code it WRIGHT™

ALLOMATRIX®

C Putty

DBM Putty with cancellous chips

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. These codes have an alpha character as the 1st character in the string followed by four digits (eg, S2117). 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. These codes are also used by the Medicaid program, but they are not payable by Medicare. However, regular HCPCS II device codes are generally used for billing non-Medicare payers.

Not all implanted items have a specific HCPCS II code. If desired, a miscellaneous HCPCS code can be used inside.

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
23150	Excision or curettage of bone cyst or benign tumor of proximal humerus	18.9	$677	NA	NA
23156	Excision or curettage of bone cyst or benign tumor of proximal humerus; with allograft	19.36	$693	NA	NA
23174	Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck	21.67	$776	NA	NA
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed	25.27	$905	NA	NA
23630	Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed	22.31	$799	NA	NA
24110	Excision or curettage of bone cyst or benign tumor, humerus	16.77	$600	NA	NA
24116	Excision or curettage of bone cyst or benign tumor, humerus; with allograft	24.65	$883	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

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
24134	Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus	21.36	$765	NA	NA
24136	Sequestrectomy (eg, for osteomyelitis or bone abscess), radial head or neck	16.47	$590	NA	NA
24138	Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process	19.27	$690	NA	NA
24145	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), radial head or neck	16.90	$605	NA	NA
24515	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), radial head or neck	25.02	$896	NA	NA
24516	Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws	24.57	$880	NA	NA
24546	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension	29.69	$1,063	NA	NA
24635	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed	19.18	$687	NA	NA
24665	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed	18.58	$665	NA	NA
24685	Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed	18.64	$667	NA	NA
24999	Unlisted procedure, humerus or elbow	0.00	$0	0.00	$0
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
25145	Sequestrectomy (eg, for osteomyelitis or bone abscess), forearm and/or wrist	14.75	$528	NA	NA
25515	Open treatment of radial shaft fracture, includes internal fixation, when performed	19.09	$683	NA	NA
25545	Open treatment of ulnar shaft fracture, includes internal fixation, when performed	17.76	$636	NA	NA
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	20.92	$749	NA	NA
25652	Open treatment of ulnar styloid fracture	17.76	$636	NA	NA
25999	Unlisted procedure, forearm or wrist	0.00	$0	0.00	$0
25628	Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed	20.51	$734	NA	NA
26230	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); metacarpal	14.17	$507	NA	NA
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	16.39	$587	NA	NA
26989	Unlisted procedure, hands or fingers	UNL	UNL	UNL	UNL
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	NA
27122	Acetabuloplasty; resection, femoral head (eg, Girdlestone procedure)	31.40	$1,124	NA	NA
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	38.83	$1,390	NA	NA
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	47.95	$1,717	NA	NA
27244	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage	35.26	$1,262	NA	NA
27245	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage	35.25	$1,262	NA	NA
27248	Open treatment of greater trochanteric fracture, includes internal fixation, when performed	21.25	$761	NA	NA
27299	Unlisted procedure, pelvis or hip joint	UNL	UNL	UNL	UNL
27355	Excision or curettage of bone cyst or benign tumor of femur	17.22	$616	NA	NA

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
27356	Excision or curettage of bone cyst or benign tumor of femur; with allograft	21.08	$755	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 (eg, osteomyelitis); metacarpal	24.30	$870	NA	NA
27450	Osteotomy, femur, shaft or supracondylar; with fixation	28.85	$1,033	NA	NA
27506	Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws	38.30	$1,371	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
27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed	27.68	$991	NA	NA
27524	Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair	21.50	$770	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
27702	Arthroplasty, ankle; with implant (total ankle)	27.76	$994	NA	NA
27703	Arthroplasty, ankle; revision, total ankle	31.83	$1,140	NA	NA
27704	Removal of ankle implant	16.46	$589	NA	NA
27726	Repair of fibula nonunion and/or malunion with internal fixation	27.66	$990	NA	NA
27759	Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage	28.57	$1,023	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
27784	Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed	20.47	$733	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
27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only	30.93	$1,107	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	UNL	UNL	UNL	UNL
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus	11.89	$426	17.59	$630
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	14.25	$510	19.47	$697
28445	Open treatment of talus fracture, includes internal fixation, when performed	30.57	$1,094	NA	NA

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
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
28899	Unlisted procedure, foot or toes	UNL	UNL	UNL	UNL
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis	29.92	$1,071	NA	NA
29907	Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis	25.11	$899	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 T means that the code pays at 100% of the rate when it is the only procedure or is the highest-weighted procedure, but pays at 50% of the rate when it is submitted with another higher-weighted procedure. Status indicator N are paid under the OPPS, but their payment is packaged into payment for a separately paid service. 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.

