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PRO-DENSE®

Injectable Regenerative Graft & Core Decompression Procedure Kit

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 bone (implantable)
S2325	Hip core decompression

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
23150	Excision or curettage of bone cyst or benign tumor of proximal humerus	18.90	$677	NA	NA
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	UNL	UNL	UNL	UNL
25130	Excision or curettage of bone cyst or benign tumor of carpal bones	12.67	$454	NA	NA
25999	Unlisted procedure, forearm or wrist	UNL	UNL	UNL	UNL
26200	Excision or curettage of bone cyst or benign tumor of metacarpal	12.73	$456	NA	NA
26989	Unlisted procedure, hands or fingers	UNL	UNL	UNL	UNL

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
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
27299	Unlisted procedure, pelvis or hip joint	UNL	UNL	UNL	UNL
27238	Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; without manipulation	13.11	$469	NA	NA
27355	Excision or curettage of bone cyst or benign tumor of femur	17.22	$616	NA	NA
27530	Closed treatment of tibial fracture, proximal (plateau); without manipulation	7.97	$285	8.58	$307
27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula	16.79	$601	NA	NA
27899	Unlisted procedure, leg or ankle	UNL	UNL	UNL	UNL
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus	11.89	$426	17.59	$630
28899	Unlisted procedure, foot or toes	UNL	UNL	UNL	UNL

CPT codes Fracture / Arthrodesis / Arthroplasty

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
27760	Closed treatment of medial malleolus fracture; without manipulation	8.64	$309	9.47	$339
27762	Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction	12.27	$439	13.45	$482
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	17.48	$626	NA	NA
27767	Closed treatment of posterior malleolus fracture; without manipulation	8.06	$289	8.01	$287
27768	Closed treatment of posterior malleolus fracture; with manipulation	12.56	$450	NA	NA
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	20.72	$742	NA	NA
27786	Closed treatment of distal fibular fracture (lateral malleolus); without manipulation	8.14	$291	9.00	$322
27788	Closed treatment of distal fibular fracture (lateral malleolus); with manipulation	10.93	$391	11.95	$428
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	18.68	$669	NA	NA
27808	Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); without manipulation	8.55	$306	9.50	$340
27810	Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); with manipulation	12.06	$432	13.28	$475
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
27816	Closed treatment of trimalleolar ankle fracture; without manipulation	8.19	$293	9.13	$327
27818	Closed treatment of trimalleolar ankle fracture; with manipulation	12.32	$441	13.73	$492
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
27824	Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; without manipulation	8.63	$309	8.88	$318
27825	Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation	14.09	$504	15.52	$556
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

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
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
28435	Closed treatment of talus fracture; with manipulation	8.26	$296	9.21	$330
28445	Open treatment of talus fracture, includes internal fixation, when performed	30.57	$1,094	NA	NA
28455	Treatment of tarsal bone fracture (except talus and calcaneus); with manipulation, each	7.42	$266	8.25	$295
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

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
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
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
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

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
26989	Unlisted procedure, hands or fingers	0129	Level I Closed Treatment Fracture	T	2.2797	$169
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		
27299	Unlisted procedure, pelvis or hip joint	0138	Level II Closed Treatment Fracture	T	2.8828	$214
27238	Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; without manipulation	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
27530	Closed treatment of tibial fracture, proximal (plateau); without manipulation	0138	Level II Closed Treatment Fracture	T	2.8828	$214
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
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
28899	Unlisted procedure, foot or toes	0129	Level I Closed Treatment Fracture	T	2.2797	$169

CPT codes Fracture / Arthrodesis / Arthroplasty

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
27760	Closed treatment of medial malleolus fracture; without manipulation	0138	Level II Closed Treatment Fracture	T	2.8828	$214
27762	Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction	0431	Level IV Closed Treatment Fracture	T	17.6908	$1,312
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	0063	Level II Treatment Fracture/Dislocation	T	57.0073	$4,227
27767	Closed treatment of posterior malleolus fracture; without manipulation	0129	Level I Closed Treatment Fracture	T	2.2797	$169
27768	Closed treatment of posterior malleolus fracture; with manipulation	0129	Level I Closed Treatment Fracture	T	2.2797	$169
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	0063	Level II Treatment Fracture/Dislocation	T	57.0073	$4,227
27786	Closed treatment of distal fibular fracture (lateral malleolus); without manipulation	0138	Level II Closed Treatment Fracture	T	2.8828	$214
27788	Closed treatment of distal fibular fracture (lateral malleolus); with manipulation	0138	Level II Closed Treatment Fracture	T	2.8828	$214
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
27808	Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); without manipulation	0138	Level II Closed Treatment Fracture	T	2.8828	$214
27810	Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); with manipulation	0139	Level III Closed Treatment Fracture	T	9.6161	$713

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
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
27816	Closed treatment of trimalleolar ankle fracture; without manipulation	0138	Level II Closed Treatment Fracture	T	2.8828	$214
27818	Closed treatment of trimalleolar ankle fracture; with manipulation	0139	Level III Closed Treatment Fracture	T	9.6161	$713
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
27824	Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; without manipulation	0138	Level II Closed Treatment Fracture	T	2.8828	$214
27825	Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation	0431	Level IV Closed Treatment Fracture	T	17.6908	$1,312
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	0129	Level I Closed Treatment Fracture	T	2.2797	$169
27871	Arthrodesis, tibiofibular joint, proximal or distal	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
28435	Closed treatment of talus fracture; with manipulation	0431	Level IV Closed Treatment Fracture	T	17.6908	$1,312
28445	Open treatment of talus fracture, includes internal fixation, when performed	0063	Level II Treatment Fracture/Dislocation	T	57.0073	$4,227
28455	Treatment of tarsal bone fracture (except talus and calcaneus); with manipulation, each	0129	Level I Closed Treatment Fracture	T	2.2797	$169
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

