FUSIONFLEX®

Demineralized Moldable Scaffold

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-to-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
+20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)	3.24	$116	NA	NA
0195T	Arthrodesis, pre-sacral interbody technique, disc space preparation, discectomy, without instrumentation, with image guidance, includes bone graft when performed; L5-S1 interspace	T	T	T	T
+0196T	Arthrodesis, pre-sacral interbody technique, disc space preparation, discectomy, without instrumentation, with image guidance, includes bone graft when performed; L4-L5 interspace (List separately in addition to code for primary procedure)	T	T	T	T
+0309T	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft, when performed, lumbar, L4-L5 interspace (List separately in addition to code for primary procedure)	T	T	T	T

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
22206	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); thoracic	70.31	$2,514	NA	NA
22207	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); lumbar	68.87	$2,462	NA	NA
22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical	51.46	$1,840	NA	NA
22212	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic	42.70	$1,527	NA	NA
22319	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; with grafting	53.12	$1,899	NA	NA
22532	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	51.17	$1,830	NA	NA
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	47.42	$1,695	NA	NA
+22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)	10.39	$371	NA	NA
22548	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process	57.08	$2,041	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	$1,768	NA	NA
+22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)	11.56	$413	NA	NA
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	36.20	$1,294	NA	NA
22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	48.18	$1,723	NA	NA
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	44.29	$1,584	NA	NA
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace	57.98	$2,073	NA	NA
22590	Arthrodesis, posterior technique, craniocervical (occiput-C2)	45.53	$1,628	NA	NA
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)	43.55	$1,557	NA	NA
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment	37.19	$1,330	NA	NA
22610	Arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)	36.38	$1,301	NA	NA
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	45.73	$1,635	NA	NA
+22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)	11.33	$405	NA	NA
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	45.22	$1,617	NA	NA
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar	53.44	$1,911	NA	NA
22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments	38.89	$1,391	NA	NA
22802	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments	60.37	$2,159	NA	NA
22804	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments	69.94	$2,501	NA	NA
22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments	53.14	$1,900	NA	NA
22810	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments	58.13	$2,078	NA	NA
22812	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments	63.57	$2,273	NA	NA

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
+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) (List separately in addition to code for primary procedure)	22.01	$787	NA	NA
+22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)	22.08	$789	NA	NA
23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release	17.41	$622	NA	NA
23170	Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle	15.99	$572	NA	NA
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	34.39	$1,230	NA	NA
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	41.69	$1,491	NA	NA
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	46.55	$1,664	NA	NA
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	50.36	$1,801	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	$904	NA	NA
23630	Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed	22.31	$798	NA	NA
23670	Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed	25.06	$896	NA	NA
23929	Unlisted procedure, shoulder	UNL	UNL	UNL	UNL
24400	Osteotomy, humerus, with or without internal fixation	23.35	$835	NA	NA
24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)	30.24	$1,081	NA	NA
24420	Osteoplasty, humerus (eg, shortening or lengthening)	28.41	$1,016	NA	NA
24515	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage	25.02	$895	NA	NA
24516	Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws	24.57	$878	NA	NA
24545	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension	26.55	$949	NA	NA
24546	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension	29.69	$1,062	NA	NA
24575	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	20.94	$749	NA	NA
24579	Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed	23.83	$852	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	$686	NA	NA
24665	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed	18.58	$664	NA	NA
24685	Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed	18.64	$666	NA	NA
24999	Unlisted procedure, humerus or elbow	UNL	UNL	UNL	UNL
25150	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); ulna	16.18	$579	NA	NA
25151	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); radius	16.74	$599	NA	NA
25332	Arthroplasty, wrist, with or without interposition, with or without external or internal fixation	23.91	$855	NA	NA
25337	Reconstruction for stabilization of unstable distal ulna or distal radioulnar joint, secondary by soft tissue stabilization (eg, tendon transfer, tendon graft or weave, or tenodesis) with or without open reduction of distal radioulnar joint	25.29	$904	NA	NA

