



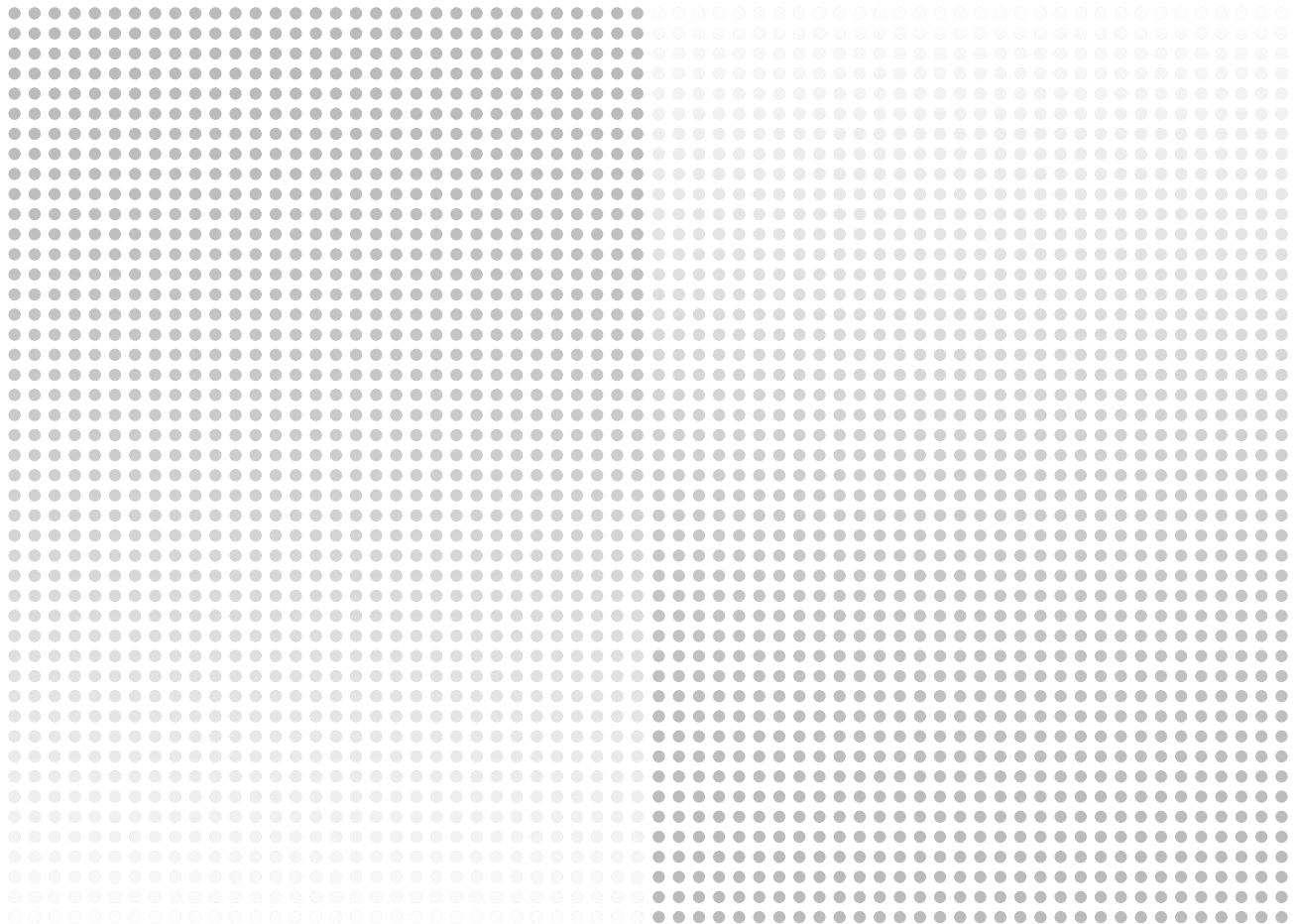
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# DEPUY SYNTHES

## 2021 ASC REIMBURSEMENT GUIDE

**Joint Reconstruction, Trauma & Extremities, Spine and Sports Medicine  
in the Ambulatory Surgery Center**



# Contents



This guide has been developed to assist in coding for the use of DePuy Synthes Joint Reconstruction, Trauma & Extremities, Spine and Sports Medicine products provided in the ambulatory surgery center (ASC) setting.

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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## ASC Facility and Physician Services

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Medicare reimburses Ambulatory Surgery Center (ASC) services under the Outpatient Prospective Payment System (OPPS), which bases payment on ASC Payment Groups. Physician payment is reimbursed under the Medicare Physician Fee Schedule (MPFS). Services are reported with Current Procedural Terminology (CPT®) codes.

