

DePuy Synthes 2021 Joint Reconstruction Reimbursement Guide

Physician and Facility

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This guide has been developed to assist physicians and facilities in coding for the use of the DePuy Synthes Joint Reconstruction 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 clavicle repair procedures are indicated below.

Knee
Hip
Shoulder
Pre-Operative Scans

Procedure Codes for Knee

CPT® Code	Description	2021 Total RVUs	2021 Medicare National Average Payment
27440	Arthroplasty, knee, tibial plateau	23.59	\$823
27441	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy	24.34	\$849
27442	Arthroplasty, femoral condyles or tibial plateau(s) knee	25.72	\$897
27443	Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy	24.13	\$842
27445	Arthroplasty, knee, hinge prosthesis (e.g. Walldius type)	37.00	\$1,291
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	34.03	\$1,187
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	37.85	\$1,321
27486	Revision of total knee arthroplasty, with or without allograft, 1 component	41.41	\$1,445
27487	Revision of total knee arthroplasty, with or without allograft; femoral or entire tibial component	51.67	\$1,803
27488	Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of space, knee	35.39	\$1,235

Procedure Codes for Hip

CPT® Code	Description	2021 Total RVUs	2021 Medicare National Average Payment
27120	Acetabuloplasty; (e.g, whitman, Colonna, haygroves or cup type)	38.31	\$1,337
27125	Hemiarthroplasty, hip, partial (e.g, femoral stem prosthesis, bipolar arthroplasty)	33.37	\$1,164
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	37.90	\$1,322
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	49.24	\$1,718
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	56.15	\$1,959
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	43.22	\$1,508
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	44.90	\$1,567
27090	Removal of hip prosthesis; (separate procedure)	24.48	\$854
27091	Removal of hip prosthesis; complicated, including total hip prosthesis, methylmethacrylate with or without insertion of spacer	46.92	\$1,637

Procedure Codes for Shoulder

CPT® Code	Description	2021 Total RVUs	2021 Medicare National Average Payment
23470	Arthroplasty, glenohumeral joint, hemiarthroplasty	35.39	\$1,235
23472	Arthroplasty, glenohumeral joint; total shoulder (glenohumeral and proximal humeral replacement (e.g. total shoulder))	42.67	\$1,489
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	47.60	\$1,661
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	51.32	\$1,791

Procedure Codes for Pre-Operative Scans

CPT® Code	Description	2021 Total RVUs	2021 Medicare National Average Payment
73200	Computer tomography, upper extremity; without contrast material	1.41	\$49
73221	Magnetic resonance (e.g. proton) imaging, any joint of upper extremity; without contrast material(s)	1.92	\$67

CPT® Code	Description	2021 Total RVUs	2021 Medicare National Average Payment
73502	Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views	0.32	\$11
73552	Radiologic examination, femur; minimum 2 views	0.26	\$9
73590	Radiological examination; tibia and fibula, 2 views	0.23	\$8
73700	Computer tomography, lower extremity; without contrast material	1.41	\$49
73721	Magnetic resonance (e.g. proton) imaging, any joint of lower extremity; without contrast material(s)	1.91	\$67
76376	3D rendering with interpretation and reporting of computer tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation	0.28	\$10
76377	3D rendering with interpretation and reporting of computer tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation	1.12	\$39
0561T	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide	NA	NA
0562T	Anatomic guide 3D0printed and designed from image data set(s); each additional anatomic guide	NA	NA

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 the following procedural groups are listed below:

Knee
Hip
Shoulder

Procedure Codes for Knee

CPT® Code	Description	Hospital Outpatient			Ambulatory Surgical Center	
		SI	APC	2021 Medicare National Average Payment	PI	2021 Medicare National Average Payment
27440	Revision of knee joint	J1	5115	\$12,315	J8	\$8,090
27441	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy	J1	5115	\$12,315	G2	\$5,896
27442	Arthroplasty, femoral condyles or tibial plateau(s) knee	J1	5115	\$12,315	J8	\$8,644
27443	Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy	J1	5115	\$12,315	J8	\$8,232
27445	Arthroplasty, knee, hinge prosthesis (e.g. Walldius type)	J1	5115	\$12,315	N/A	–
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	J1	5115	\$12,315	J8	\$8,655
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	J1	5115	\$12,315	J8	\$8,774