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
25370	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna	28.77	$1,029	NA	NA
25375	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius AND ulna	27.23	$974	NA	NA
25441	Arthroplasty with prosthetic replacement; distal radius	26.55	$949	NA	NA
25442	Arthroplasty with prosthetic replacement; distal ulna	22.70	$812	NA	NA
25446	Arthroplasty with prosthetic replacement; distal radius and partial or entire carpus (total wrist)	33.33	$1,192	NA	NA
25515	Open treatment of radial shaft fracture, includes internal fixation, when performed	19.09	$683	NA	NA
25999	Unlisted procedure, forearm or wrist	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	$934	NA	NA
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	38.83	$1,388	NA	NA
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	47.95	$1,714	NA	NA
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	54.88	$1,962	NA	NA
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	42.19	$1,508	NA	NA
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	43.83	$1,567	NA	NA
27158	Osteotomy, pelvis, bilateral (eg, congenital malformation)	40.18	$1,437	NA	NA
27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast	39.25	$1,403	NA	NA
27170	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)	33.70	$1,205	NA	NA
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	34.25	$1,225	NA	NA
27244	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)	35.26	$1,261	NA	NA
27245	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage	35.25	$1,260	NA	NA
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, (including obtaining graft when performed) and placement of transfixing device	NA	NA	13.61	$487
27280	Arthrodesis, sacroiliac joint (including obtaining graft	29.83	$1,067	NA	NA
27450	Osteotomy, femur, shaft or supracondylar; with fixation	28.85	$1,032	NA	NA
27470	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)	33.63	$1,202	NA	NA
27486	Revision of total knee arthroplasty, with or without allograft; 1 component	40.26	$1,439	NA	NA
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	50.33	$1,800	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	$1,369	NA	NA
27507	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage	27.82	$995	NA	NA
27524	Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair	21.50	$769	NA	NA
27599	Unlisted procedure, femur or knee	UNL	UNL	UNL	UNL
27720	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)	25.03	$895	NA	NA
27899	Unlisted procedure, leg or ankle	UNL	UNL	UNL	UNL
28300	Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation	18.71	$669	NA	NA
28304	Osteotomy, tarsal bones, other than calcaneus or talus	17.43	$623	23.86	$853

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
28446	Open osteochondral autograft, talus (includes obtaining graft[s])	35.10	$1,255	NA	NA
28899	Unlisted procedure, foot or toes	UNL	UNL	UNL	UNL
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	28.88	$1,033	NA	NA
29999	Unlisted procedure, arthroscopy	UNL	UNL	UNL	UNL
38220	Bone marrow; aspiration only	1.76	$63	4.66	$167

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
+20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)			N		
0195T	Arthrodesis, pre-sacral interbody technique, disc space preparation, discectomy, without instrumentation, with image guidance, includes bone graft when performed; L5-S1 interspace			C		
+0196T	Arthrodesis, pre-sacral interbody technique, disc space preparation, discectomy, without instrumentation, with image guidance, includes bone graft when performed; L4-L5 interspace (List separately in addition to code for primary procedure)			C		
+0309T	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft, when performed, lumbar, L4-L5 interspace (List separately in addition to code for primary procedure)			C		
22206	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/ vertebral body subtraction); thoracic			C		
22207	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/ vertebral body subtraction); lumbar			C		
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		
22319	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; with grafting			C		

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
22532	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic			C		
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar			C		
+22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)			C		
22548	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process			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
+22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)			C		
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	0425	Level V Musculoskeletal Procedures Except Hand and Foot	J1	137.8399	$10,220
22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic			C		
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar			C		
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace			C		
22590	Arthrodesis, posterior technique, craniocervical (occiput-C2)			C		
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)			C		
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment			C		
22610	Arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)			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
+22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)			N		
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar			C		
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar			C		
22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments			C		
22802	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments			C		
22804	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments			C		