# Joint Reconstruction

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# 04



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# Joint Reconstruction

## Procedure Codes for Knee Arthroplasty

| Procedure Codes for Knee Arthroplasty |  |    | Ambulatory Surgical Center                 | Physician   |
|---------------------------------------|--|----|--|---|
| CPT® Code                             | Description  | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 27441                                 | Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy   | G2 | \$5,896                                    | \$849   |
| 27442                                 | Arthroplasty, femoral condyles or tibial plateau(s) knee   | J8 | \$8,644                                    | \$897   |
| 27443                                 | Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy                                    | J8 | \$8,232                                    | \$842   |
| 27446                                 | Arthroplasty, knee, condyle and plateau; medial OR lateral compartment   | J8 | \$8,655                                    | \$1,187   |
| 27447                                 | Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) | J8 | \$8,774                                    | \$1,321   |

## Procedure Codes for Hip Arthroplasty

| Procedure Codes for Hip Arthroplasty |   |    | Ambulatory Surgical Center                 | Physician   |
|--------------------------------------|---|----|--|---|
| CPT® Code                            | Description   | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 27130                                | Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft | J8 | \$8,833                                    | \$1,322   |

## Procedure Codes for Shoulder Arthroplasty

| Procedure Codes for Shoulder Arthroplasty |   |    | Ambulatory Surgical Center                 | Physician   |
|---|---|----|--|---|
| CPT® Code                                 | Description   | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 23473                                     | Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component | J8 | \$8,578                                    | \$1,661   |

# Trauma & Extremities

# 06



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# Trauma & Extremities

## Procedure Codes for Elbow

| CPT® Code | Description   | PI | ASC  | Physician   |
|-----------|---|----|--|---|
|           |   |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 24164     | Removal of prosthesis, includes debridement and synovectomy when performed; radial head   | A2 | \$1,335                                    | \$743   |
| 24366     | Arthroplasty, radial head; with implant   | J8 | \$9,102                                    | \$703   |
| 24545     | Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension                                | J8 | \$8,308                                    | \$956   |
| 24579     | Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed  | J8 | \$7,765                                    | \$859   |
| 24586     | Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius)                                   | G2 | \$5,896                                    | \$1,119   |
| 24587     | Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius); with implant arthroplasty        | J8 | \$8,885                                    | \$1,120   |
| 24635     | Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed | J8 | \$4,074                                    | \$697   |
| 24665     | Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed  | A2 | \$2,944                                    | \$679   |
| 24666     | Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed; with radial head prosthetic replacement                   | J8 | \$9,137                                    | \$756   |
| 25240     | Excision distal ulna, partial or complete (eg, Darrach type or matched resection)   | A2 | \$1,335                                    | \$444   |
| 25515     | Open treatment of radial shaft fracture, includes internal fixation, when performed   | J8 | \$3,955                                    | \$691   |

|           |   |    | ASC  | Physician   |
|-----------|---|----|--|---|
| CPT® Code | Description   | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 25525     | Open treatment of radial shaft fracture, includes internal fixation, when performed, and closed treatment of distal radioulnar joint dislocation (Galeazzi fracture/ dislocation), includes percutaneous skeletal fixation, when performed  | J8 | \$3,876                                    | \$812   |
| 25526     | Open treatment of radial shaft fracture, includes internal fixation, when performed, and open treatment of distal radioulnar joint dislocation (Galeazzi fracture/ dislocation), includes internal fixation, when performed, includes repair of triangular fibrocartilage complex | A2 | \$2,944                                    | \$985   |
| 25574     | Open treatment of radial and ulnar shaft fractures; with internal fixation, when performed; of radius OR ulna   | J8 | \$4,196                                    | \$696   |
| 25575     | Open treatment of radial and ulnar shaft fractures, ; with internal fixation, when performed; of radius AND ulna  | J8 | \$4,095                                    | \$931   |

## Procedure Codes for Hand and Wrist

### Scaphoid Fracture

|           |  |    | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
| CPT® Code | Description  | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 25628     | Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed | A2 | \$2,944                                    | \$743   |

## Procedure Codes for Hand and Wrist

### DIP/PIP Fusion

|           |  |    | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
| CPT® Code | Description  | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 26860     | Arthrodesis, interphalangeal joint, with or without internal fixation  | A2 | \$1,335                                    | \$633   |
| 26861     | Arthrodesis, interphalangeal joint, with or without internal fixation; each additional interphalangeal joint (List separately in addition to code for primary procedure) | N1 | N/A  | \$105   |

|           |   |    | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
| CPT® Code | Description   | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 26862     | Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft)  | A2 | \$1,335                                    | \$794   |
| 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) | N1 | N/A  | \$232   |

## Procedure Codes for Hand and Wrist

### *Metacarpal Fracture*

|           |  |    | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
| CPT® Code | Description  | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 26615     | Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone | A2 | \$1,335                                    | \$595   |

## Procedure Codes for Hand and Wrist

### *For Bone Fusion*

|           |  |    | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
| CPT® Code | Description  | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 25800     | Arthrodesis, wrist; complete, without bone graft (includes radiocarpal and/or intercarpal and/or carpometacarpal joints) | J8 | \$4,024                                    | \$755   |
| 25810     | Arthrodesis, wrist; with iliac or other autograft (includes obtaining graft)   | J8 | \$8,342                                    | \$891   |
| 25825     | Arthrodesis, wrist; with autograft (includes obtaining graft)  | J8 | \$4,067                                    | \$815   |