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
23156	Excision or curettage of bone cyst or benign tumor of proximal humerus; with allograft	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
23174	Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
23630	Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
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
24116	Excision or curettage of bone cyst or benign tumor, humerus; with allograft	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
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
24134	Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus	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
24136	Sequestrectomy (eg, for osteomyelitis or bone abscess), radial head or neck	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
24138	Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
24145	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), radial head or neck	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
24515	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), radial head or neck	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
24516	Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
24546	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
24635	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
24665	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
24685	Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
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
25145	Sequestrectomy (eg, for osteomyelitis or bone abscess), forearm and/or wrist	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
25515	Open treatment of radial shaft fracture, includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
25545	Open treatment of ulnar shaft fracture, includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
25652	Open treatment of ulnar styloid fracture	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
25999	Unlisted procedure, forearm or wrist	0129	Level I Closed Treatment Fracture	T	2.2797	$169
25628	Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
26230	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); metacarpal	0053	Level I Hand Musculoskeletal Procedures	T	16.5603	$1,228
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
26989	Unlisted procedure, hands or fingers	0129	Level I Closed Treatment Fracture	T	2.2797	$169

CPT® Code	Description	APC	APC Title	SI	Relative Weight	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)			C		
27122	Acetabuloplasty; resection, femoral head (eg, Girdlestone procedure)			C		
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft			C		
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft			C		
27244	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage			C		
27245	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage			C		
27248	Open treatment of greater trochanteric fracture, 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
27356	Excision or curettage of bone cyst or benign tumor of femur; with allograft	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 (eg, osteomyelitis); metacarpal	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27450	Osteotomy, femur, shaft or supracondylar; with fixation			C		
27506	Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws			C		
27511	Open treatment of femoral supracondylar or transcondylar fracture without 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		
27524	Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
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
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
27702	Arthroplasty, ankle; with implant (total ankle)			C		
27703	Arthroplasty, ankle; revision, total ankle			C		

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
27704	Removal of ankle implant	0049	Level I Musculoskeletal Procedures Except Hand and Foot	Q2	22.3913	$1,660
27726	Repair of fibula nonunion and/or malunion with internal fixation	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
27759	Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
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
27784	Open treatment of proximal fibula or shaft 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
27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
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
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); 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

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
28725	Arthrodesis; subtalar	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
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis	0042	Level II Arthroscopy	T	58.5867	$4,344
29907	Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis	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 G2 is a technical variation but also means a surgical procedures whose payment is based on the hospital outpatient rate. When the Multiple Procedure Discount is Yes, it indicates that the code pays at 100% of the rate when it is the only procedure or is the highest-weighted procedure, but pays at 50% of the rate when it is submitted with another higher-weighted procedure.

For Medicare, with a few exceptions, the ASC payment for the procedure code is considered complete. In general, separate payment is not made for Implanted devices. Instead, payment for implants used in the procedure is included in the payment for the procedure. However, private payers may have carve-outs for implants.

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
23150	Excision or curettage of bone cyst or benign tumor of proximal humerus	A2	Y	32.3631	$1,426
23156	Excision or curettage of bone cyst or benign tumor of proximal humerus; with allograft	A2	Y	32.3631	$1,426
23174	Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck	A2	Y	32.3631	$1,426
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed	J8	Y	93.9112	$4,139
23630	Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed	J8	Y	93.9112	$4,139
24110	Excision or curettage of bone cyst or benign tumor, humerus	A2	Y	20.6560	$910
24116	Excision or curettage of bone cyst or benign tumor, humerus; with allograft	A2	Y	32.3631	$1,426
24120	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process	A2	Y	20.6560	$910
24134	Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus	A2	Y	32.3631	$1,426
24136	Sequestrectomy (eg, for osteomyelitis or bone abscess), radial head or neck	A2	Y	32.3631	$1,426
24138	Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process	A2	Y	32.3631	$1,426
24145	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), radial head or neck	A2	Y	32.3631	$1,426
24515	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), radial head or neck	J8	Y	93.9112	$4,139
24516	Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws	J8	Y	93.9112	$4,139
24546	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension	J8	Y	93.9112	$4,139
24635	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed	J8	Y	93.9112	$4,139
24665	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed	A2	Y	52.5892	$2,318
24685	Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed	A2	Y	52.5892	$2,318
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