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments			C		
22810	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments			C		
22812	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments			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) (List separately in addition to code for primary procedure)			C		
+22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)			C		
23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
23170	Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	0425	Level V Musculoskeletal Procedures Except Hand and Foot	J1	137.8399	$10,220
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))			C		
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	0047	Arthroplasty	T	45.3575	$3,363
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component			C		
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
23670	Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, 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
24400	Osteotomy, humerus, with or without internal fixation	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
24420	Osteoplasty, humerus (eg, shortening or lengthening)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
24515	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage	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
24545	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension	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

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
24575	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	0064	Level III Treatment Fracture/Dislocation	T	75.0875	$5,567
24579	Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed	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
25150	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); ulna	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
25151	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); radius	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
25332	Arthroplasty, wrist, with or without interposition, with or without external or internal fixation	0047	Arthroplasty	T	45.3575	$3,363
25337	Reconstruction for stabilization of unstable distal ulna or distal radioulnar joint, secondary by soft tissue stabilization (eg, tendon transfer, tendon graft or weave, or tenodesis) with or without open reduction of distal radioulnar joint	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
25370	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
25375	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius AND ulna	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
25441	Arthroplasty with prosthetic replacement; distal radius	0425	Level V Musculoskeletal Procedures Except Hand and Foot	J1	137.8399	$10,220
25442	Arthroplasty with prosthetic replacement; distal ulna	0425	Level V Musculoskeletal Procedures Except Hand and Foot	J1	137.8399	$10,220
25446	Arthroplasty with prosthetic replacement; distal radius and partial or entire carpus (total wrist)	0425	Level V Musculoskeletal Procedures Except Hand and Foot	J1	137.8399	$10,220
25515	Open treatment of radial shaft fracture, includes internal fixation, when performed	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
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		
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		
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft			C		
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft			C		

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft			C		
27158	Osteotomy, pelvis, bilateral (eg, congenital malformation)			C		
27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast			C		
27170	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)			C		
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement			C		
27244	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)			C		
27245	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage			C		
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, (including obtaining graft when performed) and placement of transfixing device	0425	Level V Musculoskeletal Procedures Except Hand and Foot	J1	137.8399	$10,220
27280	Arthrodesis, sacroiliac joint (including obtaining graft			C		
27450	Osteotomy, femur, shaft or supracondylar; with fixation			C		
27470	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)			C		
27486	Revision of total knee arthroplasty, with or without allograft; 1 component			C		
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component			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		
27507	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage			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
27599	Unlisted procedure, femur or knee	0129	Level I Closed Treatment Fracture	T	2.2797	$169
27720	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)	0064	Level III Treatment Fracture/Dislocation	T	75.0875	$5,567
27899	Unlisted procedure, leg or ankle	0129	Level I Closed Treatment Fracture	T	2.2797	$169
28300	Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28304	Osteotomy, tarsal bones, other than calcaneus or talus	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28446	Open osteochondral autograft, talus (includes obtaining graft[s])	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
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	0042	Level II Arthroscopy	T	58.5867	$4,344
29999	Unlisted procedure, arthroscopy	0041	Level I Arthroscopy	T	29.0075	$2,151
38220	Bone marrow; aspiration only	0020	Level II Excision/ Biopsy	T	11.1440	$826