## Procedure Codes for Hand and Wrist

### *Carpometacarpal, Metacarpal, Interphalangeal Fusion*

| CPT® Code | Description  | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 26841     | Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation   | A2 | \$2,944                                    | \$800   |
| 26842     | Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation; with autograft (includes obtaining graft)  | A2 | \$2,944                                    | \$864   |
| 26843     | Arthrodesis, carpometacarpal joint, digit, other than thumb, each  | J8 | \$3,986                                    | \$813   |
| 26844     | Arthrodesis, carpometacarpal joint, digit, other than thumb, each; with autograft (includes obtaining graft)   | J8 | \$4,570                                    | \$893   |
| 26850     | Arthrodesis, metacarpophalangeal joint, with or without internal fixation;   | A2 | \$2,944                                    | \$761   |
| 26852     | Arthrodesis, metacarpophalangeal joint, with or without internal fixation; with autograft (includes obtaining graft)   | A2 | \$2,944                                    | \$863   |
| 26861     | Arthrodesis, interphalangeal joint, with or without internal fixation; each additional interphalangeal joint (List separately in addition to code for primary procedure) | N1 | N/A  | \$105   |

## Procedure Codes for Hand and Wrist

### *Radial/Ulna Styloid Fractures*

| CPT® Code | Description  | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 25607     | Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation                        | J8 | \$4,221                                    | \$761   |
| 25608     | Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments         | J8 | \$4,213                                    | \$851   |
| 25609     | Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments | J8 | \$4,231                                    | \$1,081   |
| 25652     | Open treatment of ulnar styloid fracture   | J8 | \$3,827                                    | \$642   |

## Procedure Codes for Hand and Wrist

### Fracture

| CPT® Code | Description  | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 25431     | Repair of nonunion of carpal bone (excluding carpal scaphoid [navicular]) (includes obtaining graft and necessary fixation), each bone         | G2 | \$2,944                                    | \$813   |
| 25440     | Repair of nonunion, scaphoid carpal (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)   | A2 | \$2,944                                    | \$792   |
| 25606     | Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation  | A2 | \$1,335                                    | \$687   |
| 25607     | Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation                                      | J8 | \$4,221                                    | \$761   |
| 25608     | Open treatment of intraarticular distal radial fracture or epiphyseal separation with internal fixation of two fragments                       | J8 | \$4,213                                    | \$851   |
| 25609     | Open treatment of intraarticular distal radial fracture or epiphyseal separation with internal fixation of three or more fragments             | J8 | \$4,231                                    | \$1,081   |
| 25628     | Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed   | A2 | \$2,944                                    | \$743   |
| 25645     | Open treatment of carpal bone fracture (other than carpal scaphoid [navicular]), each bone   | A2 | \$1,335                                    | \$591   |
| 25652     | Open treatment of ulnar styloid fracture   | J8 | \$3,827                                    | \$642   |
| 26615     | Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone   | A2 | \$1,335                                    | \$341   |
| 26650     | Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation                            | A2 | \$1,335                                    | \$499   |
| 26665     | Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed                   | A2 | \$1,335                                    | \$646   |
| 26735     | Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each     | A2 | \$1,335                                    | \$614   |
| 26746     | Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each | A2 | \$1,335                                    | \$766   |

|           |   |    | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
| CPT® Code | Description   | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 26765     | Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each | A2 | \$1,335                                    | \$518   |
| 26785     | Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single         | A2 | \$1,335                                    | \$564   |
| 29847     | Arthroscopy, wrist, surgical; internal fixation for fracture or instability                                     | A2 | \$2,944                                    | \$562   |

## Procedure Codes for Hand and Wrist

### Other Procedures

|           |  |    | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
| CPT® Code | Description                            | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 26320     | Removal of implant from finger or hand | A2 | \$597                                      | \$361   |

## Procedure Codes for Humerus

|           |   |    | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
| CPT® Code | Description   | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 23615     | Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed | J8 | \$8,456                                    | \$911   |
| 23630     | Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed   | A2 | \$2,944                                    | \$804   |
| 24516     | Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws   | J8 | \$8,229                                    | \$886   |
| 24545     | Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension                          | J8 | \$8,308                                    | \$956   |

| CPT® Code | Description   | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
|           |   |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 24546     | Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension | J8 | \$10,972                                   | \$1,067   |
| 24575     | Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed                               | J8 | \$8,089                                    | \$754   |
| 24579     | Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed                                  | J8 | \$7,765                                    | \$859   |
| 24586     | Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius) | G2 | \$5,896                                    | \$1,119   |

## Procedure Codes for Radius

### Fracture

| CPT® Code | Description  | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 24665     | Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed                 | A2 | \$2,944                                    | \$679   |
| 25515     | Open treatment of radial shaft fracture, includes internal fixation, when performed  | J8 | \$3,955                                    | \$691   |
| 25574     | Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius OR ulna                      | J8 | \$4,196                                    | \$696   |
| 25575     | Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna                     | J8 | \$4,095                                    | \$931   |
| 25607     | Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation                          | J8 | \$4,221                                    | \$761   |
| 25608     | Open treatment of intraarticular distal radial fracture or epiphyseal separation with internal fixation of two fragments           | J8 | \$4,213                                    | \$851   |
| 25609     | Open treatment of intraarticular distal radial fracture or epiphyseal separation with internal fixation of three or more fragments | J8 | \$4,231                                    | \$1,081   |
| 25800     | Arthrodesis, wrist; complete, without bone graft (includes radiocarpal and/or intercarpal and/or carpometacarpal joints)           | J8 | \$4,024                                    | \$755   |

