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AUGMENT®

Bone Graft

2016 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. However, regular HCPCS II device codes are generally used for billing non-Medicare payers.

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 2016

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
27870	Arthrodesis, ankle, open	29.76	$1,066	NA	NA
28705	Arthrodesis; pantalar	36.18	$1,296	NA	NA
28715	Arthrodesis, triple	27.07	$970	NA	NA
28725	Arthrodesis, subtalar	22.43	$804	NA	NA
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle Arthrodesis	21.17	$758	NA	NA

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

2016 Medicare Physician Fee Schedule (MPFS) Conversion Factor is 35.8279. The CY 2015 MPFS conversion factor is $35.8013 for January 1, 2015 through March 31, 2015--as a result of Congress passing a "fix" to the sustainable growth rate (SGR) in April 2014. The "fix" provided for a zero percent update for services furnished between January 1 and March 31, 2015.

Hospital Outpatient Coding (APCs)

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

Multiple APCs can be assigned for the same case if multiple procedures are performed. The status indicator (SI) signifies how a code is handled for payment. Status Indicator C indicates an inpatient procedure, Not paid under OPPS. Patient should be admitted and billed as an inpatient. Status indicator J1 will trigger a comprehensive APC payment for the claim, meaning a single APC will be paid while all other items and services on the same date of service will no longer generate separate payment. Status indicator N services are paid under the OPPS, but their payment is packaged into payment for a separately paid service, it is a packaged service/item; no separate payment made. Local carrier determinations may also apply to N when separate payment is allowed. Status indicator T means that the code pays at 100% of the rate when it is the only procedure or is the highest-weighted procedure, but pays at 50% of the rate when it is submitted with another higher-weighted procedure.

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

CPT® Code	Description	APC	APC Title	SI	Relative Weight	Average Payment
27870	Arthrodesis, ankle, open	5125	Level 5 Musculoskeletal Procedures	J1	142.9352	$10,538
28705	Arthrodesis; pantalar	5125	Level 5 Musculoskeletal Procedures	J1	142.9352	$10,538
28715	Arthrodesis, triple	5125	Level 5 Musculoskeletal Procedures	J1	142.9352	$10,538
28725	Arthrodesis, subtalar	5124	Level 5 Musculoskeletal Procedures	J1	95.8165	$7,064
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle Arthrodesis	5124	Level 4 Musculoskeletal Procedures	J1	95.8165	$7,064

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. 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
27870	Arthrodesis, ankle, open	J8	Y	178.5239	$7,887
28705	Arthrodesis; pantalar	J8	Y	178.5239	$7,887
28715	Arthrodesis, triple	J8	Y	178.5239	$7,887
28725	Arthrodesis, subtalar	G2	Y	79.9669	$3,533
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle Arthrodesis	G2	Y	79.9669	$3,533

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 2016

ICD-10-PCS Procedure Codes

ICD-10-PCS procedure codes are used by hospitals for inpatient procedures beginning October 1, 2015. This list groups codes together by root operations representing procedures performed with AUGMENT® Bone Graft. The ICD-10-PCS root operation is cited by the third digit. Root operations identify the general objective of the procedure using the ICD-10-PCS system. The code variances represent the body part or anatomy as well as left or right side of the body.

Root Operation Title	Objective
Fusion	A fixation device, bone graft, or other to render body part immobile
Inspection	Visual/manual exploration/endoscopy
ICD-10-PCS Code	**ICD-10-PCS Description**
0SJF4ZZ	Inspection of Right Ankle Joint, Percutaneous Endoscopic Approach
0SJG4ZZ	Inspection of Left Ankle Joint, Percutaneous Endoscopic Approach
0SGF0KZ	Fusion of Right Ankle Joint with Nonautologous Tissue Substitute Open Approach
0SGG0KZ	Fusion of Left Ankle Joint with Nonautologous Tissue Substitute Open Approach
0SGH0KZ	Fusion of Right Tarsal Joint with Nonautologous Tissue Substitute Open Approach
0SGJ0KZ	Fusion of Left Tarsal Joint with Nonautologous Tissue Substitute Open Approach
0SGH0KZ	Fusion of Right Tarsal Joint with Nonautologous Tissue Substitute Open Approach
0SGJ0KZ	Fusion of Left Tarsal Joint with Nonautologous Tissue Substitute Open Approach

Hospital Inpatient Diagnosis Related Group (MS-DRGs)

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-10-CM diagnosis and ICD-10-PCS 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.

DRG	DRG Title	Relative Weight	Medicare National Unadjusted Payment
492	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with MCC	3.1585	$18,655
493	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with CC	2.0557	$12,141
494	Lower Extremity and Humerus Procedures WO CC/MCC	1.5796	$9,329
503	Foot Procedures W CC	2.2679	$13,395
504	Foot Procedures W CC	1.5941	$9,415
505	Foot Procedures WO CC/MCC	1.2590	$7,436
509	Arthroscopy	1.6562	$9,782
515	Other Musculoskeletal System and Connective Tissue OR Procedures W MCC	3.1862	$18,818
516	Other Musculoskeletal System and Connective Tissue OR Procedures W CC	2.0670	$12,208
517	Other Musculoskeletal System and Connective Tissue OR Procedures WO CC/MCC	1.7716	$10,463

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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