Procedure Codes for Hip

CPT® Code	Description	Hospital Outpatient			Ambulatory Surgical Center	
		SI	APC	2021 Medicare National Average Payment	PI	2021 Medicare National Average Payment
27125	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)	J1	5115	\$12,315	?	xxxxxx
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	J1	5115	\$12,315	J8	\$8,833
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	J1	5115	\$12,315	N/A	Excluded from payment in the ASC
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	J1	5115	\$12,315	N/A	Excluded from payment in the ASC
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	J1	5115	\$12,315	N/A	Excluded from payment in the ASC
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	J1	5115	\$12,315	N/A	Excluded from payment in the ASC

Procedure Codes for Shoulder

CPT® Code	Description	Hospital Outpatient			Ambulatory Surgical Center	
		SI	APC	2021 Medicare National Average Payment	PI	2021 Medicare National Average Payment
23470	Arthroplasty, glenohumeral joint, hemiarthroplasty	J1	5115	\$12,315	J8	\$8,932
23472	Arthroplasty, glenohumeral joint; total shoulder (glenohumeral and proximal humeral replacement (e.g. total shoulder))	J1	5115	\$12,315	N/A	Excluded from payment in the ASC
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	J1	5115	\$12,315	J8	\$8,578

Procedure Codes for Pre-Operative Scans*

CPT® Code	Description	Hospital Outpatient			Ambulatory Surgical Center	
		SI	APC	2021 Medicare National Average Payment	PI	2021 Medicare National Average Payment
73200	Computer tomography, upper extremity; without contrast material	Q3	5522	\$109	Z2	\$55
73221	Magnetic resonance (e.g. proton) imaging, any joint of upper extremity; without contrast material(s)	Q3	5523	\$230	Z2	\$117
73502	Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views	Q1	5521	\$81	N1	N/A
73552	Radiologic examination, femur; minimum 2 views	Q1	5521	\$81	N1	N/A
73590	Radiological examination; tibia and fibula, 2 views	Q1	5521	\$81	N1	N/A
73700	Computer tomography, lower extremity; without contrast material	Q3	5522	\$109	Z2	\$55
73721	Magnetic resonance (e.g. proton) imaging, any joint of lower extremity; without contrast material(s)	Q3	5523	\$230	Z2	\$117
76376	3D rendering with interpretation and reporting of computer tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation	N	–	N/A	N1	N/A
76377	3D rendering with interpretation and reporting of computer tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation	N	–	N/A	N1	N/A
0561T	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide	Q1	5733	\$56	N/A	N/A
0562T	Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide	N	–	N/A	N/A	N/A
23470	Arthroplasty, glenohumeral joint, hemiarthroplasty	J1	5115	\$12,315	J8	\$8,932

*NOTE: Coverage will vary by payer for pre-operative MRI or CT total knee arthroplasty (TKA), total hip arthroplasty (THA), unicompartmental knee replacement (UKR) or reverse shoulder arthroplasty (RSA). Providers should contact payers directly to clarify coverage policies and prior authorization requirements.

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 the following procedures are provided below:

Knee
Hip
Shoulder

MS-DRG	Description	Medicare National Average Payment*
461	Bilateral Or Multiple Major Joint Procedures of Lower Extremity with MCC	\$39,055
462	Bilateral or Multiple Major Joint Procedures of Lower Extremity without MCC	\$20,209
466	Revision Of Hip Or Knee Replacement with MCC	\$34,355
467	Revision Of Hip Or Knee Replacement with CC	\$22,986
468	Revision Of Hip Or Knee Replacement Without CC/MCC	\$18,023
469	Major Hip and Knee Replacement Or Reattachment Of Lower Extremity with MCC Or Total Ankle Replacement	\$19,825
470	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity without MCC	\$12,212
485	Knee Procedures With PFX Of Infection with MCC	\$21,902
486	Knee Procedures With PDX Of Infection with CC	\$13,809
487	Knee Procedures With PFX Of Infection without CC/MCC	\$10,543
488	Knee Procedures Without PDX Of Infection with CC/MCC	\$12,692
489	Knee Procedures Without PDX Of Infection without CC/MCC	\$8,344

MS-DRGs for Hip

MS-DRG	Description	Medicare National Average Payment*
461	Bilateral Or Multiple Major Joint Procedures of Lower Extremity with MCC	\$39,055
462	Bilateral or Multiple Major Joint Procedures of Lower Extremity without MCC	\$20,209
466	Revision Of Hip Or Knee Replacement with MCC	\$34,355
467	Revision Of Hip Or Knee Replacement with CC	\$22,986

MS-DRGs for Hip

MS-DRG	Description	Medicare National Average Payment*
468	Revision Of Hip Or Knee Replacement Without CC/MCC	\$18,022
469	Major Hip and Knee Replacement Or Reattachment Of Lower Extremity with MCC Or Total Ankle Re-placement	\$19,825
470	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity without MCC	\$12,212
New		
521	Hip Replacement with Principal Diagnosis Of Hip Fracture with MCC	\$19,690
522	Hip Replacement with Principal Diagnosis Of Hip Fracture without CC/MCC	\$14,070