## Procedure Codes for Ulna

### Fracture

| CPT® Code | Description   | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
|           |   |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 24635     | Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed | J8 | \$4,074                                    | \$697   |
| 24685     | Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed  | J8 | \$3,891                                    | \$676   |
| 25545     | Open treatment of ulnar shaft fracture, includes internal fixation, when performed  | J8 | \$3,874                                    | \$644   |
| 25574     | Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius OR ulna   | J8 | \$4,196                                    | \$696   |
| 25575     | Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna  | J8 | \$4,095                                    | \$931   |
| 25652     | Open treatment of ulnar styloid fracture  | J8 | \$3,827                                    | \$642   |

## Procedure Codes for Clavicle

### Fracture

| CPT® Code | Description  | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 23120     | Claviculectomy; partial  | A2 | \$1,335                                    | \$606   |
| 23145     | Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with autograft (includes obtaining graft)                                   | A2 | \$1,335                                    | \$719   |
| 23180     | Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), clavicle   | A2 | \$2,944                                    | \$684   |
| 23480     | Osteotomy, clavicle, with or without internal fixation;  | A2 | \$2,944                                    | \$846   |
| 23485     | Osteotomy, clavicle, with or without internal fixation; with bone graft for non-union or malunion (includes obtaining graft and/or necessary fixation) | J8 | \$8,269                                    | \$978   |

| CPT® Code | Description  | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 23515     | Open treatment of clavicular fracture, includes internal fixation, when performed                                | J8 | \$4,038                                    | \$743   |
| 23550     | Open treatment of acromioclavicular dislocation, acute or chronic;   | A2 | \$2,944                                    | \$591   |
| 23552     | Open treatment of acromioclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft) | A2 | \$3,919                                    | \$676   |

## Procedure Codes for Forefoot

### Excision

| CPT® Code | Description  | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 28108     | Excision or curettage of bone cyst or benign tumor, phalanges of foot  | A2 | \$727                                      | \$292   |
| 28110     | Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)   | A2 | \$1,335                                    | \$295   |
| 28111     | Ostectomy, complete excision; first metatarsal head  | A2 | \$1,335                                    | \$329   |
| 28112     | Ostectomy, complete excision; other metatarsal head (second, third or fourth)  | A2 | \$1,335                                    | \$317   |
| 28113     | Ostectomy, complete excision; fifth metatarsal head  | A2 | \$1,335                                    | \$432   |
| 28114     | Ostectomy, complete excision; all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (eg, Clayton type procedure) | A2 | \$1,335                                    | \$852   |
| 28124     | Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe            | P3 | \$286                                      | \$338   |
| 28126     | Resection, partial or complete, phalangeal base, each toe  | A2 | \$1,335                                    | \$251   |
| 28140     | Metatarsectomy   | A2 | \$1,335                                    | \$441   |
| 28150     | Phalangectomy, toe, each toe   | A2 | \$1,335                                    | \$284   |
| 28153     | Resection, condyle(s), distal end of phalanx, each toe   | A2 | \$1,335                                    | \$269   |
| 28160     | Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each  | A2 | \$1,335                                    | \$271   |

| CPT® Code | Description                                | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 28173     | Radical resection of tumor; metatarsal     | A2 | \$1,335                                    | \$741   |
| 28175     | Radical resection of tumor; phalanx of toe | A2 | \$727                                      | \$478   |

## Procedure Codes for Forefoot

*Repair, Revision, and/or Reconstruction*

| CPT® Code | Description   | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
|           |   |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 28285     | Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)  | A2 | \$1,335                                    | \$388   |
| 28286     | Correction, cock-up fifth toe, with plastic skin closure (eg, Ruiz-Mora type procedure)   | A2 | \$1,335                                    | \$301   |
| 28288     | Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head  | A2 | \$1,335                                    | \$442   |
| 28289     | Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant                    | A2 | \$1,335                                    | \$467   |
| 28291     | Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant                       | J8 | \$4,441                                    | \$502   |
| 28292     | Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method      | A2 | \$1,335                                    | \$490   |
| 28295     | Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal metatarsal osteotomy, any method                           | G2 | \$1,335                                    | \$634   |
| 28296     | Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method                             | A2 | \$1,335                                    | \$521   |
| 28297     | Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method | J8 | \$4,300                                    | \$615   |

| CPT® Code | Description  | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 28298     | Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method                   | J8 | \$3,805                                    | \$510   |
| 28299     | Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method                             | A2 | \$2,944                                    | \$597   |
| 28306     | Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal                                       | A2 | \$2,944                                    | \$408   |
| 28307     | Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe) | A2 | \$2,944                                    | \$421   |
| 28308     | Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each                      | A2 | \$1,335                                    | \$392   |
| 28309     | Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)       | J8 | \$3,990                                    | \$909   |
| 28310     | Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)                                    | A2 | \$2,944                                    | \$368   |
| 28312     | Osteotomy, shortening, angular or rotational correction; other phalanges, any toe  | A2 | \$1,335                                    | \$328   |
| 28315     | Sesamoidectomy, first toe (separate procedure)   | A2 | \$1,335                                    | \$333   |
| 28322     | Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)  | J8 | \$4,090                                    | \$591   |
| 28340     | Reconstruction, toe, macrodactyly; soft tissue resection   | A2 | \$1,335                                    | \$416   |
| 28341     | Reconstruction, toe, macrodactyly; requiring bone resection  | A2 | \$1,335                                    | \$496   |
| 28344     | Reconstruction, toe(s); polydactyly  | A2 | \$1,335                                    | \$283   |
| 28345     | Reconstruction, toe(s); syndactyly, with or without skin graft(s), each web  | A2 | \$727                                      | \$368   |
| 28360     | Reconstruction, cleft foot   | G2 | \$2,944                                    | \$1,130   |

