688	77.68 77.88 79.37 79.38 81.13 81.16 with 84.55
504	Foot Procedures W CC	1.5691	$9,203	
505	Foot Procedures WO CC/MCC	1.2474	$7,316	
509	Arthroscopy	1.5494	$9,088	80.21 (arthroscopy) with 84.55
513	Hand or Wrist Procedure, except Major Thumb or Joint ProcedureW CC/MCC	1.4462	$8,483	77.64 77.84 79.33 with 84.55
514	Hand or Wrist Procedure, except Major Thumb or Joint Procedure WO CC/MCC	0.8996	$5,277	
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures W MCC	3.2235	$18,907	77.31 77.81 78.51 78.59 79.29 79.39 81.29 81.59 with 84.55
516	Other Musculoskeletal System and Connective Tissue O.R. Procedures W CC	2.0434	$11,985	
517	Other Musculoskeletal System and Connective Tissue O.R. Procedures WO CC/MCC	1.7251	$10,118	
518	Back & Neck Procedures except Spinal Fusion W MCC O.R. Disc Device/Neurostimulator	3.0628	$17,965	03.53 with 84.55
519	Back & Neck Procedures except Spinal Fusion W CC	1.6468	$9,659	
520	Back & Neck Procedures except Spinal Fusion WO CC/ MCC	1.1396	$6,684	

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

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