MS-DRGs for Shoulder

MS-DRG	Description	Medicare National Average Payment*
483	Major Joint & Limb Reattachment Procedure of Upper Extremity with CC/MCC	\$15,338
515	Other Musculoskeletal System and Connective Tissue O.R. Procedure with MCC	\$20,163
516	Other Musculoskeletal System and Connective Tissue O.R. Procedure with CC	\$12,605
517	Other Musculoskeletal System and Connective Tissue O.R. Procedure without CC/ MCC	\$8,977

*MCC=Major Complications or Comorbidities

**CC=Complications or Comorbidities

*October 1, 2020-September 30, 2021

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 Knee, Hip and Shoulder joint reconstruction procedures. Please determine the appropriate ICD-10-PCS code section based on the general descriptions below, select the characters below that best describe the procedure. The first three characters outline the section, body system and operation. Once you have identified the section, the code can be coded to greater specificity by choosing the most appropriate body part, approach, device and qualifier.

ICD-10-PCS Procedure Codes for Knee

Replacement			
∅ Medical and Surgical S Lower Joints R Replacement			
Body Part	Approach	Device	Qualifier
C Knee Joint, Right D Knee Joint, Left	∅ Open	6 Synthetic Substitute, Oxidized Zirconium on Polyethylene E Articulating Spacer J Synthetic Substitute L Synthetic Substitute, Unicondylar Medial M Synthetic Substitute, Unicondylar Lateral N Synthetic Substitute, Patellofemoral	9 Cemented A Uncemented Z No Qualifier
T Knee Joint, Femoral Surface, Right U Knee Joint, Femoral Surface, Left V Knee Joint, Tibial Surface, Right W Knee Joint, Tibial Surface, Left	∅ Open	J Synthetic Substitute	9 Cemented A Uncemented Z No Qualifier
Revision			
∅ Medical and Surgical S Lower Joints R Replacement			
C Knee Joint, Right D Knee Joint, Left	∅ Open 3 Percutaneous 4 Percutaneous, Endoscopic	J Synthetic Substitute	Z No Qualifier

ICD-10-PCS Procedure Codes for Knee

Removal			
Ø Medical and Surgical S Lower Joints R Replacement			
Body Part	Approach	Device	Qualifier
C Knee Joint, Right D Knee Joint, Left	Ø Open 3 Percutaneous 4 Percutaneous, Endoscopic	8 Spacer 9 Liner E Articulating Spacer J Synthetic Substitute L Synthetic Substitute, Unicondylar Medial M Synthetic Substitute, Unicondylar Lateral N Synthetic Substitute, Patellofemoral	C Patellar Surface Z No Qualifier
T Knee Joint, Femoral Surface, Right U Knee Joint, Femoral Surface, Left V Knee Joint, Tibial Surface, Right W Knee Joint, Tibial Surface, Left	Ø Open 3 Percutaneous 4 Percutaneous, Endoscopic	J Synthetic Substitute	Z No Qualifier

ICD-10-PCS Procedure Codes for Hip

Replacement			
Ø Medical and Surgical S Lower Joints R Replacement			
Body Part	Approach	Device	Qualifier
9 Hip Joint, Right B Hip Joint, Left	Ø Open	1 Synthetic Substitute, Metal 2 Synthetic Substitute, Metal on Polyethylene 3 Synthetic Substitute, Ceramic 4 Synthetic Substitute, Ceramic on Polyethylene 6 Synthetic Substitute, Oxidized Zirconium on Polyethylene E Articulating Spacer J Synthetic Substitute	9 Cemented A Uncemented Z No Qualifier
A Hip Joint, Acetabular Surface, Right E Hip Joint, Acetabular Surface, Left R Hip Joint, Femoral Surface, Right S Hip Joint, Femoral Surface, Left	Ø Open	Ø Synthetic Substitute, Polyethylene 1 Synthetic Substitute, Metal 3 Synthetic Substitute, Ceramic J Synthetic Substitute	9 Cemented A Uncemented Z No Qualifier

Revision			
Ø Medical and Surgical S Lower Joints R Replacement			
Body Part	Approach	Device	Qualifier
9 Hip Joint, Right B Hip Joint, Left	Ø Open 3 Percutaneous 4 Percutaneous, Endoscopic	8 Spacer 9 Liner E Resurfacing Device J Synthetic Substitute	Z No Qualifier
A Hip Joint, Acetabular Surface, Right E Hip Joint, Acetabular Surface, Left R Hip Joint, Femoral Surface, Right S Hip Joint, Femoral Surface, Left	Ø Open 3 Percutaneous 4 Percutaneous, Endoscopic	J Synthetic Substitute	Z No Qualifier

