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SALVATION®

External Fixation 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.

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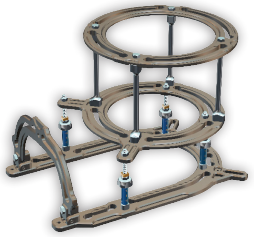

HCPCS Device Codes

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-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
20690	Application of a uniplane (pins or wires in 1 plane), unilateral, external fixation system	17.00	$608	NA	NA
20692	Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)	31.96	$1,144	NA	NA
20693	Adjustment or revision of external fixation system requiring anesthesia (eg, new pin[s] or wire[s] and/or new ring[s] or bar[s])	12.78	$457	NA	NA
20694	Removal, under anesthesia, of external fixation system	9.63	$344	12.06	$431
27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula	16.79	$601	NA	NA
27685	Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)	13.25	$474	18.95	$678
27686	Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each	16.10	$576	NA	NA
27715	Osteoplasty, tibia and fibula, lengthening or shortening	30.03	$1,075	NA	NA
27720	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)	25.03	$896	NA	NA

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
27726	Repair of fibula nonunion and/or malunion with internal fixation	27.66	$990	NA	NA
27759	Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage	28.57	$1,023	NA	NA
27860	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)	4.94	$177	NA	NA
28046	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm	20.91	$749	NA	NA
28047	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; 3 cm or greater	30.79	$1,102	NA	NA
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus	11.89	$426	17.59	$630
28320	Repair, nonunion or malunion; tarsal bones	17.40	$623	NA	NA
28322	Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)	16.56	$593	22.72	$813
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed	31.69	$1,135	NA	NA
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	35.94	$1,287	NA	NA
28445	Open treatment of talus fracture, includes internal fixation, when performed	30.57	$1,094	NA	NA
28446	Open osteochondral autograft, talus (includes obtaining graft[s])	35.10	$1,257	NA	NA
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	17.66	$632	NA	NA
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	15.07	$540	NA	NA
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	19.18	$687	25.35	$908
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed	19.18	$687	24.53	$878
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	22.57	$808	NA	NA
28705	Arthrodesis; pantalar	36.02	$1,289	NA	NA
28715	Arthrodesis; triple	26.89	$962	NA	NA
28725	Arthrodesis; subtalar	22.26	$796	NA	NA
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse	20.93	$749	NA	NA
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	22.39	$801	NA	NA
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	19.85	$710	NA	NA
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	17.85	$639	24.35	$871
28750	Arthrodesis, great toe; metatarsophalangeal joint	16.98	$607	23.48	$840
28755	Arthrodesis, great toe; interphalangeal joint	9.47	$339	14.64	$524
28760	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure)	16.59	$593	22.78	$815

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. Status indicator Q2 are packaged only if they are billed on the same date of service with any other codes with a T status indicator. If not, they are separately payable under a separate APC.

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

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
20690	Application of a uniplane (pins or wires in 1 plane), unilateral, external fixation system	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
20692	Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
20693	Adjustment or revision of external fixation system requiring anesthesia (eg, new pin[s] or wire[s] and/or new ring[s] or bar[s])	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
20694	Removal, under anesthesia, of external fixation system	0049	Level I Musculoskeletal Procedures Except Hand and Foot	Q2	22.3913	$1,660
27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27685	Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27686	Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27715	Osteoplasty, tibia and fibula, lengthening or shortening			C		
27720	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
27726	Repair of fibula nonunion and/or malunion with internal fixation	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
27759	Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
27860	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)	0045	Bone/Joint Manipulation Under Anesthesia	T	15.5135	$1,150
28046	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm	0021	Level III Excision/ Biopsy	T	18.0849	$1,341
28047	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; 3 cm or greater	0022	Level IV Excision/ Biopsy	T	24.5953	$1,824
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28320	Repair, nonunion or malunion; tarsal bones	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
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
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed	0064	Level III Treatment Fracture/ Dislocation	T	75.0875	$5,567
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
28445	Open treatment of talus fracture, includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
28446	Open osteochondral autograft, talus (includes obtaining graft[s])	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed	0062	Level I Treatment Fracture/ Dislocation	T	27.5390	$2,042
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	0063	Level II Treatment Fracture/ Dislocation	T	57.0073	$4,227
28705	Arthrodesis; pantalar	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28715	Arthrodesis; triple	0425	Level V Musculoskeletal Procedures Except Hand and Foot	J1	137.8399	$10,220
28725	Arthrodesis; subtalar	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	5,217
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	5,217
28750	Arthrodesis, great toe; metatarsophalangeal joint	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	5,217
28755	Arthrodesis, great toe; interphalangeal joint	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	1,743
28760	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure)	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	5,217

