code it WRIGHT™

VIAFLOW™

Flowable Placental Tissue Matrix

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

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 for use in the Outpatient Hospital, ASC or Physician Office settings.

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
23415	Coracoacromial ligament release, with or without acromioplasty	19.90	$712	NA	NA
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	27.68	$991	NA	NA
23440	Resection or transplantation of long tendon of biceps	21.56	$772	NA	NA
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed	25.27	$905	NA	NA
24341	Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)	21.28	$762	NA	NA
24430	Repair of nonunion or malunion, humerus; without graft (eg, compression technique)	30.19	$1,081	NA	NA
24435	Repair of nonunion or malunion, humerus; with iliac or other autograft (includes obtaining graft)	30.80	$1,103	NA	NA
24515	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage	25.02	$896	NA	NA

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
24516	Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws	24.57	$880	NA	NA
24546	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension	29.69	$1,063	NA	NA
24635	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed	19.18	$687	NA	NA
24665	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed	18.58	$665	NA	NA
24685	Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed	18.64	$667	NA	NA
25370	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna	28.77	$1,030	NA	NA
25375	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius AND ulna	27.23	$975	NA	NA
25415	Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)	27.66	$990	NA	NA
25420	Repair of nonunion or malunion, radius AND ulna; with autograft (includes obtaining graft)	33.42	$1,196	NA	NA
25425	Repair of defect with autograft; radius OR ulna	27.51	$985	NA	NA
25426	Repair of defect with autograft; radius AND ulna	32.16	$1,151	NA	NA
25574	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius OR ulna	19.22	$688	NA	NA
25575	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna	25.69	$920	NA	NA
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	19.93	$714	NA	NA
26546	Repair non-union, metacarpal or phalanx (includes obtaining bone graft with or without external or internal fixation)	27.94	$1,000	NA	NA
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	34.25	$1,226	NA	NA
27244	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage	35.26	$1,262	NA	NA
27245	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage	35.25	$1,262	NA	NA
27248	Open treatment of greater trochanteric fracture, includes internal fixation, when performed	21.25	$761	NA	NA
27269	Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed	35.63	$1,276	NA	NA
27332	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral	18.35	$657	NA	NA
27333	Suture of infrapatellar tendon; primary	16.72	$599	NA	NA
27380	Quadricepsplasty (eg, Bennett or Thompson type)	16.93	$606	NA	NA
27420	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)	21.09	$755	NA	NA
27422	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)	21.19	$759	NA	NA
27470	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)	33.63	$1,204	NA	NA
27472	Repair, nonunion or malunion, femur, distal to head and neck; with iliac or other autogenous bone graft (includes obtaining graft)	36.19	$1,296	NA	NA
27506	Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws	38.30	$1,371	NA	NA
27507	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage	27.82	$996	NA	NA
27511	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed	28.52	$1,021	NA	NA
27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed	35.52	$1,272	NA	NA

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed	27.68	$991	NA	NA
27540	Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed	23.18	$830	NA	NA
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	17.86	$639	NA	NA
27654	Repair, secondary, Achilles tendon, with or without graft	20.23	$724	NA	NA
27664	Repair, extensor tendon, leg; primary, without graft, each tendon	10.39	$372	NA	NA
27665	Repair, extensor tendon, leg; secondary, with or without graft, each tendon	11.69	$419	NA	NA
27690	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)	17.98	$644	NA	NA
27691	Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)	21.46	$768	NA	NA
27700	Arthroplasty, ankle	16.71	$598	NA	NA
27702	Arthroplasty, ankle with implant	27.76	$994	NA	NA
27703	Arthroplasty, ankle; revision, total ankle	31.83	$1,140	NA	NA
27704	Removal of ankle implant	16.46	$589	NA	NA
27720	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)	25.03	$896	NA	NA
27726	Repair of fibula nonunion and/or malunion with internal fixation	27.66	$990	NA	NA
27758	Open treatment of tibial shaft fracture (with or without fibular fracture), with plate/screws, with or without cerclage	25.49	$913	NA	NA
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	17.48	$626	NA	NA
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	20.72	$742	NA	NA
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	18.68	$669	NA	NA
27814	Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed	22.09	$791	NA	NA
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	24.03	$860	NA	NA
27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	27.36	$980	NA	NA
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	19.56	$700	NA	NA
28238	Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)	14.08	$504	19.50	$698
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
28455	Treatment of tarsal bone fracture (except talus and calcaneus); with manipulation, each	7.42	$266	8.25	$295
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