ICD-10-PCS Procedure Codes for Shoulder

Replacement			
∅ Medical and Surgical S Lower Joints R Replacement			
Body Part	Approach	Device	Qualifier
J Shoulder, Right K Shoulder, Left	∅ Open	J Synthetic Substitute	6 Humeral Surface 7 Glenoid Surface Z No Qualifier
J Shoulder, Right K Shoulder, Left	∅ Open	∅ Synthetic Substitute, Reverse Ball and Socket	Z No Qualifier
E Sternoclavicular Joint, Right F Sternoclavicular Joint, Left G Acromioclavicular Joint, Right H Acromioclavicular Joint, Left	∅ Open	J Synthetic Substitute	Z No Qualifier
Revision			
∅ Medical and Surgical S Lower Joints R Replacement			
J Shoulder, Right K Shoulder, Left	∅ Open 3 Percutaneous 4 Percutaneous, Endoscopic	8 Spacer J Synthetic Substitute	Z No Qualifier
E Sternoclavicular Joint, Right F Sternoclavicular Joint, Left G Acromioclavicular Joint, Right H Acromioclavicular Joint, Left	∅ Open 3 Percutaneous 4 Percutaneous, Endoscopic	8 Spacer J Synthetic Substitute	Z No Qualifier
Removal			
∅ Medical and Surgical S Lower Joints R Replacement			
J Shoulder, Right K Shoulder, Left	∅ Open	J Synthetic Substitute	Z No Qualifier
E Sternoclavicular Joint, Right F Sternoclavicular Joint, Left G Acromioclavicular Joint, Right H Acromioclavicular Joint, Left	∅ Open	J Synthetic Substitute	Z No Qualifier

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 for the following procedural groups:

Diagnosis Codes for Knee

ICD-10-CM	Description
M17.0	Bilateral primary osteoarthritis of knee
M17.10	Unilateral primary osteoarthritis, unspecified knee
M17.11	Unilateral primary osteoarthritis, right knee
M17.12	Unilateral primary osteoarthritis, left knee
M17.2	Bilateral post-traumatic osteoarthritis of knee
M17.30	Unilateral post-traumatic osteoarthritis, unspecified knee
M17.31	Unilateral post-traumatic osteoarthritis, right knee
M17.32	Unilateral post-traumatic osteoarthritis, left knee
M17.4	Other bilateral secondary osteoarthritis of knee
M17.5	Other unilateral secondary osteoarthritis of knee
M17.9	Osteoarthritis of knee, unspecified
M87.051	Idiopathic aseptic necrosis of right femur
M87.052	Idiopathic aseptic necrosis of left femur
M87.061	Idiopathic aseptic necrosis of right tibia
M87.062	Idiopathic aseptic necrosis of left tibia
M87.151	Osteonecrosis due to drugs, right femur
M87.152	Osteonecrosis due to drugs, left femur
M87.161	Osteonecrosis due to drugs, right tibia
M87.162	Osteonecrosis due to drugs, left tibia
M87.251	Osteonecrosis due to previous trauma, right femur
M87.252	Osteonecrosis due to previous trauma, left femur
M87.261	Osteonecrosis due to previous trauma, right tibia
M87.262	Osteonecrosis due to previous trauma, left tibia
M87.361	Other secondary osteonecrosis, right tibia