## Procedure Codes for Forefoot

### Fracture and/or Dislocation

| CPT® Code | Description  | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 27829     | Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed         | J8 | \$3,987                                    | \$732   |
| 28476     | Percutaneous skeletal fixation of metatarsal fracture, with manipulation, each   | A2 | \$1,335                                    | \$396   |
| 28485     | Open treatment of metatarsal fracture, includes internal fixation, when performed, each                                  | J8 | \$3,956                                    | \$574   |
| 28505     | Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed                  | A2 | \$1,335                                    | \$508   |
| 28525     | Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each | A2 | \$1,335                                    | \$413   |
| 28530     | Closed treatment of sesamoid fracture  | P3 | \$70                                       | \$102   |
| 28531     | Open treatment of sesamoid fracture, with or without internal fixation   | A2 | \$2,944                                    | \$184   |
| 28636     | Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation                               | A2 | \$1,335                                    | \$203   |
| 28645     | Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed                      | A2 | \$1,335                                    | \$496   |
| 28675     | Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed                          | A2 | \$1,335                                    | \$414   |

## Procedure Codes for Forefoot

### Arthrodesis

| CPT® Code | Description   | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
|           |   |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 28750     | Arthrodesis, great toe; metatarsophalangeal joint   | J8 | \$4,254                                    | \$1,249   |
| 28755     | Arthrodesis, great toe; interphalangeal joint   | A2 | \$2,944                                    | \$341   |
| 28760     | Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure) | A2 | \$2,944                                    | \$580   |

## Procedure Codes for Midfoot

### Excision

|           |   |    | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
| CPT® Code | Description   | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 28104     | Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus   | A2 | \$1,355                                    | \$441   |
| 28106     | Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with iliac or other autograft (includes obtaining graft)               | A2 | \$2,944                                    | \$434   |
| 28107     | Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with allograft   | J8 | \$4,082                                    | \$390   |
| 28116     | Osteotomy, excision of tarsal coalition   | A2 | \$1,335                                    | \$591   |
| 28122     | Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus | A2 | \$1,335                                    | \$446   |
| 28171     | Radical resection of tumor; tarsal (except talus or calcaneus)  | A2 | \$1,335                                    | \$1,140   |

## Procedure Codes for Midfoot

### Repair, Revision and/or Reconstruction

|           |   |    | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
| CPT® Code | Description   | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 28304     | Osteotomy, tarsal bones, other than calcaneus or talus  | A2 | \$2,944                                    | \$621   |
| 28305     | Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (eg, Fowler type) | J8 | \$4,226                                    | \$693   |
| 28320     | Repair, nonunion or malunion; tarsal bones  | J8 | \$8,638                                    | \$632   |

## Procedure Codes for Forefoot

### Fracture and/or Dislocation

| CPT® Code | Description   | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
|           |   |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 28450     | Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each                            | P2 | \$105                                      | \$196   |
| 28455     | Treatment of tarsal bone fracture (except talus and calcaneus); with manipulation, each                               | P3 | \$161                                      | \$265   |
| 28456     | Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus), with manipulation, each          | A2 | \$2,944                                    | \$373   |
| 28465     | Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each | J8 | \$3,888                                    | \$647   |
| 28546     | Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation                   | A2 | \$727                                      | \$360   |
| 28555     | Open treatment of tarsal bone dislocation, includes internal fixation, when performed                                 | J8 | \$3,899                                    | \$671   |
| 28606     | Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation                                | A2 | \$1,335                                    | \$390   |
| 28615     | Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed                       | J8 | \$4,024                                    | \$846   |

## Procedure Codes for Midfoot

### Arthrodesis

| CPT® Code | Description   | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
|           |   |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 28730     | Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse   | J8 | \$9,031                                    | \$753   |
| 28735     | Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)             | J8 | \$9,181                                    | \$799   |
| 28737     | Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure) | J8 | \$8,942                                    | \$699   |
| 28740     | Arthrodesis, midtarsal or tarsometatarsal, single joint   | J8 | \$4,412                                    | \$632   |

## Procedure Codes for Hindfoot

### Excision

|           |   |    | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
| CPT® Code | Description   | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 28100     | Excision or curettage of bone cyst or benign tumor, talus or calcaneus  | A2 | \$1,335                                    | \$427   |
| 28102     | Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with iliac or other autograft (includes obtaining graft)          | J8 | \$2,944                                    | \$630   |
| 28103     | Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with allograft  | J8 | \$4,165                                    | \$395   |
| 28118     | Ostectomy, calcaneus  | A2 | \$1,335                                    | \$428   |
| 28119     | Ostectomy, calcaneus; for spur, with or without plantar fascial release   | A2 | \$1,335                                    | \$368   |
| 28120     | Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus | A2 | \$1,335                                    | \$508   |
| 28130     | Talectomy (astragalectomy)  | A2 | \$2,944                                    | \$635   |
| 28300     | Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation  | J8 | \$4,146                                    | \$667   |
| 28302     | Osteotomy; talus  | A2 | \$2,944                                    | \$738   |

