code it WRIGHT™

PRO-TOE® C2

Hammertoe Implant

2015 Reimbursement Codes

The following codes contained within this document are representative of possible services or diagnoses that may be associated with use of Wright products. This is not a complete listing of possible codes. Not all of the codes are necessarily to be used together. Some codes may be considered a component of another ('bundled'). Final determination of the correct or appropriate coding for services performed are made by the claims submitter/provider and should be consistent with the billing policies of the patient's health insurance program. CPT® codes and descriptors are copyrighted by the American Medical Association (AMA). CPT® is a registered trademark of the American Medical Association.

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HCPCS Device Codes

HCPCS codes are developed and maintained by CMS and are used to report items such as medical devices, implants, drugs and supplies. C-codes are a special type of HCPCS code designed specifically for hospital use in billing Medicare for certain outpatient items and procedures. Other payers may also accept C-codes. S codes are used by private insurers to report drugs, services, and supplies for which there are no national codes but for which codes are needed by the private sector to implement policies, programs, or claims processing. They are for the purpose of meeting the particular needs of the private sector.

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

HCPCS Code	Description
C1713	Anchor/screw for opposing bone-to-bone or soft tissue bone (implantable)

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
28262	Capsulotomy, midfoot; medial release only (separate procedure)	33.92	$1,219	42.22	$1,517
28270	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)	9.59	$345	14.19	$510
28272	Capsulotomy; interphalangeal joint, each joint (separate procedure)	7.31	$263	11.39	$409
28285	Correction, hammertoe (eg interphalangeal fusion, partial or total phalangectomy)	10.84	$390	15.42	$554
28286	Correction, cock-up fifth toe, with plastic skin closure (eg, Ruiz-Mora type procedure)	8.56	$308	12.97	$466
28292	Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride, or Mayo type procedure	17.26	$620	22.75	$817
28296	Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)	14.94	$537	20.53	$738
28298	Correction, hallux valgus (bunion), with or without sesamoidectomy; by phalanx osteotomy	14.47	$520	20.73	$745

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
28304	Osteotomy, tarsal bones, other than calcaneus or talus	17.43	$626	23.86	$857
28305	Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (eg, Fowler type)	18.71	$672	NA	NA
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	18.71	$672	NA	NA
28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	13.49	$485	20.43	$734
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	10.79	$388	16.28	$585
28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	26.11	$938	NA	NA
28312	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe	9.30	$334	14.94	$537
28322	Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)	16.56	$595	22.72	$816
28340	Reconstruction, toe, macrodactyly; soft tissue resection	11.86	$426	16.68	$599
28341	Reconstruction, toe, macrodactyly; requiring bone resection	14.11	$507	19.33	$695
28360	Reconstruction, cleft foot	23.47	$843	NA	NA
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	14.47	$520	19.42	$698
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each	11.27	$405	16.07	$577
28531	Open treatment of sesamoid fracture, with or without internal fixation	5.23	$188	9.88	$355
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	7.51	$270	8.47	$304
28675	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed	11.92	$428	17.00	$611
28899	Unlisted procedure, foot or toes	UNL	UNL	UNL	UNL

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 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
28262	Capsulotomy, midfoot; medial release only (separate procedure)	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28270	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28272	Capsulotomy; interphalangeal joint, each joint (separate procedure)	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
28285	Correction, hammertoe (eg interphalangeal fusion, partial or total phalangectomy)	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28286	Correction, cock-up fifth toe, with plastic skin closure (eg, Ruiz-Mora type procedure)	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28292	Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride, or Mayo type procedure	0057	Bunion Procedures	T	36.0840	$2,675
28296	Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)	0057	Bunion Procedures	T	36.0840	$2,675
28298	Correction, hallux valgus (bunion), with or without sesamoidectomy; by phalanx osteotomy	0057	Bunion Procedures	T	36.0840	$2,675
28304	Osteotomy, tarsal bones, other than calcaneus or talus	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28305	Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (eg, Fowler type)	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28312	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28322	Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28340	Reconstruction, toe, macrodactyly; soft tissue resection	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28341	Reconstruction, toe, macrodactyly; requiring bone resection	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28360	Reconstruction, cleft foot	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	0062	Level I Treatment Fracture/ Dislocation	T	27.5390	$2,042
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each	0062	Level I Treatment Fracture/ Dislocation	T	27.5390	$2,042
28531	Open treatment of sesamoid fracture, with or without internal fixation	0062	Level I Treatment Fracture/ Dislocation	T	27.5390	$2,042
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	0062	Level I Treatment Fracture/ Dislocation	T	27.5390	$2,042
28675	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed	0062	Level I Treatment Fracture/ Dislocation	T	27.5390	$2,042
28899	Unlisted procedure, foot or toes	0129	Level I Closed Treatment Fracture	T	2.2797	$169