Diagnosis Codes for Knee

ICD-10-CM	Description
M87.362	Other secondary osteonecrosis, left tibia
Z47.1	Aftercare following joint replacement
Z47.33	Aftercare following explantation of knee joint prosthesis
Z96.651	Presence of right artificial knee joint
Z96.652	Presence of left artificial knee joint
Z96.653	Presence of artificial knee joint, bilateral
Z47.33	Aftercare following explantation of knee joint prosthesis
M05.061	Felty's syndrome, right knee
M05.062	Felty's syndrome, left knee
M05.069	Felty's syndrome, unspecified knee
M05.161	Rheumatoid lung disease with rheumatoid arthritis of right knee
M05.162	Rheumatoid lung disease with rheumatoid arthritis of left knee
M05.169	Rheumatoid lung disease with rheumatoid arthritis of unspecified knee
M05.261	Rheumatoid vasculitis with rheumatoid arthritis of right knee
M05.262	Rheumatoid vasculitis with rheumatoid arthritis of left knee
M05.269	Rheumatoid vasculitis with rheumatoid arthritis of unspecified knee
M05.361	Rheumatoid heart disease with rheumatoid arthritis of right knee
M05.362	Rheumatoid heart disease with rheumatoid arthritis of left knee
M05.369	Rheumatoid heart disease with rheumatoid arthritis of unspecified knee
M05.461	Rheumatoid myopathy with rheumatoid arthritis of right knee
M05.462	Rheumatoid myopathy with rheumatoid arthritis of left knee
M05.469	Rheumatoid myopathy with rheumatoid arthritis of unspecified knee
M05.561	Rheumatoid polyneuropathy with rheumatoid arthritis of right knee
M05.562	Rheumatoid polyneuropathy with rheumatoid arthritis of left knee
M05.569	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified knee
M05.661	Rheumatoid arthritis of right knee with involvement of other organs and systems
M05.662	Rheumatoid arthritis of left knee with involvement of other organs and systems
M05.669	Rheumatoid arthritis of unspecified knee with involvement of other organs and systems
M00.061	Staphylococcal arthritis, right knee
M00.062	Staphylococcal arthritis, left knee
M00.069	Staphylococcal arthritis, unspecified knee
M00.161	Pneumococcal arthritis, right knee
M00.162	Pneumococcal arthritis, left knee
M00.169	Pneumococcal arthritis, unspecified knee
M00.261	Other streptococcal arthritis, right knee
M00.262	Other streptococcal arthritis, left knee
M00.269	Other streptococcal arthritis, unspecified knee
M00.861	Arthritis due to other bacteria, right knee

Diagnosis Codes for Knee

ICD-10-CM	Description
M00.86	Arthritis due to other bacteria, left knee
M00.869	Arthritis due to other bacteria, unspecified knee
M21.161	Varus deformity, not elsewhere classified, right knee
M21.162	Varus deformity, not elsewhere classified, left knee
M21.169	Varus deformity, not elsewhere classified, unspecified knee
M21.061	Valgus deformity, not elsewhere classified, right knee
M21.062	Valgus deformity, not elsewhere classified, left knee
M21.069	Valgus deformity, not elsewhere classified, unspecified knee
M21.261	Flexion deformity, right knee
M21.262	Flexion deformity, left knee
M21.269	Flexion deformity, unspecified knee
M21.869	Other specified acquired deformities of unspecified lower leg
M23.40	Loose body in unspecified knee
M23.41	Loose body in right knee
M23.42	Loose body in left knee
M23.50	Chronic instability of unspecified knee
M23.51	Chronic instability of knee right knee
M23.52	Chronic instability of left knee
M21.861	Other specified acquired deformities of right lower leg
M21.862	Other specified acquired deformities of left lower leg
M22.10	Recurrent subluxation of patella unspecified knee
M22.11	Recurrent subluxation of patella right knee
M22.12	Recurrent subluxation of patella left knee Synovial cyst of popliteal space [Baker]
M71.20	Synovial cyst of popliteal space [Baker] specified knee
M71.21	Synovial cyst of popliteal space [Baker]right knee
M71.22	Synovial cyst of popliteal space [Baker] left knee
M25.561	Pain in right knee
M25.562	Pain in left knee
M25.569	Pain in unspecified knee
M25.661	Stiffness of right knee, not elsewhere classified
M25.662	Stiffness of left knee, not elsewhere classified
M25.669	Stiffness of unspecified knee, not elsewhere classified
M24.561	Contracture, right knee
M24.562	Contracture, left knee
T81.31	Disruption of external operation (surgical) wound, not elsewhere classified
T81.31XA	Disruption of external operation (surgical) wound initial encounter
T81.31XD	Disruption of external operation (surgical) wound subsequent encounter
T81.31XS	Disruption of external operation (surgical) wound, sequela
T81.32	Disruption of internal operation (surgical) wound, not elsewhere classified