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
28705	Arthrodesis; pantalar	36.02	$1,290	NA	NA
28715	Arthrodesis; triple	26.89	$963	NA	NA
28725	Arthrodesis; subtalar	22.26	$797	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	$802	NA	NA
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	19.85	$711	NA	NA
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	17.85	$639	24.35	$872
28750	Arthrodesis, great toe; metatarsophalangeal joint	16.98	$608	23.48	$841
29823	Arthroscopy, shoulder, surgical; debridement, extensive	17.64	$632	NA	NA
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)	5.05	$181	NA	NA
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	30.13	$1,079	NA	NA
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament	14.56	$521	NA	NA
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	36.67	$1,313	NA	NA
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	16.08	$576	NA	NA
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	15.49	$555	NA	NA
29882	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)	20.03	$717	NA	NA
29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)	24.14	$864	NA	NA
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	28.17	$1,009	NA	NA
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	35.08	$1,256	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
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
Injection Codes (report only when applicable to site of injection, service date and provider)					
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	0.71	$26	0.71	$26
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	1.19	$43	1.66	$59
20551	Injection(s); single tendon origin/insertion	1.22	$44	1.71	$61
20600	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance	1.02	$37	1.35	$48
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance	1.07	$38	1.42	$51
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	1.32	$47	1.70	$61
Skin Grafts, Skin Wound Replacements and Reconstruction: Report for Procedures Performed in the INPATIENT SETTING ONLY. VIAFLOW™ 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

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
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
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
Wound Reconstruction Procedures; Muscle: Report for Procedures Performed in the INPATIENT SETTING ONLY. VIAFLOW™ 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	NL	NL
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. Specifically, Status Indicator C indicates an inpatient procedure, Not paid under OPPS. Patient should be admitted and billed as an inpatient. Status indicator E codes are not payable in the hospital outpatient setting; and not recognized by OPPS but for which an alternate code may be applicable. 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. 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.

"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
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
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed	0064	Level III Treatment Fracture/Dislocation	T	75.0875	$5,567
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
24430	Repair of nonunion or malunion, humerus; without graft (eg, compression technique)	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
24435	Repair of nonunion or malunion, humerus; with iliac or other autograft (includes obtaining graft)	0425	Level V Musculoskeletal Procedures Except Hand and Foot	J1	137.8399	$10,220
24515	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage	0064	Level III Treatment Fracture/Dislocation	T	75.0875	$5,567
24516	Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws	0064	Level III Treatment Fracture/Dislocation	T	75.0875	$5,567
24546	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension	0064	Level III Treatment Fracture/Dislocation	T	75.0875	$5,567
24635	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed	0064	Level III Treatment Fracture/Dislocation	T	75.0875	$5,567
24665	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed	0063	Level II Treatment Fracture/Dislocation	T	57.0073	$4,227
24685	Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed	0063	Level II Treatment Fracture/Dislocation	T	57.0073	$4,227
25370	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
25375	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius AND ulna	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
25415	Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
25420	Repair of nonunion or malunion, radius AND ulna; with autograft (includes obtaining graft)	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
25425	Repair of defect with autograft; radius OR ulna	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
25426	Repair of defect with autograft; radius AND ulna	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
25574	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius OR ulna	0064	Level III Treatment Fracture/Dislocation	T	75.0875	$5,567
25575	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna	0064	Level III Treatment Fracture/Dislocation	T	75.0875	$5,567
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
26546	Repair non-union, metacarpal or phalanx (includes obtaining bone graft with or without external or internal fixation)	0054	Level II Hand Musculoskeletal Procedures	T	29.7967	$2,209
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement			C		
27244	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage			C		
27245	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage			C		
27248	Open treatment of greater trochanteric fracture, includes internal fixation, when performed			C		
27269	Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed			C		
27332	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27333	Suture of infrapatellar tendon; primary	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27380	Quadricepsplasty (eg, Bennett or Thompson type)	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
27420	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
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
27470	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)			C		
27472	Repair, nonunion or malunion, femur, distal to head and neck; with iliac or other autogenous bone graft (includes obtaining graft)			C		
27506	Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws			C		
27507	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage			C		