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 represents a non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight. Payment indicator J8 indicates Device-intensive procedure; paid at adjusted rate. Payment indicator N1 indicates a packaged procedure/item; no separate payment made. Payment indicator P3 is an office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs. 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
+20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)	N1	N		
0195T	Arthrodesis, pre-sacral interbody technique, disc space preparation, discectomy, without instrumentation, with image guidance, includes bone graft when performed; L5-S1 interspace	NA	NA	NA	NA
+0196T	Arthrodesis, pre-sacral interbody technique, disc space preparation, discectomy, without instrumentation, with image guidance, includes bone graft when performed; L4-L5 interspace (List separately in addition to code for primary procedure)	NA	NA	NA	NA
+0309T	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft, when performed, lumbar, L4-L5 interspace (List separately in addition to code for primary procedure)	NA	NA	NA	NA
22206	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); thoracic	NA	NA	NA	NA
22207	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); lumbar	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
22319	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; with grafting	NA	NA	NA	NA
22532	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	NA	NA	NA	NA
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	NA	NA	NA	NA
+22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)	NA	NA	NA	NA
22548	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process	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
+22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)	NA	NA	NA	NA
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	J8	N	177.9456	$7,842
22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	NA	NA	NA	NA
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	NA	NA	NA	NA
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace	NA	NA	NA	NA

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
22590	Arthrodesis, posterior technique, craniocervical (occiput-C2)	NA	NA	NA	NA
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)	NA	NA	NA	NA
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment	NA	NA	NA	NA
22610	Arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)	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
+22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)	N1	N		
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	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar	NA	NA	NA	NA
22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments	NA	NA	NA	NA
22802	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments	NA	NA	NA	NA
22804	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments	NA	NA	NA	NA
22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments	NA	NA	NA	NA
22810	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments	NA	NA	NA	NA
22812	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments	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) (List separately in addition to code for primary procedure)	NA	NA	NA	NA
+22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)	NA	NA	NA	NA
23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release	A2	Y	46.8009	$2,063
23170	Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle	A2	Y	32.3631	$1,426
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	NA	NA	NA	NA
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	NA	NA	NA	NA
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	NA	NA	NA	NA
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	NA	NA	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	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
23670	Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed	J8	Y	93.9112	$4,139
23929	Unlisted procedure, shoulder	NA	NA	NA	NA
24400	Osteotomy, humerus, with or without internal fixation	A2	Y	46.8009	$2,063
24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)	A2	Y	46.8009	$2,063
24420	Osteoplasty, humerus (eg, shortening or lengthening)	A2	Y	46.8009	$2,063
24515	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage	J8	Y	93.9112	$4,139

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
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
24545	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension	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
24575	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	J8	Y	93.9112	$4,139
24579	Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed	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
25150	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); ulna	A2	Y	32.3631	$1,426
25151	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); radius	A2	Y	32.3631	$1,426
25332	Arthroplasty, wrist, with or without interposition, with or without external or internal fixation	A2	Y	41.8423	$1,844
25337	Reconstruction for stabilization of unstable distal ulna or distal radioulnar joint, secondary by soft tissue stabilization (eg, tendon transfer, tendon graft or weave, or tenodesis) with or without open reduction of distal radioulnar joint	A2	Y	46.8009	$2,063
25370	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna	A2	Y	46.8009	$2,063
25375	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius AND ulna	A2	Y	46.8009	$2,063
25441	Arthroplasty with prosthetic replacement; distal radius	J8	N	177.9456	$7,842
25442	Arthroplasty with prosthetic replacement; distal ulna	J8	N	177.9456	$7,842
25446	Arthroplasty with prosthetic replacement; distal radius and partial or entire carpus (total wrist)	J8	N	177.9456	$7,842
25515	Open treatment of radial shaft fracture, includes internal fixation, when performed	A2	Y	52.5892	$2,318
25999	Unlisted procedure, forearm or wrist	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
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
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	NA	NA	NA	NA
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	NA	NA	NA	NA
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	NA	NA	NA	NA
27158	Osteotomy, pelvis, bilateral (eg, congenital malformation)	NA	NA	NA	NA
27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast	NA	NA	NA	NA
27170	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)	NA	NA	NA	NA
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	NA	NA	NA	NA
27244	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)	NA	NA	NA	NA