Diagnosis Codes for Knee

ICD-10-CM	Description
T81.32XA	Disruption of internal operation (surgical) wound, initial encounter
T81.32XD	Subsequent encounter
T81.32XS	Disruption of internal operation (surgical) wound, sequela
T84.012A	Broken internal right knee prosthesis initial encounter
T84.012D	Broken internal right knee prosthesis initial encounter subsequent encounter
T84.012S	Broken internal right knee prosthesis initial encounter sequela
T84.013	Broken internal left knee prosthesis
T84.013A	Broken internal left knee prosthesis initial encounter
T84.013D	Broken internal left knee prosthesis subsequent encounter
T84.013S	Broken internal left knee prosthesis sequela
T84.022A	Instability of internal right knee prosthesis initial encounter
T84.022D	Instability of internal right knee prosthesis subsequent encounter
T84.022S	Instability of internal right knee prosthesis sequela
T84.032A	Mechanical loosening of internal right knee prosthetic joint initial encounter
T84.032D	Mechanical loosening of internal right knee prosthetic joint subsequent encounter
T84.032S	Mechanical loosening of internal right knee prosthetic joint sequela
T84.033A	Mechanical loosening of internal left knee prosthetic joint initial encounter
T84.033D	Mechanical loosening of internal left knee prosthetic joint subsequent encounter
T84.033S	Mechanical loosening of internal left knee prosthetic joint sequela
T84.052	Periprosthetic osteolysis of internal prosthetic right knee joint
T84.052A	Periprosthetic osteolysis of internal prosthetic right knee joint initial encounter
T84.052D	Periprosthetic osteolysis of internal prosthetic right knee joint subsequent encounter
T84.052S	Periprosthetic osteolysis of internal prosthetic right knee joint sequela
T84.053A	Periprosthetic osteolysis of internal prosthetic left knee joint initial encounter
T84.053D	Periprosthetic osteolysis of internal prosthetic left knee joint subsequent encounter
T84.053S	Periprosthetic osteolysis of internal prosthetic left knee joint sequela
T84.062A	Wear of articular bearing surface of internal prosthetic right knee joint initial encounter
T84.062D	Wear of articular bearing surface of internal prosthetic right knee joint subsequent encounter
T84.062S	Wear of articular bearing surface of internal prosthetic right knee joint sequela
T56.2X1A	Toxic effect of chromium and its compounds, accidental (unintentional) initial encounter
T56.2X1D	Toxic effect of chromium and its compounds, accidental (unintentional) subsequent encounter
T56.2X1S	Toxic effect of chromium and its compounds, accidental (unintentional)sequela
T56.91XA	Toxic effect of unspecified metal, accidental (unintentional) initial encounter
T56.91XD	Toxic effect of unspecified metal, accidental (unintentional) subsequent encounter
T56.91XS	Toxic effect of unspecified metal, accidental (unintentional) sequela

Diagnosis Codes for Knee

ICD-10-CM	Description
M16.10	Unilateral primary osteoarthritis, unspecified hip
M16.11	Unilateral primary osteoarthritis, right hip
M16.12	Unilateral primary osteoarthritis, left hip
M16.2	Bilateral osteoarthritis resulting from hip dysplasia
M16.3	Unilateral osteoarthritis resulting from hip dysplasia
M16.30	Unilateral osteoarthritis resulting from hip dysplasia, unspecified hip
M16.31	Unilateral osteoarthritis resulting from hip dysplasia, right hip
M16.32	Unilateral osteoarthritis resulting from hip dysplasia, left hip
M16.4	Bilateral post-traumatic osteoarthritis of hip
M16.50	Unilateral post-traumatic osteoarthritis, unspecified hip
M16.51	Unilateral post-traumatic osteoarthritis, right hip
M16.52	Unilateral post-traumatic osteoarthritis, left hip
M16.6	Other bilateral secondary osteoarthritis of hip
M16.7	Other unilateral secondary osteoarthritis of hip
M16.9	Osteoarthritis of hip, unspecified
M87.051	Idiopathic aseptic necrosis of right femur
M87.052	Idiopathic aseptic necrosis of left femur
M87.059	Idiopathic aseptic necrosis of unspecified femur
M87.151	Osteonecrosis due to drugs, right femur
M87.152	Osteonecrosis due to drugs, left femur
M87.159	Osteonecrosis due to drugs, unspecified femur
M87.351	Other secondary osteonecrosis, right femur
M87.352	Other secondary osteonecrosis, left femur
M87.353	Other secondary osteonecrosis, unspecified femur
M05.051	Felty's syndrome, right hip
M05.052	Felty's syndrome, left hip
M05.059	Felty's syndrome, unspecified hip
M05.151	Rheumatoid lung disease with rheumatoid arthritis of right hip
M05.152	Rheumatoid lung disease with rheumatoid arthritis of left hip
M05.159	Rheumatoid lung disease with rheumatoid arthritis of unspecified hip
M05.251	Rheumatoid vasculitis with rheumatoid arthritis of right hip
M05.252	Rheumatoid vasculitis with rheumatoid arthritis of left hip
M05.259	Rheumatoid vasculitis with rheumatoid arthritis of unspecified hip
M05.351	Rheumatoid heart disease with rheumatoid arthritis of right hip
M05.352	Rheumatoid heart disease with rheumatoid arthritis of left hip
M05.359	Rheumatoid heart disease with rheumatoid arthritis of unspecified hip
M05.451	Rheumatoid myopathy with rheumatoid arthritis of right hip
M05.452	Rheumatoid myopathy with rheumatoid arthritis of left hip
M05.459	Rheumatoid myopathy with rheumatoid arthritis of unspecified hip