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
27511	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed			C		
27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed			C		
27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed			C		
27540	Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed			C		
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, secondary, Achilles tendon, with or without graft	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
27664	Repair, extensor tendon, leg; primary, without graft, each tendon	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	$2,601
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
27690	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
27691	Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	$3,762
27700	Arthroplasty, ankle	0047	Arthroplasty	T	45.3575	$3,363
27702	Arthroplasty, ankle with implant			C		
27703	Arthroplasty, ankle; revision, total ankle			C		
27704	Removal of ankle implant	0049	Level I Musculoskeletal Procedures Except Hand and Foot	Q2	22.3913	$1,660
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
27758	Open treatment of tibial shaft fracture (with or without fibular fracture), with plate/screws, with or without cerclage	0063	Level II Treatment Fracture/Dislocation	T	57.0073	$4,227
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	0063	Level II Treatment Fracture/Dislocation	T	57.0073	$4,227
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	0063	Level II Treatment Fracture/Dislocation	T	57.0073	$4,227
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	0063	Level II Treatment Fracture/Dislocation	T	57.0073	$4,227
27814	Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed	0063	Level II Treatment Fracture/Dislocation	T	57.0073	$4,227
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	0063	Level II Treatment Fracture/Dislocation	T	57.0073	$4,227
27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	0064	Level III Treatment Fracture/Dislocation	T	75.0875	$5,567

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	0063	Level II Treatment Fracture/Dislocation	T	57.0073	$4,227
28238	Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)	0056	Level II Foot Musculoskeletal Procedures	T	70.3645	$5,217
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
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
28455	Treatment of tarsal bone fracture (except talus and calcaneus); with manipulation, each	0129	Level I Closed Treatment Fracture	T	2.2797	$169
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
29823	Arthroscopy, shoulder, surgical; debridement, extensive	0042	Level II Arthroscopy	T	58.5867	$4,344

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)			N		
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	0042	Level II Arthroscopy	T	58.5867	$4,344
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament	0041	Level I Arthroscopy	T	29.0075	$2,151
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	0042	Level II Arthroscopy	T	58.5867	$4,344
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	0041	Level II Arthroscopy	T	29.0075	$2,151
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	0041	Level II Arthroscopy	T	29.0075	$2,151
29882	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)	0041	Level II Arthroscopy	T	29.0075	$2,151
29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)	0041	Level II Arthroscopy	T	29.0075	$2,151
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	85.2438	$6,320
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
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
Injection Codes (report only when applicable to site of injection, service date and provider)						
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	0437	Level II Drug Administration	S	0.7218	$54
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	0204	Level I Nerve Injections	T	2.8475	$211
20551	Injection(s); single tendon origin/insertion	0204	Level I Nerve Injections	T	2.8475	$211
20600	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance	0204	Level I Nerve Injections	T	2.8475	$211
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance	0204	Level I Nerve Injections	T	2.8475	$211
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	0204	Level I Nerve Injections	T	2.8475	$211

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

Ambulatory Surgery Center (ASC) Coding

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

Multiple procedures can be paid for the same case if multiple codes are submitted. The payment indicator (PI) signifies how a code is handled for payment. Specifically, payment indicator A2 means a surgical procedure whose payment is based on the hospital outpatient rate. Payment indicator G2 represents a non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight. Payment indicator J8 indicates Device-intensive procedure; paid at adjusted rate. Payment indicator N1 indicates a packaged procedure/item; no separate payment made. Payment indicator P3 is an office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs. NA indicates surgical procedures excluded from payment in ASCs for CY 2015. When the Multiple Procedure Discount is Yes, it indicates that the code pays at 100% of the rate when it is the only procedure or is the highest-weighted procedure, but pays at 50% of the rate when it is submitted with another higher-weighted procedure.