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
27245	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage	NA	NA	NA	NA
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, (including obtaining graft when performed) and placement of transfixing device	J8	N	177.9456	$7,842
27280	Arthrodesis, sacroiliac joint (including obtaining graft	NA	NA	NA	NA
27450	Osteotomy, femur, shaft or supracondylar; with fixation	NA	NA	NA	NA
27470	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)	NA	NA	NA	NA
27486	Revision of total knee arthroplasty, with or without allograft; 1 component	NA	NA	NA	NA
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	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
27507	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage	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
27599	Unlisted procedure, femur or knee	NA	NA	NA	NA
27720	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)	G2	Y	52.5892	$2,318
27899	Unlisted procedure, leg or ankle	NA	NA	NA	NA
28300	Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation	A2	Y	64.9113	$2,861
28304	Osteotomy, tarsal bones, other than calcaneus or talus	A2	Y	64.9113	$2,861
28446	Open osteochondral autograft, talus (includes obtaining graft[s])	G2	Y	64.9113	$2,861
28899	Unlisted procedure, foot or toes	NA	NA	NA	NA
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	G2	Y	54.0462	$2,382
29999	Unlisted procedure, arthroscopy	NA	NA	NA	NA
38220	Bone marrow; aspiration only	P3	Y		

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 FUSIONFLEX™ though other codes may also be appropriate. The ICD-9-CM book should always be referenced for diagnostic coding.

IDC-9-CM Diagnosis	Description
716.17	Traumatic arthropathy, ankle and foot
718.47	Contracture of joint, ankle and foot
719.87	Other specified disorders of joint, ankle and foot
731.3	Major osseous defects
732.5	Juvenile osteochondrosis of foot
733.19	Pathologic fracture of other specified site
733.81	Malunion of fracture
733.82	Nonunion of fracture
733.91	Arrest of bone development or growth
733.93	Stress fracture of tibia or fibula
733.94	Stress fracture of metatarsals
733.95	Stress fracture of other bone

IDC-9-CM Diagnosis	Description
733.96	Stress fracture of femoral neck
733.97	Stress fracture of shaft of femur
733.98	Stress fracture of pelvis
733.99	Other disorders of bone and cartilage
735.2	Hallux rigidus
736.70	Unspecified deformity of ankle and foot, acquired
736.71	Acquired equinovarus deformity
736.72	Equinus deformity of foot, acquired
736.73	Cavus deformity of foot, acquired
736.76	Other acquired calcaneus deformity
736.79	Other acquired deformities of ankle and foot
738.05	Closed dislocation of metatarsophalangeal (joint)

IDC-9-CM Diagnosis	Description
738.15	Open dislocation of metatarsophalangeal (joint)
738.9	Acquired deformity of unspecified site
754.50	Talipes varus
754.51	Talipes equinovarus
754.53	Metatarsus varus
754.59	Other varus deformities of feet
754.60	Talipes valgus
754.61	Congenital pes planus
754.62	Talipes calcaneovalgus
754.69	Other valgus deformities of feet
754.70	Talipes, unspecified
754.71	Talipes cavus
754.79	Other deformities of feet
755.67	Congenital anomalies of foot, not elsewhere classified
805.XX	Fracture of vertebral column without mention of spinal cord injury
808.XX	Fracture of Pelvis
812.XX	Fracture of Humerus
813.XX	Fracture of Radius
820.XX	Fracture of neck of femur
821.XX	Fracture of other and unspecified parts of femur
823.XX	Fracture of tibia and fibula
825.0	Fracture of calcaneus, closed