Diagnosis Codes for Hip

ICD-10-CM	Description
M05.551	Rheumatoid polyneuropathy with rheumatoid arthritis of right hip
M05.552	Rheumatoid polyneuropathy with rheumatoid arthritis of left hip
M05.559	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified hip
M05.651	Rheumatoid arthritis of right hip with involvement of other organs and systems
M05.652	Rheumatoid arthritis of left hip with involvement of other organs and systems
M05.659	Rheumatoid arthritis of unspecified hip with involvement of other organs and systems
M00.259	Other streptococcal arthritis, unspecified hip
M00.851	Arthritis due to other bacteria, right hip
M00.852	Arthritis due to other bacteria, left hip
M00.859	Arthritis due to other bacteria, unspecified hip
Q65.00	Congenital dislocation of unspecified hip, unilateral
Q65.01	Congenital dislocation of right hip, unilateral
Q65.02	Congenital dislocation of left hip, unilateral
Q65.1	Congenital dislocation of hip, bilateral
Q65.30	Congenital partial dislocation of unspecified hip, unilateral
Q65.31	Congenital partial dislocation of right hip, unilateral
Q65.32	Congenital partial dislocation of left hip, unilateral
Q65.4	Congenital partial dislocation of hip, bilateral
Q65.81	Congenital coxa valga
Q65.82	Congenital coxa vara
Q65.89	Other specified congenital deformities of hip
M24.7	Protrusio acetabuli
M25.551	Pain in right hip
M25.552	Pain in left hip
M25.559	Pain in unspecified hip
M25.651	Stiffness of right hip, not elsewhere classified
M25.652	Stiffness of left hip, not elsewhere classified
M25.659	Stiffness of unspecified hip, not elsewhere classified
M25.751	Osteophyte, right hip
M25.752	Osteophyte, left hip
M25.759	Osteophyte, unspecified hip
M24.551	Contracture, right hip
M24.552	Contracture, left hip
M24.559	Contracture, unspecified hip
M24.651	Ankylosis, right hip
M24.652	Ankylosis, left hip
M24.659	Ankylosis, unspecified hip
M24.451	Recurrent dislocation, right hip
M24.452	Recurrent dislocation, left hip
M24.459	Recurrent dislocation, unspecified hip

Diagnosis Codes for Hip

ICD-10-CM	Description
M21.751	Unequal limb length (acquired), right femur
M21.752	Unequal limb length (acquired), left femur
M21.759	Unequal limb length (acquired), unspecified femur
M70.60	Trochanteric bursitis unspecified hip
M70.61	Trochanteric bursitis right hip
M70.62	Trochanteric bursitis left hip
M70.70	Other bursitis of hip unspecified hip
M70.71	Other bursitis of hip right hip
M70.72	Other bursitis of hip left hip
M61.051	Myositis ossificans traumatica, right thigh
M61.052	Myositis ossificans traumatica, left thigh
M61.059	Myositis ossificans traumatica, unspecified thigh
M54.16	Radiculopathy lumbar region
M54.06	Panniculitis affecting regions of neck and back lumbar region
M97.11	Periprosthetic fracture around internal prosthetic right knee joint
M97.11XA	Periprosthetic fracture around internal prosthetic right knee joint initial encounter
M97.11XD	Periprosthetic fracture around internal prosthetic right knee joint subsequent encounter
M97.11XS	Periprosthetic fracture around internal prosthetic right knee joint sequela
M97.12	Periprosthetic fracture around internal prosthetic left knee joint
M97.12XA	Periprosthetic fracture around internal prosthetic left knee joint initial encounter
M97.12XD	Periprosthetic fracture around internal prosthetic left knee joint subsequent encounter
M97.12XS	Periprosthetic fracture around internal prosthetic left knee joint sequela
Z47.32	Aftercare following explantation of hip joint prosthesis
Z96.641	Presence of right artificial hip joint
Z96.642	Presence of left artificial hip joint
Z96.643	Presence of left artificial hip joint bilateral
T81.32	Disruption of internal operation (surgical) wound, not elsewhere classified
T84.010	Broken internal right hip prosthesis
T84.010	Broken internal right hip prosthesis
T84.010A	Broken internal right hip prosthesis initial encounter
T84.010D	Broken internal right hip prosthesis subsequent encounter
T84.010S	Broken internal right hip prosthesis sequela
T84.011	Broken internal left hip prosthesis
T84.011A	Broken internal left hip prosthesis initial encounter
T84.011D	Broken internal left hip prosthesis subsequent encounter
T84.03	Mechanical loosening of internal prosthetic joint
T84.030	Mechanical loosening of internal right hip prosthetic joint
T84.030A	Mechanical loosening of internal right hip prosthetic joint initial encounter

