



EVOLVE[®]

Radial Head Plate System

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
24366	Arthroplasty, radial head; with implant	19.41	\$695	NA	NA
24586	Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius)	30.94	\$1,108	NA	NA
24666	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed; with radial head prosthetic replacement	20.90	\$748	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 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 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.

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
24366	Arthroplasty, radial head; with implant	0425	Level V Musculoskeletal Procedures Except Hand and Foot	J1	137.8399	\$10,220
24586	Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius)	0064	Level III Treatment Fracture/Dislocation	T	75.0875	\$5,567
24666	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed; with radial head prosthetic replacement	0064	Level III Treatment Fracture/Dislocation	T	75.0875	\$5,567

Reference: Medicare Program: Hospital Outpatient Prospective Payment System Final Rule Addendum C - Final HCPCS Codes Payable Under the 2015 OPPS by APC

Ambulatory Surgery Center (ASC) Coding

Medicare's prospective payment system for ASCs is based on the systems used for hospital outpatient services and physician office-based procedures. Each CPT code for an ASC-covered procedure is assigned a relative weight and flat payment amount which is then adjusted for the ASC setting.

Multiple procedures can be paid for the same case if multiple codes are submitted. The payment indicator (PI) signifies how a code is handled for payment. Specifically, payment indicator A2 means a surgical procedure whose payment is based on the hospital outpatient rate. Payment indicator J8 indicates Device-intensive procedure; paid at adjusted rate. 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
24366	Arthroplasty, radial head; with implant	J8	N	177.9456	\$7,842
24586	Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius)	J8	Y	93.9112	\$4,139
24666	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed; with radial head prosthetic replacement	J8	Y	93.9112	\$4,139

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 EVOLVE® Radial Head Plate System, 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.

ICD-9-CM Diagnosis	Description
714.0	Rheumatoid arthritis
716.12	Traumatic arthropathy, upper arm
718.52	Ankylosis of joint [elbow]
718.82	Other joint derangement, not elsewhere classified [instability of elbow joint]
719.42	Pain in joint [elbow]
733.81	Malunion of fracture
733.82	Nonunion of fracture
736.89	Other acquired deformity of other parts of limb
813.05	Fracture radial head
813.08	Closed fracture of radius with ulna, upper end [any part]
813.15	Open fracture of head of radius
813.18	Open fracture of radius with ulna, upper end (any part)

ICD-9-CM Diagnosis	Description
905.2	Late effect of fracture of upper extremities
996.40	Unspecified mechanical complication of internal orthopedic device, implant, and graft
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
996.67	Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft
V43.62	Elbow joint replacement

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
492	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with MCC	3.1873	\$18,695	
493	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with CC	2.0354	\$11,938	79.31 81.84
494	Lower Extremity and Humerus Procedures WO CC/MCC	1.5397	\$9,031	
510	Shoulder, Elbow or Forearm Procedure except Major Joint Procedure W MCC	2.2857	\$13,407	
511	Shoulder, Elbow or Forearm Procedure except Major Joint Procedure W CC	1.6509	\$9,683	79.32
512	Shoulder, Elbow or Forearm Procedure except Major Joint Procedure WO CC/MCC	1.2963	\$7,603	

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.



1023 Cherry Road
Memphis, TN 38117
800 238 7117
901 867 9971
www.wright.com