## Procedure Codes for Hindfoot

### Fracture and/or Dislocation

|           |   |    | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
| CPT® Code | Description   | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 27766     | Open treatment of medial malleolus fracture, includes internal fixation, when performed         | A2 | \$2,944                                    | \$625   |
| 27769     | Open treatment of posterior malleolus fracture, includes internal fixation, when performed      | G2 | \$2,944                                    | \$754   |
| 27784     | Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed | A2 | \$2,944                                    | \$728   |

| CPT® Code | Description   | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
|           |   |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 27792     | Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed   | J8 | \$3,928                                    | \$666   |
| 27814     | Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed | J8 | \$3,951                                    | \$789   |
| 27822     | Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip                                   | J8 | \$3,953                                    | \$903   |
| 27823     | Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip                                      | J8 | \$3,912                                    | \$1,017   |
| 28406     | Percutaneous skeletal fixation of calcaneal fracture, with manipulation   | A2 | \$2,944                                    | \$573   |
| 28415     | Open treatment of calcaneal fracture, includes internal fixation, when performed  | J8 | \$4,145                                    | \$1,156   |
| 28420     | Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)                                  | J8 | \$8,125                                    | \$1,337   |
| 28436     | Percutaneous skeletal fixation of talus fracture, with manipulation   | G2 | \$2,944                                    | \$504   |
| 28445     | Open treatment of talus fracture, includes internal fixation, when performed  | J8 | \$4,121                                    | \$1,054   |
| 28576     | Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation   | A2 | \$2,944                                    | \$398   |
| 28585     | Open treatment of talotarsal joint dislocation, includes internal fixation, when performed  | J8 | \$4,211                                    | \$701   |

## Procedure Codes for Hindfoot

### Arthrodesis

| CPT® Code | Description  | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 27870     | Arthrodesis, ankle, open   | J8 | \$8,712                                    | \$1,042   |
| 28705     | Arthrodesis; pantalar  | J8 | \$11,849                                   | \$1,249   |
| 28715     | Arthrodesis; triple  | J8 | \$8,992                                    | \$967   |
| 28725     | Arthrodesis; subtalar  | J8 | \$8508                                     | \$798   |
| 29899     | Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis | J8 | \$3,929                                    | \$1,051   |

## Procedure Codes for Foot and Ankle

### Other Procedures

| CPT® Code | Description  | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 27704     | Removal of ankle implant   | A2 | \$1,335                                    | \$588   |
| 20900     | Bone graft, any donor area; minor or small (eg, dowel or button) | A2 | \$2,944                                    | \$187   |

## Procedure Codes for Tibia

### Fracture

| CPT® Code | Description   | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
|           |   |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 27758     | Open treatment of tibial shaft fracture (with or without fibular fracture), with plate/screws, with or without cerclage                     | J8 | \$8,311                                    | \$923   |
| 27759     | Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or | J8 | \$8,106                                    | \$1,028   |
| 27792     | Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed                                   | J8 | \$3,928                                    | \$666   |

| CPT® Code | Description   | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
|           |   |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 27814     | Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed | J8 | \$3,951                                    | \$789   |
| 27822     | Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip                                   | J8 | \$3,953                                    | \$903   |
| 27823     | Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip                                      | J8 | \$3,912                                    | \$1,017   |
| 27826     | Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only                    | J8 | \$3,917                                    | \$881   |
| 27827     | Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only                     | J8 | \$8,376                                    | \$1,154   |
| 27828     | Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula          | J8 | \$8,320                                    | \$1,369   |
| 27829     | Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed  | J8 | \$3,987                                    | \$732   |

## Procedure Codes for External Fixation

Uniplane and Multiplane

| CPT® Code | Description  | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 20690     | Application of a uniplane (pins or wires in 1 plane), unilateral, external fixation system   | J8 | \$4,194                                    | \$613   |
| 20692     | Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type) | J8 | \$9,112                                    | \$1,148   |
| 20693     | Adjustment or revision of external fixation system requiring anesthesia (eg., new pin[s] or wire[s] and/or new ring[s] or bar[s])      | A2 | \$2,944                                    | \$455   |
| 20694     | Removal, under anesthesia, of external fixation system   | A2 | \$727                                      | \$348   |

