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ACTISHIELD™

Amniotic Barrier Membrane

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
C9399	Unclassified drug or biological

HCPCS code C9399 (Unclassified drug or biological) is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned. Reference: MLN Matters® Number: MM7672 Revised.

ACTISHIELD™ Wound Care: Applicability of the following HCPCS codes is for the INPATIENT SETTING ONLY, ACTISHIELD™ is NOT Licensed by Wright Medical for Wound Care Use in the Outpatient Hospital, ASC or Physician Office Settings

Q4100	Skin substitute, not otherwise specified
C5271	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
+C5272	each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)
C5273	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
+C5274	each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
C5275	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
+C2576	each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)
C2577	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
+C2578	each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

HCPCS codes describing skin substitutes (Q4100 – Q4130) should only be reported when used with one of the CPT codes describing application of a skin substitute (15271-15278). Reference: MLN Matters® Number: MM7672 Revised. Q4100 is classified as 'low cost skin substitute' Reference: Federal Register, Document Citation: 79 FR 66769 Rules and Regulations; Final Hospital Outpatient Payment; Table 34—Skin Substitute Assignments to High Cost and Low Cost Groups.

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.
"NL" indicates not licensed by Wright Medical in the Outpatient Hospital, ASC or Physician Ofiice Settings.

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
+15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	6.08	$218	6.08	$218
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	23.47	$840	NA	NA
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	24.33	$871	NA	NA
23415	Coracoacromial ligament release, with or without acromioplasty	19.90	$715	NA	NA
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	27.68	$990	NA	NA
23440	Resection or transplantation of long tendon of biceps	21.56	$775	NA	NA
23462	Capsulorrhaphy, anterior, any type; with coracoid process transfer	30.46	$1,095	NA	NA
23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability	32.11	$1,154	NA	NA
24341	Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)	21.28	$765	NA	NA
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft	22.13	$795	NA	NA
24345	Repair medial collateral ligament, elbow, with local tissue	20.22	$727	NA	NA
23929	Unlisted procedure, shoulder	UNL	UNL	UNL	UNL
25260	Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle	17.92	$644	NA	NA
25270	Repair, tendon or muscle, extensor, forearm and/or wrist; primary, single, each tendon or muscle	13.91	$500	NA	NA
25272	Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, single, each tendon or muscle	15.80	$568	NA	NA
25275	Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)	19.08	$686	NA	NA
25316	Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist; with tendon(s) transfer	26.12	$939	NA	NA
25320	Capsulorrhaphy or reconstruction, wrist, open (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability	28.09	$1,009	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	$909	NA	NA
26350	Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land); primary or secondary without free graft, each tendon	19.95	$717	NA	NA
26356	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon	30.75	$1,105	NA	NA
26370	Repair or advancement of profundus tendon, with intact superficialis tendon; primary, each tendon	21.29	$765	NA	NA
26372	Repair or advancement of profundus tendon, with intact superficialis tendon; secondary with free graft (includes obtaining graft), each tendon	24.96	$897	NA	NA