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. Payment indicator J8 specifies a device-intensive procedure; paid at adjusted rate. Patment indicator P2 indicates payment is based on OPPS relative payment weight. 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
23150	Excision or curettage of bone cyst or benign tumor of proximal humerus	A2	Y	32.3631	$1,426
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
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
26989	Unlisted procedure, hands or fingers	NA	NA	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)	NA	NA	NA	NA
27238	Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; without manipulation	A2	Y	2.6594	$117
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
27530	Closed treatment of tibial fracture, proximal (plateau); without manipulation	A2	Y	2.6594	$117
27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula	A2	Y	32.3631	$1,426
27899	Unlisted procedure, leg or ankle	NA	NA	NA	NA
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus	A2	Y	21.6844	$956
28899	Unlisted procedure, foot or toes	NA	NA	NA	NA

CPT codes Fracture / Arthrodesis / Arthroplasty

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
27760	Closed treatment of medial malleolus fracture; without manipulation	A2	Y	2.6594	$117
27762	Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction	A2	Y	16.3198	$719
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	A2	Y	52.5892	$2,318
27767	Closed treatment of posterior malleolus fracture; without manipulation	P2	Y	2.1030	$93
27768	Closed treatment of posterior malleolus fracture; with manipulation	G2	Y	2.1030	$93
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	G2	Y	52.5892	$2,318
27786	Closed treatment of distal fibular fracture (lateral malleolus); without manipulation	A2	Y	2.6594	$117
27788	Closed treatment of distal fibular fracture (lateral malleolus); with manipulation	A2	Y	2.6594	$117
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	A2	Y	52.5892	$2,318

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
27808	Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); without manipulation	A2	Y	2.6594	$117
27810	Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); with manipulation	A2	Y	8.8709	$391
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
27816	Closed treatment of trimalleolar ankle fracture; without manipulation	A2	Y	2.6594	$117
27818	Closed treatment of trimalleolar ankle fracture; with manipulation	A2	Y	8.8709	$391
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
27824	Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; without manipulation	A2	Y	2.6594	$117
27825	Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation	A2	Y	16.3198	$719
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
28435	Closed treatment of talus fracture; with manipulation	A2	Y	16.3198	$719
28445	Open treatment of talus fracture, includes internal fixation, when performed	A2	Y	52.5892	$2,318
28455	Treatment of tarsal bone fracture (except talus and calcaneus); with manipulation, each	P2	Y	2.1030	$93
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

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 PRO-DENSE® Bone Graft Substitute and PRO-DENSE® Core Decompression Procedure Kit, 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
213.6	Benign neoplasm of pelvic bones, sacrum, and coccyx
213.7	Benign neoplasm of long bones of lower limb
213.8	Benign neoplasm of short bones of lower limb
238.0	Neoplasm of uncertain behavior of bone and articular cartilage
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

IDC-9-CM Diagnosis	Description
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
736.70	Unspecified deformity of ankle and foot, acquired
820.00	Closed fracture of intracapsular section of neck of femur, unspecified
820.01	Closed fracture of epiphysis (separation) (upper) of neck of femur
820.02	Closed fracture of midcervical section of neck of femur
820.03	Closed fracture of base of neck; Cervicotrochanteric section
820.09	Other closed transcervical fracture of neck of femur
820.21	Closed fracture of intertrochanteric section of neck of femur
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
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 (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	$19,887	84.55 with 81.56
470	Major joint replacement or reattachment of lower extremity W/O MCC	2.1137	$12,398	
480	Hip & Femur Procedures except major joint W MCC	3.0052	$17,627	84.55 with 77.05 or 78.55
481	Hip & Femur Procedures except major joint W CC	1.9776	$11,600	
482	Hip & Femur Procedures except major joint W/O CC/ MCC	1.6243	$9,527	
492	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur W MCC	3.1873	$18,695	84.55 with 78.57, 79.26, 79.36, 79.87, 81.11 or 81.12
493	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur W CC	2.0354	$11,938	
494	Lower Extremity and Humerus Procedures W/O CC/ MCC	1.5397	$9,031	
495	Local excision and removal internal fixation devices except hip and femur W MCC	3.0476	$17,876	84.55 with 77.62 , 77.63 or 77.67
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	84.55 with 77.65
499	Local excision and removal internal fixation devices hip and femur WO CC/MCC	1.0753	$6,307	
503	Foot Procedures W CC	2.3338	$13,688	84.55 with 77.68, 79.37, 81.13, or 81.16
504	Foot Procedures W CC	1.5691	$9,203	
505	Foot Procedures WO CC/MCC	1.2474	$7,316	
513	Hand or Wrist Procedure, except Major Thumb or Joint ProcedureW CC/MCC	1.4462	$8,483	84.55 with 77.64
514	Hand or Wrist Procedure, except Major Thumb or Joint Procedure W/O CC/MCC	0.8996	$5,277	
515	Other Musculoskeletal System and Connective Tissue OR Procedures W MCC	3.2235	$18,907	84.55 with 77.29, 77.39, 81.29 or 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.

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