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
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
25145	Sequestrectomy (eg, for osteomyelitis or bone abscess), forearm and/or wrist	A2	Y	32.3631	$1,426
25515	Open treatment of radial shaft fracture, includes internal fixation, when performed	A2	Y	52.5892	$2,318
25545	Open treatment of ulnar shaft fracture, includes internal fixation, when performed	A2	Y	52.5892	$2,318
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	J8	Y	93.9112	$4,139
25652	Open treatment of ulnar styloid fracture	G2	Y	52.5892	$2,318
25999	Unlisted procedure, forearm or wrist	NA	NA	NA	NA
25628	Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed	A2	Y	52.5892	$2,318
26230	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); metacarpal	A2	Y	15.2769	$673
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	A2	Y	52.5892	$2,318
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
27122	Acetabuloplasty; resection, femoral head (eg, Girdlestone procedure)	NA	NA	NA	NA
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	NA	NA	NA	NA
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	NA	NA	NA	NA
27244	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage	NA	NA	NA	NA
27245	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage	NA	NA	NA	NA
27248	Open treatment of greater trochanteric fracture, 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
27356	Excision or curettage of bone cyst or benign tumor of femur; with allograft	G2	Y	2.1030	$93
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		
27360	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); metacarpal	A2	Y	32.3631	$1,426
27450	Osteotomy, femur, shaft or supracondylar; with fixation	NA	NA	NA	NA
27506	Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws	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
27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed	NA	NA	NA	NA
27524	Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair	G2	Y	52.5892	$2,318
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

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
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
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
27726	Repair of fibula nonunion and/or malunion with internal fixation	G2	Y	52.5892	$2,318
27759	Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage	J8	Y	93.9112	$4,139
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
27784	Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed	A2	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
27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only	J8	Y	93.9112	$4,139
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
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus	A2	Y	21.6844	$956
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); 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
28899	Unlisted procedure, foot or toes	NA	NA	NA	NA
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis	A2	Y	54.0462	$2,382
29907	Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis	G2	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 ALLOMATRIX® C Putty , 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
714.0	Rheumatoid arthritis
344.60	Cauda equina syndrome without mention of neurogenic bladder
344.61	Cauda equina syndrome with neurogenic bladder
715.X7	Osteoarthrosis, ankle and foot
733.11	Pathologic fracture of humerus
733.12	Pathologic fracture of distal radius and ulna
733.13	Pathologic fracture of vertebrae
733.14	Pathologic fracture of neck of femur
733.15	Pathologic fracture of other specified part of femur
733.16	Pathologic fracture of tibia or fibula
733.20	Cyst of bone [metatarsal head]
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
733.96	Stress fracture of femoral neck
733.97	Stress fracture of shaft of femur
733.98	Stress fracture of pelvis
736.70	Unspecified deformity of ankle and foot, acquired
808.0	Closed fracture of acetabulum
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

IDC-9-CM Diagnosis	Description
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
808.X	Closed or open fracture of acetabulum, pubis, ilium, ishium, or multiple sites of pelvis
812.XX	Closed and open fractures of humerus
813.XX	Closed and open fractures of radius and ulna
814.0X	Closed and open fractures of carpal bones
820.XX	Closed and open fracturesof neck of femur, unspecified
821.XX	Closed and open fractures of femur
823.XX	Closed and open fractures of tibia and fibula
825.XX	Closed and open fractures of one or more tarsal and metarsal bones
905.4	Late effect of fracture of lower extremities
996.41	Mechanical loosening of prosthetic joint
996.42	Dislocation of prosthetic joint
996.43	Broken prosthetic joint implant
996.44	Peri-prosthetic fracture around prosthetic joint
996.45	Peri-prosthetic osteolysis
996.46	Articular bearing surface wear of prosthetic joint
996.47	Other mechanical complication of prosthetic joint implant
996.49	Other mechanical complication of other internal orthopedic device, implant, and graft

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

Diagnosis Related Groups (MS-DRGs) is the prospective payment system Medicare uses to reimburse hospitals for inpatient services. Each inpatient stay is assigned to a specific group based on clinical and resource similarities for its ICD-9-CM diagnosis and procedure codes. Only one DRG is assigned to each inpatient case, regardless of the number of diagnosis and procedure codes.Both CC and MCC refer to secondary diagnoses that are designated as complications/comorbidities (CC) or major complications/comorbidities (MCC). Each DRG has a relative weight which is then converted to a flat payment amount using standard operating and capital amounts.