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
26392	Removal of synthetic rod and insertion of flexor tendon graft, hand or finger (includes obtaining graft), each rod	27.48	$987	NA	NA
26410	Repair, extensor tendon, hand, primary or secondary; without free graft, each tendon	15.80	$568	NA	NA
26416	Removal of synthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each rod	24.98	$36	NA	NA
26418	Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon	16.18	$581	NA	NA
26449	Tenolysis, complex, extensor tendon, finger, including forearm, each tendon	19.77	$710	NA	NA
26476	Lengthening of tendon, extensor, hand or finger, each tendon	16.44	$587	NA	NA
26478	Lengthening of tendon, flexor, hand or finger, each tendon	17.28	$618	NA	NA
26480	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon	21.03	$756	NA	NA
26485	Transfer or transplant of tendon, palmar; without free tendon graft, each tendon	22.63	$813	NA	NA
26496	Opponensplasty; other methods	23.96	$861	NA	NA
26502	Reconstruction of tendon pulley, each tendon; with tendon or fascial graft (includes obtaining graft) (separate procedure)	20.00	$716	NA	NA
26540	Repair of collateral ligament, metacarpophalangeal or interphalangeal joint	18.38	$660	NA	NA
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	19.93	$713	NA	NA
26989	Unlisted procedure, hands or fingers	UNL	UNL	UNL	UNL
27409	Repair, primary, torn ligament and/or capsule, knee; collateral and cruciate ligaments	27.61	$992	NA	NA
27422	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)	21.19	$758	NA	NA
27427	Ligamentous reconstruction (augmentation), knee; extra-articular	20.36	$732	NA	NA
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)	31.88	$1,141	NA	NA
27429	Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular	35.82	$36	NA	NA
27430	Quadricepsplasty (eg, Bennett or Thompson type)	21.02	$752	NA	NA
27558	Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair, with augmentation/reconstruction	34.24	$36	NA	NA
27599	Unlisted procedure, femur or knee	UNL	UNL	UNL	UNL
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon	18.83	$677	NA	NA
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	19.63	$702	NA	NA
27654	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	20.23	$724	NA	NA
27659	Repair, flexor tendon, leg; secondary, with or without graft, each tendon	13.71	$490	NA	NA
27658	Repair, flexor tendon, leg; primary, without graft, each tendon	10.69	$384	NA	NA
27665	Repair, extensor tendon, leg; secondary, with or without graft, each tendon	11.69	$418	NA	NA
27675	Repair, dislocating peroneal tendons; without fibular osteotomy	13.78	$495	NA	NA
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon	12.31	$442	NA	NA
27681	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision[s])	15.61	$561	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
27695	Repair, primary, disrupted ligament, ankle; collateral	13.62	$489	NA	NA
27696	Repair, primary, disrupted ligament, ankle; both collateral ligaments	15.74	$566	NA	NA
27698	Repair, secondary, disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)	18.27	$657	NA	NA
27870	Arthrodesis, ankle, open	29.53	$1,061	NA	NA
27871	Arthrodesis, tibiofibular joint, proximal or distal	19.58	$704	NA	NA
27899	Unlisted procedure, leg or ankle	UNL	UNL	UNL	UNL

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
28200	Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon	9.20	$329	14.09	$504
28208	Repair, tendon, extensor, foot; primary or secondary, each tendon	8.96	$320	13.70	$490
28220	Tenolysis, flexor, foot; single tendon	8.68	$312	13.01	$467
28225	Tenolysis, extensor, foot; single tendon	7.41	$266	11.76	$423
28313	Reconstruction, angular deformity of toe, soft tissue procedures only (eg, overlapping second toe, fifth toe, curly toes)	10.28	$369	15.24	$548
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	22.39	$801	NA	NA
28899	Unlisted procedure, foot or toes	UNL	UNL	UNL	UNL
64702	Neuroplasty; digital, 1 or both, same digit	14.24	$512	NA	NA
64704	Neuroplasty; nerve of hand or foot	9.05	$324	NA	NA
64708	Neuroplasty, major peripheral nerve, arm or leg, open; other than specified	14.24	$510	NA	NA
64712	Neuroplasty, major peripheral nerve, arm or leg, open; sciatic nerve	16.32	$584	NA	NA
64713	Neuroplasty, major peripheral nerve, arm or leg, open; brachial plexus	20.58	$737	NA	NA
64714	Neuroplasty, major peripheral nerve, arm or leg, open; lumbar plexus	18.50	$665	NA	NA
64718	Neuroplasty and/or transposition; ulnar nerve at elbow	16.87	$606	NA	NA
64719	Neuroplasty and/or transposition; ulnar nerve at wrist	11.40	$408	NA	NA
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	12.15	$435	12.23	$438
64722	Decompression; unspecified nerve(s) (specify)	10.60	$379	NA	NA
64726	Decompression; plantar digital nerve	7.88	$283	NA	NA
Skin Grafts, Skin Wound Replacements and Reconstruction: Report for Procedures Performed in the INPATIENT SETTING ONLY. ACTISHIELD™ is NOT Licensed by Wright Medical for Wound Care Use in the Outpatient Hospital, ASC or Physician Office Settings					
13160	Secondary closure of surgical wound or dehiscence, extensive or complicated	22.97	$822	NL	NL
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less	14.29	$512	NL	NL
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm	18.60	$666	NL	NL
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less	16.16	$579	NL	NL
14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm	20.44	$732	NL	NL
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	18.00	$644	NL	NL
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm	22.13	$792	NL	NL
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	22.13	$792	NL	NL
14061	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm	19.16	$686	NL	NL
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm	23.69	$848	NL	NL
14350	Filleted finger or toe flap, including preparation of recipient site	19.76	$707	NL	NL
15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	20.39	$730	NL	NL
15110	Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	20.17	$722	NL	NL
15115	Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children	20.50	$734	NL	NL
15120	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	19.89	$712	NL	NL
15130	Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	16.20	$580	NL	NL
15135	Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children	20.96	$750	NL	NL