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

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

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
28262	Capsulotomy, midfoot; medial release only (separate procedure)	A2	Y	21.6844	$956
28270	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)	A2	Y	21.6844	$956
28272	Capsulotomy; interphalangeal joint, each joint (separate procedure)	P3	Y	NA	$257
28285	Correction, hammertoe (eg interphalangeal fusion, partial or total phalangectomy)	A2	Y	21.6844	$956
28286	Correction, cock-up fifth toe, with plastic skin closure (eg, Ruiz-Mora type procedure)	A2	Y	21.6844	$956
28292	Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride, or Mayo type procedure	A2	Y	33.2875	$1,467
28296	Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)	A2	Y	33.2875	$1,467
28298	Correction, hallux valgus (bunion), with or without sesamoidectomy; by phalanx osteotomy	A2	Y	33.2875	$1,467
28304	Osteotomy, tarsal bones, other than calcaneus or talus	A2	Y	64.9113	$2,861
28305	Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (eg, Fowler type)	A2	Y	64.9113	$2,861
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	A2	Y	21.6844	$956
28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	A2	Y	21.6844	$956
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	A2	Y	21.6844	$956
28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	A2	Y	64.9113	$2,861
28312	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe	A2	Y	21.6844	$956
28322	Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)	A2	Y	21.6844	$956
28340	Reconstruction, toe, macrodactyly; soft tissue resection	A2	Y	21.6844	$956
28341	Reconstruction, toe, macrodactyly; requiring bone resection	A2	Y	21.6844	$956
28360	Reconstruction, cleft foot	NA	NA	NA	NA
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	A2	Y	25.4047	$1,120
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each	A2	Y	25.4047	$1,120
28531	Open treatment of sesamoid fracture, with or without internal fixation	A2	Y	25.4047	$1,120
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	A2	Y	25.4047	$1,120
28675	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed	A2	Y	25.4047	$1,120
28899	Unlisted procedure, foot or toes	NA	NA	NA	NA

Reference: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Final Rule, Addendum AA -- Final ASC Covered Surgical Procedures for CY 2015 (Including Surgical Procedures for Which Payment is Packaged), Addendum EE -- Surgical Procedures Proposed to be Excluded from Payment in ASCs for CY 2015

ICD-9-CM Diagnosis Codes

ICD-9-CM diagnosis codes are used by all providers, including physicians, hospitals and ASCs, and in all settings, including inpatient and outpatient. Diagnosis codes indicate the reason for the procedure and are mandatory for reimbursement. The codes shown below are those that are common with procedures using the PRO-TOE® C-2 System though other codes may also be appropriate. The ICD-9-CM book should always be referenced for diagnostic coding.

IDC-9-CM Diagnosis	Description
714.0	Rheumatoid arthritis
715.17	Osteoarthrosis, localized, primary, ankle and foot
715.97	Osteoarthrosis, unspecified whether generalized or localized, ankle and foot
716.17	Traumatic arthropathy, ankle and foot
718.28	Pathological dislocation of joint, other specified sites
718.47	Contracture of joint, ankle and foot
718.57	Ankylosis of joint, ankle and foot
719.27	Villonodular synovitis, ankle and foot
719.87	Other specified disorders of joint, ankle and foot
726.79	Other enthesopathy of ankle and tarsus
727.00	Synovitis and tenosynovitis, unspecified
727.1	Bunion
727.81	Contracture of tendon (sheath)
731.3	Major osseous defects
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
733.94	Stress fracture of metatarsals
733.95	Stress fracture of other bone
733.99	Other disorders of bone and cartilage
735.0	Hallux valgus (acquired)
735.1	Hallux varus (acquired)
735.2	Hallux rigidus
735.3	Hallux malleus
735.4	Other hammer toe (acquired)
735.5	Claw toe (acquired)
735.8	Other acquired deformities of toe
735.9	Unspecified acquired deformity of toe
736.71	Acquired equinovarus deformity
736.73	Cavus deformity of foot, acquired
736.74	Claw foot, acquired

IDC-9-CM Diagnosis	Description
736.75	Cavovarus deformity of foot, acquired
736.79	Other acquired deformities of ankle and foot
738.05	Closed dislocation of metatarsophalangeal (joint)
738.15	Open dislocation of metatarsophalangeal (joint)
754.50	Talipes varus
754.52	Metatarsus primus varus
754.53	Metatarsus varus
754.69	Other congenital valgus deformity of feet
754.71	Talipes cavus
755.38	Longitudinal deficiency, tarsals or metatarsals, complete or partial (with or without incomplete phalangeal deficiency)
755.65	Macrodactylia of toes
755.66	Other specified congenital deformities of toes
755.67	Congenital anomalies of foot, not elsewhere classified
755.69	Other anomalies of lower limb, including pelvic girdle
825.20	Closed fracture of unspecified bone(s) of foot [except toes]
825.25	Closed fracture of metatarsal bone(s)
825.29	Other closed fracture of tarsal and metatarsal bones
826.0	Closed fracture of one or more phalanges of foot
826.1	Open fracture of one or more phalanges of foot
838.05	Closed dislocation of metatarsophalangeal (joint)
838.06	Closed dislocation of interphalangeal (joint), foot
838.15	Open dislocation of metatarsophalangeal (joint)
838.16	Open dislocation of interphalangeal (joint), foot
845.12	Sprain of metatarsophalangeal (joint) of foot
905.4	Late effect of fracture of lower extremities
906.4	Late effect of crushing
928.3	Crushing injury of toes
996.49	Other mechanical complication of other internal orthopedic device, implant, and graft
996.78	Other complications due to other internal orthopedic device, implant, and graft

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

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

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

DRG	DRG Title	Relative Weight	Medicare National Unadjusted Payment	ICD-9-CM Procedure Codes and Descriptions
500	Soft tissue procedures W MCC	3.2420	$19,016	83.85
501	Soft tissue procedures W CC	1.6474	$9,663	
502	Soft tissue procedures WO CC/MCC	1.1597	$6,802	
503	Foot Procedures W CC	2.3338	$13,688	77.28 77.38 77.51 77.53 77.56 77.57 77.58 77.59 78.29 78.48 79.38 79.88 80.48 83.84
504	Foot Procedures W CC	1.5691	$9,203	
505	Foot Procedures WO CC/MCC	1.2474	$7,316	
515	Other Musculoskeletal System and Connective Tissue OR Procedures W MCC	3.2235	$18,907	77.29 77.39
516	Other Musculoskeletal System and Connective Tissue OR Procedures W CC	2.0434	$11,985	
517	Other Musculoskeletal System and Connective Tissue OR Procedures WO CC/MCC	1.7251	$10,118	

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

Disclaimer

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

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