For Medicare, with a few exceptions, the MS-DRG payment for the procedure is considered complete and payment for implants is included in the MS-DRG payment. However, private payers may have carve-outs for implants.

DRG	DRG Title	Relative Weight	Medicare National Unadjusted Payment	ICD-9-CM Procedure Codes and Descriptions
466	Revision of Hip or Knee Replacement W MCC	5.1513	$30,212	84.55 with 81.53
467	Revision of Hip or Knee Replacement W CC	3.4231	$20,076	
468	Revision of Hip or Knee Replacement WO CC/MCC	2.7652	$16,219	

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 81.51 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 77.85 78.55 79.35
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	
492	Lower Extrem & Humer Proc Except Hip,Foot,Femur W MCC	3.1873	$18,695	41.98 & 84.55 with 77.02 77.07 77.87 78.57 79.36 81.11 81.12 81.49
493	Lower Extrem & Humer Proc Except Hip,Foot,Femur W CC	2.0354	$11,939	
494	Lower Extrem & Humer Proc Except Hip,Foot,Femur WO CC/MCC	1.5397	$9,031	
495	Local Excision & Removal Int Fix Devices Exc Hip & Femur W MCC	3.0476	$17,876	41.98 & 84.55 with 77.62 77.63 77.67 80.07
496	Local Excision & Removal Int Fix Devices Exc Hip & Femur W CC	1.7289	$10,141	
497	Local Excision & Removal Int Fix Devices Exc Hip & Femur WO CC/MCC	1.2230	$7,173	
498	Local Excision & Removal Int Fix Devices of Hip & Femur W CC/MCC	2.1416	$12,562	84.55 with 77.65
499	Local Excision & Removal Int Fix Devices of Hip & Femur WO CC/MCC	1.0753	$6,307	
503	Foot Procedures W MCC	2.3338	$13,689	84.55 with 77.08 77.68 77.88 79.37 81.13
504	Foot Procedures W CC	1.5691	$9,204	
505	Foot Procedures WO CC/MCC	1.2474	$7,317	
509	Arthroscopy	1.5494		84.55 with 80.27
510	Shoulder,Elbow or Forearm Proc,Exc Major Joint Proc W MCC	2.2857	$13,407	84.55 with 77.03 79.32
511	Shoulder,Elbow or Forearm Proc,Exc Major Joint Proc W CC	1.6509	$9,683	
512	Shoulder,Elbow or Forearm Proc,Exc Major Joint Proc WO CC/MCC	1.2963	$7,603	
513	Hand or Wrist Proc, Except Major Thumb or Joint Proc W CC/MCC	1.4462	$8,483	84.55 with 77.04 77.64 77.84 79.33
514	Hand or Wrist Proc, Except Major Thumb or Joint Proc WO CC/MCC	0.8996	$5,277	
515	Other Musculoskelet Sys & Conn Tiss O.R. Proc W MCC	3.2235	$18,907	84.55 with 81.59
516	Other Musculoskelet Sys & Conn Tiss O.R. Proc W CC	2.0434	$11,986	
517	Other Musculoskelet Sys & Conn Tiss O.R. Proc WO CC/MCC	1.7251	$10,119	

Reference: Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals Table 5— List of Medicare Severity Diagnosis Related Groups (MS-DRGs) Relative Weighting Factors—FY 2015 Final Rule

Disclaimer

The coding and reimbursement information and data provided by Wright Medical Technology is presented for informational purposes only and is accurate as of its date of publication. It is the provider's responsibility to report the codes that accurately describe the products and services furnished to individual patients. Reimbursement is dynamic. Laws and regulations regarding reimbursement change frequently and providers are solely responsible for all decisions related to coding and billing including determining, if and under what circumstances, it is appropriate to seek reimbursement for products and services and for obtaining pre-authorization, if necessary. For these reasons, providers are advised to contact Medicare and/or specific payers if they have any questions regarding billing, coverage and payment. Likewise, providers should contact a medical specialty society or the AMA for coding clarification. Providers should check the complete and current HCPCS and/or CPT manual to see and consider all possible HCPCS and/or CPT codes. Wright Medical Technology makes no representation or warranty regarding this information or its completeness or accuracy and will bear no responsibility for the results or consequences of the use of this information.

WRIGHT™
FOCUSED EXCELLENCE

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

™Trademarks and ®Registered marks of Wright Medical Technology, Inc.
©2015 Wright Medical Technology, Inc. All Rights Reserved.

012125A_14-Apr-2015