



GRAVITY[®]

Titanium Suture Anchor

2015 Reimbursement Codes

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

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HCPCS Device Codes

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

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

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

Reference: "List of Device Category Codes for Present or Previous Pass-Through Payment and Related Definitions", January 2015

CPT[®] Codes

Codes for internal or external fixation are to be used only when internal or external fixation is not already listed as part of the basic procedure.

Physician Coding

Resource based relative value scale (RBRVS) is the prospective payment system Medicare uses to reimburse physicians. Each service has relative value units (RVUs) that indicate its rank compared to all other services in terms of the relative costs of the resources required, including physician work, practice expenses, and malpractice insurance. The RVU is converted to a flat payment amount using a standardized conversion factor.

Different sites of services have different RVUs and payment:

- Facility RVUs represent surgical services provided in hospitals, ambulatory surgical centers, or skilled nursing facilities.
- Non-Facility RVUs represent surgical services provided in physician's offices.
- RVUs and payments are usually lower in the Facility setting because the facility is incurring some of the costs. RVUs and payments are usually higher in the Non-Facility setting because the physician incurs all costs there and the physician must be reimbursed for those costs.

"NA" indicates that the Non-Facility RVUs do not exist because the service is expected to be performed in a facility.

"UNL" indicates the CPT code as unlisted, and therefore Non-Facility or Facility RVUs cannot be calculated.

CPT [®] CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
20924	Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)	14.50	\$519	NA	NA
23395	Muscle transfer, any type, shoulder or upper arm; single	36.68	\$1,313	NA	NA
24341	Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331)	21.28	\$762	NA	NA
25310	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon	17.60	\$630	NA	NA
25316	Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist; with tendon(s) transfer	26.12	\$935	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	\$1,006	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	\$905	NA	NA

CPT® CODE	Description	Facility		Non-Facility	
		RVUs	Medicare Average Payment	RVUs	Medicare Average Payment
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon	18.83	\$674	NA	NA
27654	Repair, secondary, Achilles tendon, with or without graft	20.23	\$724	NA	NA
27665	Repair, extensor tendon, leg; secondary, with or without graft, each tendon	11.69	\$419	NA	NA
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon	12.31	\$441	NA	NA
27687	Gastrocnemius recession (eg, Strayer procedure)	13.02	\$466	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
27695	Repair, primary, disrupted ligament, ankle; collateral	13.62	\$488	NA	NA
27696	Repair, primary, disrupted ligament, ankle; both collateral ligaments	15.74	\$564	NA	NA
27698	Repair, secondary, disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)	18.27	\$654	NA	NA
28200	Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon	9.20	\$329	14.09	\$504
28270	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)	9.59	\$343	14.19	\$508
28285	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)	10.84	\$388	15.42	\$552

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 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.

"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
20924	Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	\$2,601
23395	Muscle transfer, any type, shoulder or upper arm; single	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	\$3,762
24341	Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331)	0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	50.7327	\$3,762
25310	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon	0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	35.0819	\$2,601
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

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
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
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon	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
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
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
27687	Gastrocnemius recession (eg, Strayer procedure)	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
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
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
28200	Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	\$1,743
28270	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	\$1,743
28285	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)	0055	Level I Foot Musculoskeletal Procedures	T	23.5061	\$1,743

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. N1 indicates a packaged procedure/item; no separate payment made. 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
20924	Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)	A2	Y	32.3631	\$1,426

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
23395	Muscle transfer, any type, shoulder or upper arm; single	A2	Y	46.8009	\$2,063
24341	Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331)	A2	Y	46.8009	\$2,063
25310	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon	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	78.6374	\$3,466
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
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon	A2	Y	46.8009	\$2,063
27654	Repair, secondary, Achilles tendon, with or without graft	A2	Y	46.8009	\$2,063
27665	Repair, extensor tendon, leg; secondary, with or without graft, each tendon	A2	Y	32.3631	\$1,426
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon	A2	Y	32.3631	\$1,426
27687	Gastrocnemius recession (eg, Strayer procedure)	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
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
28200	Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon	A2	Y	21.6844	\$956
28270	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)	A2	Y	21.6844	\$956
28285	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)	A2	Y	21.6844	\$956

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
492	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with MCC	3.1873	\$18,695	81.49
493	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with CC	2.0354	\$11,938	
494	Lower Extremity and Humerus Procedures W/O CC/MCC	1.5397	\$9,031	

DRG	DRG Title	Relative Weight	Medicare National Unadjusted Payment	ICD-9-CM Procedure Codes and Descriptions
500	Soft Tissue Procedures W MCC	3.2420	\$19,016	83.41 83.61 83.64 83.65 83.72 83.75 83.77 83.91
501	Soft Tissue Procedures W CC	1.6474	\$9,663	
502	Soft Tissue Procedures W/O CC/MCC	1.1597	\$6,802	
503	Foot Procedures W CC	2.3338	\$13,688	80.48 81.94
504	Foot Procedures W CC	1.5691	\$9,203	
505	Foot Procedures W/O CC/MCC	1.2474	\$7,316	

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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