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

Ambulatory Surgery Center (ASC) Coding

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

Multiple procedures can be paid for the same case if multiple codes are submitted. The payment indicator (PI) signifies how a code is handled for payment. Specifically, payment indicator A2 means a surgical procedure whose payment is based on the hospital outpatient rate. Payment indicator G2 is a technical variation but also means a surgical procedures whose payment is based on the hospital outpatient rate. Payment indicator J8 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. 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
20690	Application of a uniplane (pins or wires in 1 plane), unilateral, external fixation system	A2	Y	32.3631	$1,426
20692	Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)	A2	Y	32.3631	$1,426

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
20693	Adjustment or revision of external fixation system requiring anesthesia (eg, new pin[s] or wire[s] and/or new ring[s] or bar[s])	A2	Y	32.3631	$1,426
20694	Removal, under anesthesia, of external fixation system	A2	N	20.6560	$910
27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula	A2	Y	32.3631	$1,426
27685	Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)	A2	Y	32.3631	$1,426
27686	Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each	A2	Y	32.3631	$1,426
27715	Osteoplasty, tibia and fibula, lengthening or shortening	NA	NA	NA	NA
27720	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)	G2	Y	52.5892	$2,318
27726	Repair of fibula nonunion and/or malunion with internal fixation	G2	Y	52.5892	$2,318
27759	Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage	J8	Y	93.9112	$4,139
27860	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)	A2	Y	14.3112	$631
28046	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm	G2	Y	16.6833	$735
28047	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; 3 cm or greater	G2	Y	22.6892	$1,000
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus	A2	Y	21.6844	$956
28320	Repair, nonunion or malunion; tarsal bones	A2	Y	64.9113	$2,861
28322	Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)	A2	Y	21.6844	$956
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed	J8	Y	93.9112	$4,139
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	A2	Y	52.5892	$2,318
28445	Open treatment of talus fracture, includes internal fixation, when performed	A2	Y	52.5892	$2,318
28446	Open osteochondral autograft, talus (includes obtaining graft[s])	G2	Y	64.9113	$2,861
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	A2	Y	52.5892	$2,318
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	A2	Y	52.5892	$2,318
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	A2	Y	52.5892	$2,318
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed	A2	Y	25.4047	$1,120
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	A2	Y	52.5892	$2,318
28705	Arthrodesis; pantalar	A2	Y	64.9113	$2,861
28705	Arthrodesis; triple	J8	N	177.9456	$7,842
28715	Arthrodesis; subtalar	J8	N	177.9456	$7,842
28725	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse	A2	Y	64.9113	$2,861
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	A2	Y	64.9113	$2,861

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
28735	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	A2	Y	64.9113	$2,861
28737	Arthrodesis, midtarsal or tarsometatarsal, single joint	A2	Y	64.9113	$2,861
28740	Arthrodesis, great toe; metatarsophalangeal joint	A2	Y	64.9113	$2,861
28750	Arthrodesis, great toe; interphalangeal joint	A2	Y	64.9113	$2,861
28755	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure)	A2	Y	21.6844	$956
28760	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure	A2	Y	64.9113	$2,861

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

ICD-9-CM Diagnosis Codes

ICD-9-CM diagnosis codes are used by all providers, including physicians, hospitals and ASCs, and in all settings, including inpatient and outpatient. Diagnosis codes indicate the reason for the procedure and are mandatory for reimbursement. The codes shown below are those that are common with procedures using the SALVATION™ External Fixation 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
213.7	Benign neoplasm of long bones of lower limb
213.8	Benign neoplasm of short bones of lower limb
215.3	Other benign neoplasm of connective and other soft tissue of lower limb, including hip
238.0	Neoplasm of uncertain behavior of bone and articular cartilage
239.2	Neoplasm of unspecified nature of bone, soft tissue, and skin
250.60	Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled
250.61	Diabetes with neurological manifestations, type I [juvenile type], not stated as uncontrolled
250.62	Diabetes with neurological manifestations, type II or unspecified type, uncontrolled
250.63	Diabetes with neurological manifestations, type I [juvenile type], uncontrolled
713.5	Arthropathy associated with neurological disorders
714.0	Rheumatoid arthritis
714.1	Felty's syndrome
714.30	Polyarticular juvenile rheumatoid arthritis, chronic or unspecified
714.32	Osteoarthrosis, localized, not specified whether primary or secondary, upper arm
715.17	Osteoarthrosis, localized, primary, ankle and foot
715.27	Osteoarthrosis, localized, secondary, ankle and foot
715.37	Osteoarthrosis, localized, not specified whether primary or secondary, ankle and foot
715.97	Osteoarthrosis, unspecified whether generalized or localized, ankle and foot
716.17	Traumatic arthropathy, ankle and foot
718.27	Pathological dislocation of joint, ankle and foot
718.28	Pathological dislocation of joint, other specified sites
718.46	Contracture of joint, lower leg
718.47	Contracture of joint, ankle and foot
718.77	Developmental dislocation of joint, ankle and foot