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less	18.01	$645	NL	NL
15220	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less	17.50	$627	NL	NL
15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less	22.81	$817	NL	NL
15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less	24.45	$875	NL	NL
+15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	6.08	$218	NL	NL
19366	Breast reconstruction with other technique	40.08	$1,440	NL	NL
Skin Substitute ACTISHIELD™ Graft Application: Report following Primary Skin Wound Replacements and Reconstruction Procedure(s) in the INPATIENT SETTING ONLY. ACTISHIELD™ is NOT Licensed by Wright Medical for Wound Care Use in the Outpatient Hospital, ASC or Physician Office Settings					
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	2.42	$87	NL	NL
+15272	each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	0.50	$18	NL	NL
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	5.76	$207	NL	NL
+15274	each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	1.31	$47	NL	NL
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	2.74	$98	NL	NL
+15276	each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	0.71	$26	NL	NL
+15278	each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	1.64	$59	NL	NL
+15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	6.08	$218	NL	NL
Wound Reconstruction Procedures; Muscle: Report for Procedures Performed in the INPATIENT SETTING ONLY. ACTISHIELD™ is NOT Licensed by Wright Medical for Wound Care Use in the Outpatient Hospital, ASC or Physician Office Settings					
15732	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)	31.87	$1,141	NL	NL
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk	37.57	$1,345	NA	NA
15736	Muscle, myocutaneous, or fasciocutaneous flap; upper extremity	32.44	$1,161	NL	NL
15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity	35.10	$1,257	NL	NL
15756	Free muscle or myocutaneous flap with microvascular anastomosis	66.37	$2,376	NL	NL

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
+15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)			N		
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
23415	Coracoacromial ligament release, with or without acromioplasty	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
23440	Resection or transplantation of long tendon of biceps	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
23462	Capsulorrhaphy, anterior, any type; with coracoid process transfer	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
23929	Unlisted procedure, shoulder	0129	Level I Closed Treatment Fracture	T	2.2797	$169
24341	Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
24345	Repair medial collateral ligament, elbow, with local tissue	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
25260	Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
25270	Repair, tendon or muscle, extensor, forearm and/or wrist; primary, single, each tendon or muscle	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
25272	Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, single, each tendon or muscle	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
25275	Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
25316	Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist; with tendon(s) transfer	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
25320	Capsulorrhaphy or reconstruction, wrist, open (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
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
26350	Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land); primary or secondary without free graft, each tendon	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
26356	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
26370	Repair or advancement of profundus tendon, with intact superficialis tendon; primary, each tendon	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
26372	Repair or advancement of profundus tendon, with intact superficialis tendon; secondary with free graft (includes obtaining graft), each tendon	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
26392	Removal of synthetic rod and insertion of flexor tendon graft, hand or finger (includes obtaining graft), each rod	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
26410	Repair, extensor tendon, hand, primary or secondary; without free graft, each tendon	0053	Level I Hand Musculoskeletal Procedures	T	16.5603	$1,228
26416	Removal of synthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each rod	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
26418	Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon	0053	Level I Hand Musculoskeletal Procedures	T	16.5603	$1,228
26449	Tenolysis, complex, extensor tendon, finger, including forearm, each tendon	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
26476	Lengthening of tendon, extensor, hand or finger, each tendon	0053	Level I Hand Musculoskeletal Procedures	T	16.5603	$1,228
26478	Lengthening of tendon, flexor, hand or finger, each tendon	0053	Level I Hand Musculoskeletal Procedures	T	16.5603	$1,228
26480	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
26485	Transfer or transplant of tendon, palmar; without free tendon graft, each tendon	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
26496	Opponensplasty; other methods	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
26502	Reconstruction of tendon pulley, each tendon; with tendon or fascial graft (includes obtaining graft) (separate procedure)	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
26540	Repair of collateral ligament, metacarpophalangeal or interphalangeal joint	0053	Level I Hand Musculoskeletal Procedures	T	16.5603	$1,228
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
26989	Unlisted procedure, hands or fingers	0129	Level I Closed Treatment Fracture	T	2.2797	$169