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

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
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
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed	J8	Y	93.9112	$4,139
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
24430	Repair of nonunion or malunion, humerus; without graft (eg, compression technique)	A2	Y	78.6374	$3,466
24435	Repair of nonunion or malunion, humerus; with iliac or other autograft (includes obtaining graft)	J8	N	177.9456	$7,842
24515	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage	J8	Y	93.9112	$4,139
24516	Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws	J8	Y	93.9112	$4,139
24546	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension	J8	Y	93.9112	$4,139
24635	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed	J8	Y	93.9112	$4,139
24665	Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed	A2	Y	52.5892	$2,318
24685	Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed	A2	Y	52.5892	$2,318
25370	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna	A2	Y	32.3631	$1,426
25375	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius AND ulna	A2	Y	32.3631	$1,426
25415	Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)	A2	Y	78.6374	$3,466
25420	Repair of nonunion or malunion, radius AND ulna; with autograft (includes obtaining graft)	A2	Y	78.6374	$3,466
25425	Repair of defect with autograft; radius OR ulna	A2	Y	46.8009	$2,063
25426	Repair of defect with autograft; radius AND ulna	A2	Y	46.8009	$2,063
25574	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius OR ulna	J8	Y	93.9112	$4,139
25575	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna	J8	Y	93.9112	$4,139
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	A2	Y	52.5892	$2,318
26546	Repair non-union, metacarpal or phalanx (includes obtaining bone graft with or without external or internal fixation)	P2	Y	2.6594	$117
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	NA	NA	NA	NA

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
27244	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage	NA	NA	NA	NA
27245	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage	NA	NA	NA	NA
27248	Open treatment of greater trochanteric fracture, includes internal fixation, when performed	NA	NA	NA	NA
27269	Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed	NA	NA	NA	NA
27332	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral	A2	Y	32.3631	$1,426
27333	Suture of infrapatellar tendon; primary	A2	Y	32.3631	$1,426
27380	Quadricepsplasty (eg, Bennett or Thompson type)	A2	Y	32.3631	$1,426
27420	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)	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
27470	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)	NA	NA	NA	NA
27472	Repair, nonunion or malunion, femur, distal to head and neck; with iliac or other autogenous bone graft (includes obtaining graft)	NA	NA	NA	NA
27506	Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws	NA	NA	NA	NA
27507	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage	NA	NA	NA	NA
27511	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed	NA	NA	NA	NA
27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed	NA	NA	NA	NA
27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed	NA	NA	NA	NA
27540	Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed	NA	NA	NA	NA
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	A2	Y	46.8009	$2,063
27654	Repair, secondary, Achilles tendon, with or without graft	A2	Y	46.8009	$2,063
27664	Repair, extensor tendon, leg; primary, without graft, each tendon	A2	Y	32.3631	$1,426
27665	Repair, extensor tendon, leg; secondary, with or without graft, each tendon	A2	Y	32.3631	$1,426
27690	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)	A2	Y	46.8009	$2,063
27691	Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)	A2	Y	46.8009	$2,063
27700	Arthroplasty, ankle	A2	Y	41.8423	$1,844
27702	Arthroplasty, ankle with implant	NA	NA	NA	NA
27703	Arthroplasty, ankle; revision, total ankle	NA	NA	NA	NA
27704	Removal of ankle implant	A2	N	20.6560	$910
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
27758		A2	Y	52.5892	$2,318
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	A2	Y	52.5892	$2,318
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	G2	Y	52.5892	$2,318

