



## **“C” CODE DEVICE CATEGORY CODES APPLICABLE TO WRIGHT MEDICAL TECHNOLOGY PRODUCTS**

As indicated in section 1833(t)(6) of the Social Security Act, payments for pass-through devices are limited to at least two years but no more than three years. Note that payment for pass-through devices is based on the charge on the individual bill, converted to cost by application of a hospital-specific cost-to-charge ratio, and subject (in some instances) to a reduction that offsets the cost of similar devices already included in the APC payment rate for the associated procedure. Device-to-procedure code edits were implemented on January 1, 2007 for specific devices. These edits look at the device code billed and return the claim if a procedure in which the device is used is not also billed on the same claim. For specific edits, refer to the latest procedure-to-device and device-to-procedure edits lists, which may both be downloaded from <http://www.cms.hhs.gov/HospitalOutpatientPPS/>.

For a complete list of C-Code descriptors, visit <http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/HospitalOutpatientPPS/Downloads/Complelist-DeviceCats-opp.pdf>

**Anchor for opposing bone-to-bone or soft tissue-to-bone (C1713)** - Implantable pins and/or screws that are used to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone. Screws oppose tissues via drilling as follows: soft tissue-to-bone, tendon-to-bone, or bone-to-bone fixation. Pins are inserted or drilled into bone, principally with the intent to facilitate stabilization or oppose bone-to-bone. This may include orthopedic plates with accompanying washers and nuts. This category also applies to synthetic bone substitutes that may be used to fill bony void or gaps (i.e., bone substitute implanted into a bony defect created from trauma or surgery).

**Joint device (C1776)** - An artificial joint such as a finger or toe that is implanted in a patient. Typically, a joint device functions as a substitute to its natural counterpart and is not used (as are anchors) to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone.

Disclaimer:

The data above is for informational purposes only. It is the customer's responsibility to determine which combination of codes from any listing provided actually applies to that specific patient encounter. Providers of services or items are ultimately responsible for the content of the bills they present to Medicare or any other payer.

**The customer shall be solely responsible for: (i) determining if, and under what circumstances, it can seek third party reimbursement for Devices; (ii) obtaining, as necessary, third party payor pre-authorizations for the Devices; and (iii) any and all coding, billing, coverage, and collection of payment from third party payors or patients.**

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