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
27409	Repair, primary, torn ligament and/or capsule, knee; collateral and cruciate ligaments	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
27422	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
27427	Ligamentous reconstruction (augmentation), knee; extra-articular	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)	0425	Level V Musculoskeletal Procedures Except Hand and Foot	J1	137.8399	$10,220
27429	Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
27430	Quadricepsplasty (eg, Bennett or Thompson type)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
27558	Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair, with augmentation/reconstruction			C		
27599	Unlisted procedure, femur or knee	0129	Level I Closed Treatment Fracture	T	2.2797	$169
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
27654	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
27659	Repair, flexor tendon, leg; secondary, with or without graft, each tendon	0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	22.3913	$1,660
27658	Repair, flexor tendon, leg; primary, without graft, each tendon	0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	22.3913	$1,660
27665	Repair, extensor tendon, leg; secondary, with or without graft, each tendon	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27675	Repair, dislocating peroneal tendons; without fibular osteotomy	0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	22.3913	$1,660
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27681	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision[s])	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
27695	Repair, primary, disrupted ligament, ankle; collateral	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27696	Repair, primary, disrupted ligament, ankle; both collateral ligaments	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
27698	Repair, secondary, disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27870	Arthrodesis, ankle, open	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
27871	Arthrodesis, tibiofibular joint, proximal or distal	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
27899	Unlisted procedure, leg or ankle	0129	Level I Closed Treatment Fracture	T	2.2797	$169
28200	Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28208	Repair, tendon, extensor, foot; primary or secondary, each tendon	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28220	Tenolysis, flexor, foot; single tendon	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28225	Tenolysis, extensor, foot; single tendon	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28313	Reconstruction, angular deformity of toe, soft tissue procedures only (eg, overlapping second toe, fifth toe, curly toes)	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	$1,743
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	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
64702	Neuroplasty; digital, 1 or both, same digit	0220	Level I Nerve Procedures	T	18.6600	$1,384
64704	Neuroplasty; nerve of hand or foot	0220	Level I Nerve Procedures	T	18.6600	$1,384
64708	Neuroplasty, major peripheral nerve, arm or leg, open; other than specified	0220	Level I Nerve Procedures	T	18.6600	$1,384
64712	Neuroplasty, major peripheral nerve, arm or leg, open; sciatic nerve	0220	Level I Nerve Procedures	T	18.6600	$1,384
64713	Neuroplasty, major peripheral nerve, arm or leg, open; brachial plexus	0220	Level I Nerve Procedures	T	18.6600	$1,384
64714	Neuroplasty, major peripheral nerve, arm or leg, open; lumbar plexus	0220	Level I Nerve Procedures	T	18.6600	$1,384
64718	Neuroplasty and/or transposition; ulnar nerve at elbow	0220	Level I Nerve Procedures	T	18.6600	$1,384
64719	Neuroplasty and/or transposition; ulnar nerve at wrist	0220	Level I Nerve Procedures	T	18.6600	$1,384
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	0220	Level I Nerve Procedures	T	18.6600	$1,384
64722	Decompression; unspecified nerve(s) (specify)	0220	Level I Nerve Procedures	T	18.6600	$1,384
64726	Decompression; plantar digital nerve	0220	Level I Nerve Procedures	T	18.6600	$1,384

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. Payment indicator N1 indicates a packaged procedure/item; no separate payment made. Payment indicator P3 indicates the payment rate is capped at the Medicare Professional Fee Schedule practice expense rate. 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
+15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	A2	Y	28.6245	$1,262
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	A2	Y	46.8009	$2,063
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	A2	Y	46.8009	$2,063
23415	Coracoacromial ligament release, with or without acromioplasty	A2	Y	46.8009	$2,063
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	A2	Y	46.8009	$2,063
23440	Resection or transplantation of long tendon of biceps	A2	Y	32.3631	$1,426
23462	Capsulorrhaphy, anterior, any type; with coracoid process transfer	A2	Y	46.8009	$2,063
23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability	A2	Y	46.8009	$2,063
23929	Unlisted procedure, shoulder	NA	NA	NA	NA
24341	Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)	A2	Y	46.8009	$2,063
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft	A2	Y	46.8009	$2,063
24345	Repair medial collateral ligament, elbow, with local tissue	A2	Y	32.3631	$1,426
25260	Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle	A2	Y	32.3631	$1,426
25270	Repair, tendon or muscle, extensor, forearm and/or wrist; primary, single, each tendon or muscle	A2	Y	32.3631	$1,426
25272	Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, single, each tendon or muscle	A2	Y	32.3631	$1,426
25275	Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)	A2	Y	32.3631	$1,426
25316	Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist; with tendon(s) transfer	A2	Y	32.3631	$1,426
25320	Capsulorrhaphy or reconstruction, wrist, open (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability	A2	Y	46.8009	$2,063
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
26350	Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land); primary or secondary without free graft, each tendon	A2	Y	46.8009	$2,063
26356	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon	A2	Y	27.4875	$1,211
26370	Repair or advancement of profundus tendon, with intact superficialis tendon; primary, each tendon	A2	Y	27.4875	$1,211
26372	Repair or advancement of profundus tendon, with intact superficialis tendon; secondary with free graft (includes obtaining graft), each tendon	A2	Y	27.4875	$1,211
26392	Removal of synthetic rod and insertion of flexor tendon graft, hand or finger (includes obtaining graft), each rod	A2	Y	27.4875	$1,211
26410	Repair, extensor tendon, hand, primary or secondary; without free graft, each tendon	A2	Y	15.2769	$673
26416	Removal of synthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each rod	A2	Y	27.4875	$1,211