# Spine

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# 26



|  |    |
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## Procedure Codes for Spinal Decompression

|           |  |    | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
| CPT® Code | Description  | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 62380     | Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar                           | G2 | \$2,944                                    | Carrier Priced  |
| 63001     | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; cervical                             | G2 | \$2,944                                    | \$1,270   |
| 63003     | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; thoracic                             | G2 | \$2,944                                    | \$1,272   |
| 63005     | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis | G2 | \$2,944                                    | \$1,232   |
| 63011     | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; sacral                               | G2 | \$2,944                                    | \$1,131   |
| 63012     | Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)   | G2 | \$2,944                                    | \$1,229   |
| 63015     | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; cervical                        | G2 | \$2,944                                    | \$1,523   |
| 63016     | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; thoracic                        | G2 | \$2,944                                    | \$1,569   |

| CPT® Code | Description  | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 63017     | Laminectomy with exploration and/or decompression of spinal cord and/ or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; lumbar   | G2 | \$2,944                                    | \$1,300   |
| 63020     | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical  | G2 | \$2,944                                    | \$1,195   |
| 63030     | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/ or excision of herniated intervertebral disc; 1 interspace, lumbar   | G2 | \$2,944                                    | \$1,005   |
| 63035     | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)                        | N1 | N/A  | \$197   |
| 63040     | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical  | G2 | \$2,944                                    | \$1,431   |
| 63042     | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/ or excision of herniated intervertebral disc, reexploration, single interspace; lumbar   | G2 | \$2,944                                    | \$1,334   |
| 63043     | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure) | N1 | N/A  | N/A   |

| CPT® Code | Description  | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 63044     | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure) | N1 | N/A  | N/A   |
| 63045     | Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical  | G2 | \$2,944                                    | \$1,326   |
| 63046     | Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic  | G2 | \$2,944                                    | \$1,266   |
| 63047     | Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar  | G2 | \$2,944                                    | \$1,139   |
| 63055     | Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic   | G2 | \$2,944                                    | \$1,675   |
| 63056     | Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)                                    | G2 | \$2,944                                    | \$1,536   |
| 63057     | Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)  | N1 | N/A  | \$329   |
| 63064     | Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; single segment   | G2 | \$2,944                                    | \$1,838   |

| CPT® Code | Description   | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
|           |   |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 63066     | Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; each additional segment (List separately in addition to code for primary procedure)   | N1 | N/A  | \$211   |
| 63075     | Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, single interspace  | G2 | \$2,944                                    | \$1,398   |
| 63076     | Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)   | N1 | N/A  | \$251   |
| 0274T     | Percutaneous laminotomy/ laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic                         | G2 | \$2,944                                    | Carrier Priced  |
| 0275T     | Percutaneous laminotomy/ laminectomy interlaminar approach) for decompression of neural elements (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar | J8 | \$3,941                                    | Restricted Coverage   |

## Procedure Codes for Thoracolumbar and Sacroiliac Joint Arthrodesis

Procedure codes for thoracolumbar arthrodesis through an anterior or lateral approach

| CPT® Code | Description  | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 22585     | Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure) | N1 | N/A  | \$335   |

## Procedure Codes for Thoracolumbar and Sacroiliac Joint Arthrodesis

Procedure codes for thoracolumbar arthrodesis through a posterior or posterolateral approach

| CPT® Code | Description  | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
|           |  |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 22612     | Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)   | J8 | \$8,628                                    | \$1,634   |
| 22614     | Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)                                    | N1 | N/A  | \$401   |
| 27279     | Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device | J8 | \$12,974                                   | \$888   |
| 22554     | Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2  | J8 | \$8,506                                    | \$1,296   |

## Procedure Codes for Disc Arthroplasty

| CPT® Code | Description   | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
|           |   |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 22856     | Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyctomy for nerve root or spinal cord decompression and microdissection), single interspace; cervical | J8 | \$11,871                                   | \$1,679   |

## Procedure Codes for Vertebral Augmentation

|           |  |    | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
| CPT® Code | Description  | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 22510     | Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic   | G2 | \$1,335                                    | \$439   |
| 22511     | Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral   | G2 | \$1,335                                    | \$413   |
| 22512     | Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)   | N1 | N/A  | \$210   |
| 22513     | Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic  | G2 | \$2,944                                    | \$523   |
| 22514     | Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar  | G2 | \$2,944                                    | \$489   |
| 22515     | Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure) | N1 | N/A  | \$224   |

## Procedure Codes for Halo Placement

|           |  |    | Ambulatory Surgical Center                 | Physician   |
|-----------|--|----|--|---|
| CPT® Code | Description  | PI | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 20650     | Insertion of wire or pin with application of skeletal traction, including removal (separate procedure) | A2 | \$1,335                                    | \$162   |
| 20665     | Removal of tongs or halo applied by another individual   | G2 | \$137                                      | \$97  |

# Implant Removal

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**Procedure Codes for Unspecified  
Removal of Implant**

|              |  |    | Ambulatory<br>Surgical Center                 | Physician   |
|--------------|--|----|---|---|
| CPT®<br>Code | Description  | PI | 2021 Medicare National<br>ASC Average Payment | 2021 Medicare National<br>Average Physician Payment<br>(Facility Setting) |
| 20670        | Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)     | A2 | \$597   | \$148   |
| 20680        | Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate) | A2 | \$1,000                                       | \$431   |

