

DePuy Synthes 2020 Hand and Wrist Reimbursement Guide

Physician and Facility

Contents

This guide has been developed to assist physicians and facilities in coding for the use of the DePuy Synthes hand and wrist implants and devices.

These procedures may be a covered service if they meet all of the requirements established by Medicare and private payers. It is essential that each claim be coded properly and supported with appropriate documentation in the medical record.

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Physician Services

Current Procedural Terminology (CPT®) codes and Medicare Physician Fee Schedule values for common hand and wrist procedures are indicated below. CPT® coding has been provided for the following procedural groups:

Fixation of Scaphoid Fracture
 DIP/PIP Fusion
 Fixation of Metacarpal Fracture
 Four Bone Fusion
 Carpometacarpal Joint Fusion
 Fixation of Radial/Ulna Styloid Fracture

Procedure Codes for Hand and Wrist

Scaphoid Fracture

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
25628	Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed	20.73	\$748

DIP/PIP Fusion

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
26860	Arthrodesis, interphalangeal joint, with or without internal fixation;	16.64	\$601
26861	Arthrodesis, interphalangeal joint, with or without internal fixation; each additional interphalangeal joint (List separately in addition to code for primary procedure)	2.98	\$108
26862	Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft)	21.19	\$765
26863	Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft), each additional joint (List separately in addition to code for primary procedure)	6.62	\$239

Metacarpal Fracture

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	16.55	\$597

Four Bone Fusion

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
25800	Arthrodesis, wrist; complete, without bone graft (includes radiocarpal and/or intercarpal and/or carpometacarpal joints)	21.10	\$761

CMC Joint Fusion

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
26841	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation;	21.26	\$767
26842	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation; with autograft (includes obtaining graft)	22.86	\$825
26843	Arthrodesis, carpometacarpal joint, digit, other than thumb, each;	21.65	\$781
26844	Arthrodesis, carpometacarpal joint, digit, other than thumb, each; with autograft (includes obtaining graft)	23.96	\$865

Radial/Ulna Styloid Fractures

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	21.20	\$765
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments	23.78	\$858
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments	30.26	\$1,092
25652	Open treatment of ulnar styloid fracture	17.93	\$647

Facility Services

Outpatient Services

Medicare reimburses outpatient hospital and Ambulatory Surgery Center (ASC) services under the Outpatient Prospective Payment System (OPPS), which bases payment on Ambulatory Payment Classifications (APCs) and ASC Payment Groups. Services are reported with CPT® codes. The Medicare national average payments for common hand and wrist procedures in the outpatient setting are listed below.

Procedure Codes for Hand and Wrist

Scaphoid Fracture

CPT® Code	Description	Hospital Outpatient			Ambulatory Surgical Center	
		SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
25628	Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed	J1	5114	\$5,981	A2	\$2,803

DIP/PIP Fusion

CPT® Code	Description	Hospital Outpatient			Ambulatory Surgical Center	
		SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
26860	Arthrodesis, interphalangeal joint, with or without internal fixation;	J1	5113	\$2,737	A2	\$1,286
26861	Arthrodesis, interphalangeal joint, with or without internal fixation; each additional interphalangeal joint (List separately in addition to code for primary procedure)	N	N/A	N/A	N1	N/A
26862	Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft)	J1	5113	\$2,737	A2	\$1,286
26863	Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft), each additional joint (List separately in addition to code for primary procedure)	N	N/A	N/A	N1	N/A

Metacarpal Fracture

CPT® Code	Description	Hospital Outpatient			Ambulatory Surgical Center	
		SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	J1	5113	\$2,737	A2	\$1,286

Four Bone Fusion

CPT® Code	Description	Hospital Outpatient			Ambulatory Surgical Center	
		SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
25800	Arthrodesis, wrist; complete, without bone graft (includes radiocarpal and/or intercarpal and/or carpometacarpal joints)	J1	5114	\$5,981	J8	\$4,076

Carpometacarpal Joint Fusion

CPT® Code	Description	Hospital Outpatient			Ambulatory Surgical Center	
		SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
26841	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation;	J1	5114	\$5,981	A2	\$2,803
26842	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation; with autograft (includes obtaining graft)	J1	5114	\$5,981	A2	\$2,803
26843	Arthrodesis, carpometacarpal joint, digit, other than thumb, each;	J1	5114	\$5,981	A2	\$2,803
26844	Arthrodesis, carpometacarpal joint, digit, other than thumb, each; with autograft (includes obtaining graft)	J1	5114	\$5,981	J8	\$2,803

Radial/Ulna Styloid Fracture

CPT® Code	Description	Hospital Outpatient			Ambulatory Surgical Center	
		SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	J1	5114	\$5,981	J8	\$4,037
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments	J1	5114	\$5,981	J8	4,020
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments	J1	5114	\$5,981	J8	4,036
25652	Open treatment of ulnar styloid fracture	J1	5114	\$5,981	G2	\$2,803