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
26418	Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon	A2	Y	15.2769	$673
26449	Tenolysis, complex, extensor tendon, finger, including forearm, each tendon	A2	Y	27.4875	$1,211
26476	Lengthening of tendon, extensor, hand or finger, each tendon	A2	Y	15.2769	$673
26478	Lengthening of tendon, flexor, hand or finger, each tendon	A2	Y	15.2769	$673
26480	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon	A2	Y	27.4875	$1,211
26485	Transfer or transplant of tendon, palmar; without free tendon graft, each tendon	A2	Y	27.4875	$1,211
26496	Opponensplasty; other methods	A2	Y	27.4875	$1,211
26502	Reconstruction of tendon pulley, each tendon; with tendon or fascial graft (includes obtaining graft) (separate procedure)	A2	Y	27.4875	$1,211
26540	Repair of collateral ligament, metacarpophalangeal or interphalangeal joint	A2	Y	15.2769	$673
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	A2	Y	27.4875	$1,211
26989	Unlisted procedure, hands or fingers	NA	NA	NA	NA
27409	Repair, primary, torn ligament and/or capsule, knee; collateral and cruciate ligaments	A2	Y	46.8009	$2,063
27422	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)	A2	Y	46.8009	$2,063
27427	Ligamentous reconstruction (augmentation), knee; extra-articular	A2	Y	78.6374	$3,466
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)	J8	N	177.9456	$7,842
27429	Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular	A2	Y	78.6374	$3,466
27430	Quadricepsplasty (eg, Bennett or Thompson type)	A2	Y	46.8009	$2,063
27558	Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair, with augmentation/reconstruction	NA	NA	NA	NA
27599	Unlisted procedure, femur or knee	NA	NA	NA	NA
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon	A2	Y	46.8009	$2,063
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	A2	Y	46.8009	$2,063
27654	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	A2	Y	46.8009	$2,063
27659	Repair, flexor tendon, leg; secondary, with or without graft, each tendon	A2	Y	20.6560	$910
27658	Repair, flexor tendon, leg; primary, without graft, each tendon	A2	Y	20.6560	$910
27665	Repair, extensor tendon, leg; secondary, with or without graft, each tendon	A2	Y	32.3631	$1,426
27675	Repair, dislocating peroneal tendons; without fibular osteotomy	A2	Y	20.6560	$910
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon	A2	Y	32.3631	$1,426
27681	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision[s])	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
27695	Repair, primary, disrupted ligament, ankle; collateral	A2	Y	32.3631	$1,426
27696	Repair, primary, disrupted ligament, ankle; both collateral ligaments	A2	Y	32.3631	$1,426
27698	Repair, secondary, disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)	A2	Y	32.3631	$1,426
27870	Arthrodesis, ankle, open	A2	Y	78.6374	$3,466
27871	Arthrodesis, tibiofibular joint, proximal or distal	A2	Y	78.6374	$3,466
27899	Unlisted procedure, leg or ankle	NA	NA	NA	NA
28200	Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon	A2	Y	21.6844	$956
28208	Repair, tendon, extensor, foot; primary or secondary, each tendon	A2	Y	21.6844	$956

