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G-FORCE®

Tenodesis System

2015 Reimbursement Codes

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

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HCPCS Device Codes

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

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

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

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

CPT® Codes

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

Physician Coding

Resource based relative value scale (RBVBS) 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,

See also: http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

2015 Medicare Physician Fee Schedule (MPFS) Conversion Factor: The CY 2015 MPFS conversion factor is $35.8013 for January 1, 2015 through March 31, 2015--as a result of Congress passing a "fix" to the sustainable growth rate (SGR) in April 2014. The "fix" provided for a zero percent update for services furnished between January 1 and March 31, 2015.

Hospital Outpatient Coding (APCs)

Ambulatory payment classifications (APCs) is the prospective payment system Medicare uses to reimburse hospitals for outpatient services. Each CPT® code for a significant procedure is assigned to a specific APC class based on clinical and resource similarities. Each APC has a relative weight that indicates its rank compared to all other procedures in terms of the relative costs. The relative weight is then converted to a flat payment amount using a standardized conversion factor.

Multiple APCs can be assigned for the same case if multiple procedures are performed. The status indicator (SI) signifies how a code is handled for payment. Specifically, status indicator T means that the code pays at 100% of the rate when it is the only procedure or is the highest-weighted procedure, but pays at 50% of the rate when it is submitted with another higher-weighted procedure.

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	Medicare 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
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 G2 is a technical variation but also means a surgical procedures whose payment is based on the hospital outpatient rate. When the Multiple Procedure Discount is Yes, it indicates that the code pays at 100% of the rate when it is the only procedure or is the highest-weighted procedure, but pays at 50% of the rate when it is submitted with another higher-weighted procedure.

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

CPT® Code	Description	PI	Multi-Procedure Discounting?	Relative Weight	Medicare Average Payment
20924	Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)	A2	Y	32.3631	$1,426
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

ICD-9-CM Diagnosis Codes

ICD-9-CM diagnosis codes are used by all providers, including physicians, hospitals and ASCs, and in all settings, including inpatient and outpatient. Diagnosis codes indicate the reason for the procedure and are mandatory for reimbursement. The codes shown below are those that are common with procedures using the G-FORCE® Titanium Suture Anchor System though other codes may also be appropriate. The ICD-9-CM book should always be referenced for diagnostic coding.

IDC-9-CM Diagnosis	Description
334.1	Hereditary spastic paraplegia
334.9	Paralysis, unspecified
337.1	Atheoid cerebral palsy
343.0	Congenital diplegia
343.1	Congenital hemiplegia
343.2	Congenital quadriplegia
343.3	Congenital monoplegia
343.4	Infantile hemiplegia
343.8	Other specified infantile cerebral palsy
343.9	Infantile cerebral palsy, unspecified
344.00	Quadriplegia, unspecified
344.01	Quadriplegia, C1-C4, complete
344.02	Quadriplegia, C1-C4, incomplete
344.03	Quadriplegia, C5-C7, complete
344.04	Quadriplegia, C5-C7, incomplete
344.09	Other quadriplegia
344.1	Paraplegia

IDC-9-CM Diagnosis	Description
344.2	Diplegia of upper limbs
344.30	Monoplegia of lower limb affecting unspecified side
344.31	Monoplegia of lower limb affecting dominant side
344.32	Monoplegia of lower limb affecting nondominant side
344.40	Monoplegia of upper limb affecting unspecified side
344.41	Monoplegia of upper limb affecting dominant side
344.42	Monoplegia of upper limb affecting nondominant side
437.8	Other and Ill-defined cerebrovascular disease
438.50	Paralytic syndrome affecting unspecified side as late effect of cerebrovascular disease
438.89	Late effects of cerebrovascular disease
714.0	Rheumatoid arthritis
715.16	Osteoarthrosis localized, primary, lower leg
715.17	Osteoarthrosis, localized, primary, ankle and foot
715. 26	Osteoarthrosis localized, secondary, lower leg
715.37	Osteoarthrosis, localized, not specified whether primary or secondary, ankle and foot