IDC-9-CM Diagnosis	Description
825.1	Fracture of calcaneus, open
825.23	Closed fracture of cuboid
825.33	Open fracture of cuboid
905.1	Late effect of spine without spinal cord lesion
905.2	Late effect of fracture of upper extremities
905.3	Late effect of fracture of neck of femur
905.4	Late effect of fracture of lower extremities
909.3	Late effect of complications of surgical and medical care
996.41	Mechanical loosening of prosthetic joint
996.43	Broken prosthetic joint implant
996.45	Peri-prosthetic osteolysis
996.49	Other mechanical complication of other internal orthopedic device, implant, and graft
996.66	Infection and inflammatory reaction due to internal joint prosthesis
996.67	Infection and inflammatory reaction due to other internal orthopedic device, implant and graft
996.78	Other complications due to other internal orthopedic device, implant, and graft
V45.4	Arthrodesis status
V43.66	Organ or tissue replaced by other means, ankle
V54.82	Aftercare following explantation of joint prosthesis
V88.29	Acquired absence of other joint

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

Diagnosis Related Groups (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
028	Spinal Procedures W MCC	5.3968	$31,655	03.53
029	Spinal Procedures W CC or Spinal Neurostimulators	3.1573	$18,519	
030	Spinal Procedures WO CC/MCC	1.7835	$10,461	
459	Spinal Fusion Except Cervical W MCC	6.6686	$39,115	81.00 81.04 81.05 81.06 81.07 81.08
460	Spinal Fusion Except Cervical WO MCC	3.9998	$23,461	

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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	$30,215	07.07
467	Revision of Hip or Knee Replacement W CC	3.4231	$20,078	
468	Revision of Hip or Knee Replacement WO CC/MCC	2.7652	$16,219	
469	Major joint replacement or reattachment of lower extremity W MCC	3.3905	$19,887	81.51 81.52
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	81.01 81.02 81.03
472	Cervical Spinal Fusion W CC	2.9166	$17,107	
473	Cervical Spinal Fusion WO CC/MCC	2.2655	$13,288	
480	Hip & Femur Procedures except major joint W MCC	3.0052	$17,627	77.35 78.05 78.55 81.40
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	
483	Major Joint or Limb Reattachment Procedure of Upper Extremities	2.4205	$14,197	81.81 81.88
488	Knee Procedures Without Principal Diagnosis of Infection W CCMCC	1.7225	$10,103	78.06 81.47
489	Knee Procedures Without Principal Diagnosis of Infection WO CC/MCC	1.3186	$7,734	
492	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur W MCC	3.1873	$18,695	77.32 78.02 78.07 78.42 78.52 78.55 79.31 79.35 80.99
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	$17,875	77.63 77.69
496	Local Excision and Removal Internal Fixation Devices Except Hip and Femur W CC	1.7289	$10,140	
497	Local Excision and Removal Internal Fixation Devices Except Hip and Femur WO CCMCC	1.2230	$7,173	
503	Foot Procedures W CC	2.3338	$13,688	77.28 77.38 78.08 78.58 81.15
504	Foot Procedures W CC	1.5691	$9,203	
505	Foot Procedures WO CCMCC	1.2474	$7,316	
506	Major Thumb or Joint Procedures	1.2881	$7,555	81.74 81.75 81.79

DRG	DRG Title	Relative Weight	Medicare National Unadjusted Payment	ICD-9-CM Procedure Codes and Descriptions
507	Major Shoulder or Elbow With Joint Procedures W CC/ MCC	1.9154	$11,235	81.83 81.85
508	Major Shoulder or Elbow With Joint Procedures WO CC/MCC	1.5198	$8,914	
509	Arthroscopy	1.5494	$9,088	80.21 80.22 80.25 80.26
510	Shoulder, Elbow or Forearm Procedure except Major Joint Procedure W MCC	2.2857	$13,407	77.33 78.03 78.53 79.32
511	Shoulder, Elbow or Forearm Procedure except Major Joint Procedure W CC	1.6509	$9,683	
512	Shoulder, Elbow or Forearm Procedure except Major Joint Procedure WO CC/MCC	1.2963	$7,603	
513	Hand or Wrist Procedure, except Major Thumb or Joint Procedure W CCMCC	1.4462	$8,483	81.25
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	77.39 78.01 78.09 81.97
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	

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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