Hospital Inpatient Services

Medicare reimburses inpatient hospital services under the Inpatient Prospective Payment System (IPPS), which bases payment on MS-DRGs (Medicare Severity Diagnosis Related Groups). The MS-DRGs and Medicare national average payments for hand and wrist procedures are provided below:

MS-DRGs for Hand and Wrist Procedures

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
510	Shoulder, elbow or forearm procedures, except major joint procedures with MCC	2.7880	\$17,463
511	Shoulder, elbow or forearm procedures, except major joint procedures with CC	1.8842	\$11,802
512	Shoulder, elbow or forearm procedures, except major joint procedures without CC/MCC	1.5138	\$9,482
513	Hand or Wrist Procedures, Except Major Thumb or Joint Procedures with CC/MCC	1.5771	\$9,879
514	Hand or Wrist Procedures, Except Major Thumb or Joint Procedures without CC/MCC	1.0668	\$6,682
907	Other O.R. procedures for injuries with MCC	3.9896	\$24,990
908	Other O.R. procedures for injuries with CC	2.0631	\$12,923
909	Other O.R. procedures for injuries without CC/MCC	1.3187	\$8,260
957	Other O.R. procedures for multiple significant trauma with MCC	7.5337	\$47,189
958	Other O.R. procedures for multiple significant trauma with CC	4.1909	\$26,251
959	Other O.R. procedures for multiple significant trauma without CC/ MCC	2.8005	\$17,542

*MCC=Major Complications or Comorbidities

**CC=Complications or Comorbidities

Procedure Codes

Medicare uses The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and Procedure Coding System (PCS) codes to identify diagnoses and procedures in the hospital inpatient setting. Hospitals must report the principal diagnosis using the appropriate ICD-10-CM code, as well as any secondary diagnoses – some of which may be considered CCs or MCCs for MS-DRG assignment. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.” The circumstances of inpatient admission always govern the selection of principal diagnosis.

For patient admissions involving procedures, hospitals must also report ICD-10-PCS procedure code(s) for the surgical and other procedures as well as ICD-10-CM diagnosis codes.

Listed below are the ICD-10-PCS procedure codes associated with common hand and wrist procedures. Please determine the appropriate ICD-10-PCS code section based on the general descriptions in the right hand column.

ICD-10-PCS	Description (See current ICD-10-PCS book for complete descriptions)
OPSH04Z	Reposition Right Radius with Internal Fixation Device, Open Approach
OPSJ04Z	Reposition Left Radius with Internal Fixation Device, Open Approach
OPSK04Z	Reposition Right Ulna with Internal Fixation Device, Open Approach
OPSL04Z	Reposition Left Ulna with Internal Fixation Device, Open Approach
OPSM04Z	Reposition Right Carpal with Internal Fixation Device, Open Approach
OPSN04Z	Reposition Left Carpal with Internal Fixation Device, Open Approach
OPSP04Z	Reposition Right Metacarpal with Internal Fixation Device, Open Approach
OPSQ04Z	Reposition Left Metacarpal with Internal Fixation Device, Open Approach
ORGN04Z	Fusion of Right Wrist Joint with Internal Fixation Device, Open Approach
ORGP04Z	Fusion of Left Wrist Joint with Internal Fixation Device, Open Approach
ORGS04Z	Fusion of Right Carpometacarpal Joint with Internal Fixation Device, Open Approach
ORGT04Z	Fusion of Left Carpometacarpal Joint with Internal Fixation Device, Open Approach
ORGW04Z	Fusion of Right Finger Phalangeal Joint with Internal Fixation Device, Open Approach
ORSN04Z	Reposition Right Wrist Joint with Internal Fixation Device, Open Approach
ORSP04Z	Reposition Left Wrist Joint with Internal Fixation Device, Open Approach
ORSQ04Z	Reposition Right Carpal Joint with Internal Fixation Device, Open Approach
ORSR04Z	Reposition Left Carpal Joint with Internal Fixation Device, Open Approach

Diagnosis Codes

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes entered on hospital and physician claims are important in conveying information about the patient's condition to payers. All healthcare providers must report the principal diagnosis using the appropriate ICD- 10-CM code, as well as any secondary diagnoses. Payers use this information to evaluate the medical necessity for the episode of care and the appropriateness of the treatment the patient received.

Diagnosis codes should be reported to the highest level of specificity available – a code is invalid if it has not been coded to the full number of digits required for that code.