IDC-9-CM Diagnosis	Description
715.90	Osteoarthritis
715.97	Osteoarthrosis, unspecified whether generalized or localized, ankle and foot
716.17	Traumatic arthropathy, ankle and foot
717.0	Old bucket handle tear of medial meniscus
717.1	Derangement of anterior horn of medial meniscus
717.2	Derangement of posterior horn of medial meniscus
717.3	Other and unspecified derangement of medial meniscus
717.40	Derangement of lateral meniscus, unspecified
717.41	Bucket handle tear of lateral meniscus
717.42	Derangement of anterior horn of lateral meniscus
717.43	Derangement of posterior horn of lateral meniscus
717.5	Derangement of meniscus, not elsewhere classified
717.7	Chondromalacia patellae
717.83	Old disruption of anterior cruciate ligament
718.41	Contracture of joint, shoulder region
718.42	Contracture of joint, upper arm
718.46	Contracture of joint, lower leg
718.47	Contracture of joint, ankle and foot
718.87	Other joint derangement, not elsewhere classified, ankle and foot
719.86	Other specified and unspecified disorder of joint, lower leg
719.87	Other specified disorders of joint, ankle and foot
730.10	Chronic Osteomyelitis
731.3	Major osseous defects
732.7	Osteochondritis dissecans
733.81	Malunion of fracture
733.82	Nonunion of fracture
733.90	Traumatic osteochondral injury
733.91	Arrest of bone development or growth
733.95	Stress fracture of other bone
733.99	Other disorders of bone and cartilage
735.0	Hallux valgus (acquired)
735.1	Hallux varus (acquired)
735.2	Hallux rigidus
735.3	Hallux malleus
735.4	Other hammer toe (acquired)
735.8	Other acquired deformities of toe
736.71	Acquired equinovarus deformity
736.73	Cavus deformity of foot, acquired
736.74	Claw foot, acquired
736.75	Cavovarus deformity of foot, acquired
736.79	Other acquired deformities of ankle and foot
738.05	Closed dislocation of metatarsophalangeal (joint)
738.15	Open dislocation of metatarsophalangeal (joint)
754.50	Talipes varus
754.51	Talipes equinovarus

IDC-9-CM Diagnosis	Description
754.52	Metatarsus primus varus
754.53	Metatarsus varus
754.59	Other varus deformities of feet
754.60	Talipes valgus
754.61	Congenital pes planus
754.70	Talipes, unspecified
754.71	Talipes cavus
755.38	Longitudinal deficiency, tarsals or metatarsals, complete or partial (with or without incomplete phalangeal deficiency)
755.66	Other specified congenital deformities of toes
755.67	Congenital anomalies of foot, not elsewhere classified
756.89	Other specified anomalies of muscle, tendon, fascia, and connective tissue
815.09	Closed fracture, multiple sites of metacarpus
816.01	Closed fracture of middle or proximal phalanx or phalanges of hand
817.0	Multiple closed fractures of hand bones
834.12	Open dislocation interphalangeal (joint), hand
836.1	Tear of lateral cartilage or meniscus of knee, current
836.2	Other tear of cartilage or meniscus of knee, current
838.02	Closed dislocation of midtarsal (joint)
838.05	Closed dislocation of metatarsophalangeal (joint)
838.06	Closed dislocation of interphalangeal (joint), foot
838.15	Open dislocation of metatarsophalangeal (joint)
838.16	Open dislocation of interphalangeal (joint), foot
844.0	Sprain of lateral collateral ligament of knee
844.2	Sprain of cruciate ligament of knee
845.01	Sprain of deltoid (ligament), ankle
845.02	Sprain of calcaneofibular (ligament) of ankle
845.09	Ankle Sprain
880.20	Open wound of shoulder region, with tendon involvement
880.23	Open wound of upper arm, with tendon involvement
881.20	Open wound of forearm, with tendon involvement
890.2	Open wound of hip and thigh, with tendon involvement
891.1	Open wound of knee, leg [except thigh], and ankle, complicated
891.2	Open wound of knee, leg [except thigh], and ankle, with tendon involvement
892.2	Open wound of foot except toe(s) alone, with tendon involvement
893.2	Open wound of toe(s) alone, with tendon involvement
905.4	Late effect of fracture of lower extremities
909.3	Late effect of complications of surgical and medical care
928.20	Crushing injury of foot
928.21	Crushing injury of ankle
928.3	Crushing injury ofmultiple sites of lower limb
928.8	Crushing injury of toes
958.6	Volkman's ischemic contracture

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. With CC and with 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 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 WO CC/MCC	1.5397	$9,031	
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 WO CC/MCC	1.2474	$7,316	

Reference: Medicare Program: 2015 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 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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