# Sports Medicine

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**36**



Shoulder

**37**

Knee

**38**

## Procedure Codes for Shoulder

| CPT® Code | Description   | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
|           |   |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 23410     | Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute                       | A2 | \$2,944                                    | \$845   |
| 23412     | Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic                     | A2 | \$2,944                                    | \$878   |
| 23420     | Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty) | A2 | \$2,944                                    | \$1,003   |
| 29827     | Arthroscopy, shoulder, surgical; with rotator cuff repair                                     | A2 | \$2,944                                    | \$1,101   |
| 23455     | Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)                          | A2 | \$2,944                                    | \$1,023   |
| 23460     | Capsulorrhaphy, anterior, any type; with bone block   | A2 | \$2,944                                    | \$1,123   |
| 29806     | Arthroscopy, shoulder, surgical; capsulorrhaphy   | A2 | \$2,944                                    | \$1,089   |
| 29807     | Arthroscopy, shoulder, surgical; repair of SLAP lesion  | A2 | \$2,944                                    | \$1,064   |
| 23462     | Capsulorrhaphy, anterior, any type; with coracoid process transfer                            | A2 | \$2,944                                    | \$1,099   |
| 23465     | Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block                     | G2 | \$2,944                                    | \$1,152   |
| 23466     | Capsulorrhaphy, glenohumeral joint, any type multi-directional instability                    | A2 | \$2,944                                    | \$1,150   |
| 23430     | Biceps tenodesis tenodesis of long tendon of biceps   | A2 | \$2,944                                    | \$767   |
| 29828     | Biceps tenodesis arthroscopy, shoulder, surgical; biceps tenodesis                            | G2 | \$2,944                                    | \$945   |
| 29805     | Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)       | A2 | \$1,335                                    | \$486   |
| 29819     | Arthroscopy, shoulder, surgical; with removal of loose body or foreign body                   | A2 | \$1,335                                    | \$607   |
| 29820     | Arthroscopy, shoulder, surgical; synovectomy, partial   | A2 | \$2,944                                    | \$556   |
| 29821     | Arthroscopy, shoulder, surgical; synovectomy, complete  | A2 | \$1,335                                    | \$614   |
| 29822     | Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures             | A2 | \$1,335                                    | \$559   |
| 29823     | Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures        | A2 | \$1,335                                    | \$612   |

## Procedure Codes for Knee

| CPT® Code | Description   | PI | Ambulatory Surgical Center                 | Physician   |
|-----------|---|----|--|---|
|           |   |    | 2021 Medicare National ASC Average Payment | 2021 Medicare National Average Physician Payment (Facility Setting) |
| 29888     | Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction   | J8 | \$4,045                                    | \$1,006   |
| 29889     | Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction  | J8 | \$8,080                                    | \$1,259   |
| 29880     | Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed | A2 | \$1,335                                    | \$580   |
| 29881     | Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed  | A2 | \$1,335                                    | \$560   |
| 29882     | Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)   | A2 | \$1,335                                    | \$712   |
| 29883     | Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)  | A2 | \$1,335                                    | \$864   |
| 29884     | Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)   | A2 | \$1,335                                    | \$639   |
| 27403     | Arthrotomy with meniscus repair, knee   | A2 | \$2,944                                    | \$666   |
| 29870     | Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)   | A2 | \$1,335                                    | \$420   |
| 29873     | Arthroscopy, knee, surgical; with lateral release   | A2 | \$1,335                                    | \$553   |
| 29874     | Arthroscopy, knee, surgical; for removal of loose body or foreign body  | A2 | \$1,335                                    | \$555   |
| 29875     | Arthroscopy, knee, surgical; synovectomy, limited (eg. Plica or shelf resection) (separate procedure)   | A2 | \$1,335                                    | \$513   |
| 29877     | Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)   | A2 | \$1,335                                    | \$641   |

# HCPCS Codes and Revenue Codes

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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. Additionally, many ambulatory surgery centers will also use C codes for internal tracking purposes. 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 trauma, spine, joint reconstruction and sports medicine procedures.

| 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). |
| C1776      | Joint device (implantable)  |
| C9399      | Unclassified drugs or biologicals   |

Revenue codes allow hospitals to categorize services provided by 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 services associated with radial head procedures are listed in the following table.

| HCPCS Code | Description                               |
|------------|---|
| 0270       | Medical/Surgical Supplies                 |
| 0271       | Medical/Surgical Supplies: Non-sterile    |
| 0272       | Medical/Surgical Supplies: Sterile        |
| 0278       | Medical/Surgical Supplies: Other Implants |

# Modifiers

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The modifiers outlined below may be used to report special circumstance during trauma, spine and joint reconstruction surgeries. This list includes some of the most common modifiers used in conjunction with these surgeries 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  |
|-----------|--|
| 52        | <p>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).</p>  |
| 58        | <p>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.</p>  |
| 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> |
| 73        | <p>Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia: Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.</p>  |
| 74        | <p>Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia: Due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.</p>   |

| Modifiers | Description  |
|-----------|--|
| 78        | Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Healthcare Professional Following Initial Procedure for a Related Procedure During the Postoperative Period: It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.) |
| 79        | Unrelated Procedure or Service by the Same Physician During the Postoperative Period: The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)  |
| 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 2021 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 2021 Medicare Outpatient Prospective Payment System, Final Rule [CMS-1736-FC], Federal Register, December 2, 2020 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 2021 Medicare Physician Fee Schedule, Final Rule [CMS-1734-F]. Federal Register, December 02, 2020. No geographic adjustments have been made to the reported payment rates. Calendar Year 2021 Medicare Inpatient Final Rule, Final Rule [CMS-1735-F] and [CMS-1735-CN]. Federal Register, September 02, 2020 and December 01, 2020. No geographic adjustments have been made to the reported payment rates. Final National Average DRG Payment.

## 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. P2 - Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on OPPS relative payment weight.

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