The table below includes examples only of ICD-10-CM diagnosis codes associated with hand and wrist conditions:

ICD-10-CM	Description (See current ICD-10-CM Diagnosis book for complete descriptions)
M25.331-M25.339	Other instability of the wrist
M80.041A-M80.849S	Osteoporosis of the hand
M84.341A-M84.346S	Stress fractures of the hand and fingers
M84.441A-M84.446S	Pathological fractures of the hand and fingers
S52.371K-S52.379S	Galeazzi's fracture of radius
S52.501A-S52.509S	Fracture of the lower end of radius
S52.511A-S52.513S	Displaced fracture of radial styloid
S52.514 -S52.516S	Nondisplaced fracture of radial styloid
S52.521A-S52.529S	Torus fracture of lower end of radius
S52.531A-S52.539S	Colles' fracture of radius
S52.541A-S52.549S	Smith's fracture of radius
S52.551A-S52.559S	Extraarticular fracture of lower end of radius
S52.561K-S52.569S	Barton's fracture of radius
S52.571K-S52.579S	Intraarticular fracture of lower end of radius
S52.591A-S52.599S	Other fractures of lower end of radius
S52.611A-S52.613S	Displaced fracture of ulna styloid process
S52.614A-S52.616S	Nondisplaced fracture of ulna styloid process
S59.201A-S59.209S	Physeal fractures of lower end of radius
S62.001A-S62.036S	Fractures of navicular [scaphoid] bone
S62.101A-S62.109S	Fractures of carpal bone
S62.111A-S62.116S	Fractures of triquetrum [cuneiform] bone
S62.121A-S62.126S	Fractures of lunate [semilunar]
S62.131A-S62.136S	Fractures of capitate [os magnum] bone
S62.141A-S62.156S	Fractures of hook process of hamate [unciform] bone
S62.161A-S62.166S	Fractures of pisiform
S62.171A-S62.176S	Fractures of trapezium [larger multangular]

ICD-10-CM	Description (See current ICD-10-CM Diagnosis book for complete descriptions)
S62.181A-S62.186S	Fractures of trapezoid [smaller multangular]
S62.201A-S62.209S	Fractures of first metacarpal bone
S62.211A-S62.213S	Bennett's fracture
S62.221A-S62.226S	Rolando's fracture
S62.231A-S62.399S	Fractures of metacarpal bone
S62.501A-S62.669S	Fractures of phalanx
S67.40XA-S67.92XS	Crushing injuries of hand and wrist

HCPCS Codes and Revenue Codes

Medicare uses HCPCS (C-codes) to track device cost information for future APC rate-setting purposes. No additional payment will be provided to the facility. All appropriate C-codes should be added to the hospital's chargemaster to report device costs used in the outpatient setting. CMS will return a hospital claim if the appropriate tracking code is not identified on the claim when a device-dependent procedure is performed. The tables below may be referenced when reporting various DePuy Synthes hand and wrist fixation products.

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

Revenue codes allow hospitals to categorize services provided by the revenue center for cost reporting. For Medicare, revenue codes must be included for each service on a CMS 1450 (UB-04) claim form. Sample revenue codes that hospital facilities may use to track costs for fixation devices associated with hand and wrist procedures are listed in the following table.

Revenue Code	Description
0278	Medical/Surgical Supplies: Other Implants

Modifiers

The modifiers outlined below may be used to report special circumstance during hand and wrist surgery. These include some of the most common modifiers used in conjunction with foot and ankle surgery and do not represent a full listing. Please refer to the most up to date version of the AMA CPT® Code book for a complete listing.

Modifiers	Description
22	Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient’s condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.
47	Anesthesia by Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures.
50	Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code.
51	Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated “add-on” codes (see Appendix D).
52	Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).
53	Discontinued Procedure: Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient’s anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period: It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.

Modifiers	Description
59	<p>Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.</p>
80	<p>Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).</p>
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)

Notes

Not all codes provided are applicable for the recommended uses of DePuy Synthes products. The most appropriate code for the patient's clinical presentation must be selected. CPT® copyright 2019 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT®, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Sources

Calendar Year 2020 Medicare Outpatient Prospective Payment System, Final Rule [CMS-1717-FC], Federal Register, November 12, 2019 and its associated addenda. Medicare payment allowable rates shown above do not reflect the automatic payment cuts required under the sequestration process of the 2011 Budget Control Act. Calendar Year 2020 Medicare Physician Fee Schedule, Final Rule [CMS-1715-F]. Federal Register, November 15, 2019. No geographic adjustments have been made to the reported payment rates. Calendar Year 2020 Medicare Inpatient Final Rule, Final Rule [CMS-1716-F]. Federal Register, August 16, 2019. No geographic adjustments have been made to the reported payment rates. Final National Average DRG Payment.

Status Indicator (SI) Definitions

J1 - Hospital Part B services paid through a Comprehensive APC. **N** – Items and Services Packaged into APC Rates

Payment Indicator (PI) Definitions

A2 - Surgical procedure on ASC list in CY 2007, payment based on OPPS relative payment weight; **G2** - Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight; **J8** - Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate. **N1**- Packaged service/item; no separate payment made.

FOR ADDITIONAL QUESTIONS OR INFORMATION CONTACT

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