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	A2	Y	52.5892	$2,318
27814	Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed	A2	Y	52.5892	$2,318
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	A2	Y	52.5892	$2,318
27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	J8	Y	93.9112	$4,139
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	A2	Y	52.5892	$2,318
28238	Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)	A2	Y	64.9113	$2,861
28320	Repair, nonunion or malunion; tarsal bones	A2	Y	21.6844	$956
28322	Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)	A2	Y	64.9113	$2,861
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
28455	Treatment of tarsal bone fracture (except talus and calcaneus); with manipulation, each	P2	Y	2.1030	$93
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
28715	Arthrodesis; triple	J8	N	177.9456	$7,842
28725	Arthrodesis; subtalar	A2	Y	64.9113	$2,861
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;	A2	Y	64.9113	$2,861
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	A2	Y	64.9113	$2,861
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	A2	Y	64.9113	$2,861
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	A2	Y	64.9113	$2,861
28750	Arthrodesis, great toe; metatarsophalangeal joint	A2	Y	64.9113	$2,861
29823	Arthroscopy, shoulder, surgical; debridement, extensive	A2	Y	54.0462	$2,382
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)	N1	N		
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	A2	Y	54.0462	$2,382
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament	A2	Y	26.7594	$1,179
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	NA	NA	NA	NA
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	A2	Y	26.7594	$1,179

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	A2	Y	26.7594	$1,179
29882	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)	A2	Y	26.7594	$1,179
29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)	A2	Y	26.7594	$1,179
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	A2	Y	78.6374	$3,466
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	A2	Y	78.6374	$3,466
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
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
Injection Codes (report only when applicable to site of injection, service date and provider)					
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	NA	NA	NA	NA
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	P3	Y		$30
20551	Injection(s); single tendon origin/insertion	P3	Y		$32
20600	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance	P3	Y		$22
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance	P3	Y		$24
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	P3	Y		$29

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 (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. **Wound Procedural codes are underlined and bolded.**

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	04.43 04.49 04.79
041	Peripheral/Cranial Nerve & other nervous system procedure W CC OR PERIPH NEUROSTIM	2.1267	$12,474	
042	Peripheral/Cranial Nerve & other nervous system procedure WO CC/MCC	1.8586	$10,902	

DRG	DRG Title	Relative Weight	Medicare National Unadjusted Payment	ICD-9-CM Procedure Codes and Descriptions
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 W/O CC/MCC	1.9463	$11,416	
469	Major joint replacement or reattachment of lower extremity W MCC	3.3905	$19,887	81.56
470	Major joint replacement or reattachment of lower extremity WO MCC	2.1137	$12,398	
480	Hip & Femur Procedures except major joint W MCC	3.0052	$17,627	78.05 78.45 78.75 79.35 81.40
481	Hip & Femur Procedures except major joint W CC	1.9776	$11,600	
482	Hip & Femur Procedures except major joint WO CC/MCC	1.6243	$9,527	
495	Local Excision and Removal Internal Fixation Devices Except Hip and Femur W MCC	3.0476	$17,876	80.81
496	Local Excision and Removal Internal Fixation Devices Except Hip and Femur W CC	1.7289	$10,141	
497	Local Excision and Removal Internal Fixation Devices Except Hip and Femur WO CC/MCC	1.2230	$7,173	
500	Soft Tissue Procedures W MCC	3.2420	$5,865	81.95 83.62 83.65 83.71 83.73 83.74 83.75 83.81 83.82 83.88 **81.95** **83.61** **83.64** **83.65**
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	78.08 78.48 79.37 81.13 81.16 81.71
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 81.85
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	78.03 78.43 79.32 81.93 83.63 **81.93**
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	

DRG	DRG Title	Relative Weight	Medicare National Unadjusted Payment	ICD-9-CM Procedure Codes and Descriptions
513	Hand or Wrist Procedure, except Major Thumb or Joint Procedure W CC/MCC	1.4462	$8,483	78.44 86.61 86.62
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	78.01 78.09 with 79.39 81.29 81.59
516	Other Musculoskeletal System and Connective Tissue O.R. Procedures W CC	2.0434	$11,985	
517	Other Musculoskeletal System and Connective Tissue O.R. Procedures WO CC/MCC	1.7251	$10,118	

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

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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