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
28220	Tenolysis, flexor, foot; single tendon	P3	Y	6.4694	$285
28225	Tenolysis, extensor, foot; single tendon	A2	Y	21.6844	$956
28313	Reconstruction, angular deformity of toe, soft tissue procedures only (eg, overlapping second toe, fifth toe, curly toes)	A2	Y	21.6844	$956
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	A2	Y	64.9113	$2,861
28899	Unlisted procedure, foot or toes	NA	NA	NA	NA
64702	Neuroplasty; digital, 1 or both, same digit	A2	Y	17.2139	$759
64704	Neuroplasty; nerve of hand or foot	A2	Y	17.2139	$759
64708	Neuroplasty, major peripheral nerve, arm or leg, open; other than specified	G2	Y	17.2139	$759
64712	Neuroplasty, major peripheral nerve, arm or leg, open; sciatic nerve	G2	Y	17.2139	$759
64713	Neuroplasty, major peripheral nerve, arm or leg, open; brachial plexus	G2	Y	17.2139	$759
64714	Neuroplasty, major peripheral nerve, arm or leg, open; lumbar plexus	G2	Y	17.2139	$759
64718	Neuroplasty and/or transposition; ulnar nerve at elbow	A2	Y	17.2139	$759
64719	Neuroplasty and/or transposition; ulnar nerve at wrist	A2	Y	17.2139	$759
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	A2	Y	17.2139	$759
64722	Decompression; unspecified nerve(s) (specify)	A2	Y	17.2139	$759
64726	Decompression; plantar digital nerve	A2	Y	17.2139	$759

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

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
040	Peripheral/Cranial Nerve & other nervous system procedure W MCC	3.7960	$22,265	04.49 04.79
041	Peripheral/Cranial Nerve & other nervous system procedure W CC or Peripheral Neurostimulator	2.1267	$12,474	
042	Peripheral/Cranial Nerve & other nervous system procedure WO CC/MCC	1.8586	$10,902	
463	Wound debridement & skin graft except hand, for musculo-connective tissue disease W MCC	5.3345	$31,289	86.63 86.66 86.67 86.69 86.70 86.72 86.73 86.74 86.75
464	Wound debridement & skin graft except hand, for musculo-connective tissue disease W CC	3.0085	$17,646	
465	Wound debridement & skin graft except hand, for musculo-connective tissue disease WO CC/MCC	1.9463	$11,416	
487	Knee Procedures W principal diagnosis of infection WO CC/MCC	1.5630	$9,168	81.44 81.45 81.46 81.47 81.49
488	Knee Procedures WO principal diagnosis of infection W CC/MCC	1.7225	$10,103	
489	Knee Procedures WO principal diagnosis of infection WO CC/MCC	1.3186	$7,734	

DRG	DRG Title	Relative Weight	Medicare National Unadjusted Payment	ICD-9-CM Procedure Codes and Descriptions
500	Soft Tissue Procedures W MCC	3.2420	$5,865	81.95 83.61 83.62 83.63 83.64 83.65 83.71 83.73 83.75 83.76 83.79 83.81 83.85 83.86 83.88 83.91
501	Soft Tissue Procedures W CC	1.6474	$5,865	
502	Soft Tissue Procedures WO CC/MCC	1.1597	$5,865	
503	Foot Procedures W CC	2.3338	$13,688	81.75 81.94
504	Foot Procedures W CC	1.5691	$9,203	
505	Foot Procedures WO CC/MCC	1.2474	$7,316	
506	Major Thumb or Joint Procedures W MCC	1.2881	$7,555	81.83
507	Major Thumb or Joint Procedures W CC/MCC	1.9154	$11,235	
508	Major Thumb or Joint Procedures WO CC/MCC	1.5198	$8,914	
510	Shoulder, Elbow or Forearm Procedure except Major Joint Procedure W MCC	2.2857	$13,407	81.82 81.93 83.63
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 CC/MCC	1.4462	$8,483	82.33 82.41 82.42 82.43 82.44 82.51 82.52 82.54 82.55 82.56 82.57 82.71 82.85 86.61 86.62 86.63
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	81.96
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	

DRG	DRG Title	Relative Weight	Medicare National Unadjusted Payment	ICD-9-CM Procedure Codes and Descriptions
576	Skin Graft Excison for Skin Ulcer OR Cellulitis W MCC	4.1423	$24,295	85.82 85.83 85.84 85.85
577	Skin Graft Excison for Skin Ulcer OR Cellulitis W CC	1.9812	$11,620	
578	Skin Graft Excison for Skin Ulcer OR Cellulitis WO CC/MCC	1.3162	$7,720	

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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