IDC-9-CM Diagnosis	Description
718.87	Other joint derangement, not elsewhere classified, ankle and foot
719.47	Pain in joint, ankle and foot
719.67	Other symptoms referable to joint, ankle and foot
719.87	Other specified disorders of joint, ankle and foot
731.3	Major osseous defects
732.7	Osteochondritis dissecans
727.81	Contracture of tendon (sheath)
733.19	Pathologic fracture of other specified site
733.44	Aseptic necrosis of talus
733.49	Aseptic necrosis of bone, other
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
734	Flat foot
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
736.70	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
736.74	Claw foot, acquired

IDC-9-CM Diagnosis	Description
736.75	Cavovarus deformity of foot, acquired
736.76	Other acquired calcaneus deformity
736.79	Other acquired deformities of ankle and foot
754.50	Talipes varus
754.51	Talipes equinovarus
754.52	Metatarsus primus varus
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
754.89	Other specified nonteratogenic anomalies
755.66	Other specified congenital deformities of toes
755.67	Congenital anomalies of foot, not elsewhere classified
823.XX	Open and Closed fractures of tibia and fibula
824.0	Fracture of medial malleolus, closed
824.1	Fracture of medial malleolus, open
824.X	Open and Closed fractures of distal tibia
825.0	Fracture of calcaneus, closed
825.1	Fracture of calcaneus, open
825.2X	Closed fractures of other tarsal and metatarsal bones

IDC-9-CM Diagnosis	Description
825.3X	Open fractures of other tarsal and metatarsal bones
827.0	Other, multiple and ill-defined fractures of lower limb, closed
827.1	Other, multiple and ill-defined fractures of lower limb, open
828.0	Closed multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum
828.1	Open multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum
837.0	Closed dislocation of ankle
837.1	Open dislocation of ankle
838.XX	Open and closed dislocation of foot bones
905.4	Late effect of fracture of lower extremities
928.20	Crushing injury of foot
928.21	Crushing injury of ankle
928.3	Crushing injury of toes
996.40	Unspecified mechanical complication of internal orthopedic device, implant, and graft
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
996.78	Other complications due to other internal orthopedic device, implant, and graft
V53.7	Fitting and adjustment of orthopedic devices
V54.01	Other aftercare involving internal fixation device
V54.16	Aftercare for healing traumatic fracture of lower leg
V54.26	Aftercare for healing pathologic fracture of lower leg
V54.89	Aftercare for healing pathologic fracture of lower leg

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

Medicare Severity 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. 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
492	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with MCC	3.1873	$18,695	Surgical application of an external fixation device: 78.10 78.17 78.18 78.19 and surgical procedure 77.38 77.57 77.58 77.67 77.68 77.78 77.79 78.08 78.37 78.48 78.57 78.58 78.67 78.68 78.69 79.26 79.27 79.36 79.37 79.88 80.90 81.11 81.12 81.13 81.14 81.15 81.16 83.32 83.49 83.85
493	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with 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	78.67 78.68 78.69
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 CC/MCC	1.2230	$7,173	
981	Extensive O.R. Procedure Unrelated to Principal Diagnosis W MCC	4.9968	$29,308	MS DRGs 981-983 are resultant if principal diagnosis of 250.60 - 250.63 with surgical application of an external fixation device: 78.10 78.17 78.18 78.19 and surgical procedure 77.38 77.58 77.67 77.68 77.78 77.79 78.08 78.48 78.57 78.58 81.11 81.12 81.13 81.14 81.15 81.16
982	Extensive O.R. Procedure Unrelated to Principal Diagnosis W CC	2.8150	$16,511	
983	Extensive O.R. Procedure Unrelated to Principal Diagnosis WO CC/MCC	1.8039	$10,580	

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

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