Diagnosis Codes for Hip

ICD-10-CM	Description
T84.030D	Mechanical loosening of internal right hip prosthetic joint subsequent encounter
T84.030S	Mechanical loosening of internal right hip prosthetic joint sequela
T84.031	Mechanical loosening of internal left hip prosthetic joint
T84.031A	Mechanical loosening of internal left hip prosthetic joint initial encounter
T84.031D	Mechanical loosening of internal left hip prosthetic joint subsequent encounter
T84.031S	Mechanical loosening of internal left hip prosthetic joint sequela
T84.050	Periprosthetic osteolysis of internal prosthetic right hip joint
T84.050A	Periprosthetic osteolysis of internal prosthetic right hip joint initial encounter
T84.050D	Periprosthetic osteolysis of internal prosthetic right hip joint subsequent encounter
T84.050S	Periprosthetic osteolysis of internal prosthetic right hip joint sequela
T84.051	Periprosthetic osteolysis of internal prosthetic left hip joint
T84.051A	Periprosthetic osteolysis of internal prosthetic left hip joint initial encounter
T84.051D	Periprosthetic osteolysis of internal prosthetic left hip joint subsequent encounter
T84.051S	Periprosthetic osteolysis of internal prosthetic left hip joint sequela
M97.01	Periprosthetic fracture around internal prosthetic right hip joint
M97.01XA	Periprosthetic fracture around internal prosthetic right hip joint initial encounter
M97.01XD	Periprosthetic fracture around internal prosthetic right hip joint subsequent encounter
M97.01XS	Periprosthetic fracture around internal prosthetic right hip joint sequela
M97.02	Periprosthetic fracture around internal prosthetic left hip joint
M97.02XA	Periprosthetic fracture around internal prosthetic left hip joint initial encounter
M97.02XD	Periprosthetic fracture around internal prosthetic left hip joint subsequent encounter
M97.02XS	Periprosthetic fracture around internal prosthetic left hip joint sequela
T56.2X1	Toxic effect of chromium and its compounds, accidental (unintentional)
T56.2X1A	Toxic effect of chromium and its compounds, accidental (unintentional) initial encounter
T56.2X1D	Toxic effect of chromium and its compounds, accidental (unintentional) subsequent encounter
T56.2X1S	Toxic effect of chromium and its compounds, accidental (unintentional) sequela
T84.090	Other mechanical complication of internal right hip prosthesis
T84.090A	Other mechanical complication of internal right hip prosthesis initial encounter
T84.090D	Other mechanical complication of internal right hip prosthesis subsequent encounter
T84.090S	Other mechanical complication of internal right hip prosthesis sequela
T84.091	Other mechanical complication of internal left hip prosthesis
T84.091A	Other mechanical complication of internal left hip prosthesis initial encounter
T84.091D	Other mechanical complication of internal left hip prosthesis subsequent encounter
T84.091S	Other mechanical complication of internal left hip prosthesis sequela

Diagnosis Codes for Shoulder

ICD-10-CM	Description
M19.01	Primary osteoarthritis, shoulder
M19.011	Primary osteoarthritis, right shoulder
M19.012	Primary osteoarthritis, left shoulder
M19.019	Primary osteoarthritis, unspecified shoulder
M19.11	Post-traumatic osteoarthritis, shoulder
M19.111	Post-traumatic osteoarthritis, right shoulder
M19.112	Post-traumatic osteoarthritis, left shoulder
M19.119	Post-traumatic osteoarthritis, unspecified shoulder
M19.21	Secondary osteoarthritis, shoulder
M19.211	Secondary osteoarthritis, right shoulder
M19.212	Secondary osteoarthritis, left shoulder
M19.219	Secondary osteoarthritis, unspecified shoulder
M25.01	Hemarthrosis, shoulder
M25.011	Hemarthrosis, right shoulder
M25.012	Hemarthrosis, left shoulder
M25.019	Hemarthrosis, unspecified shoulder
M25.111	Fistula, right shoulder
M25.112	Fistula, left shoulder
M25.119	Fistula, unspecified shoulder
M25.211	Flail joint, right shoulder
M25.212	Flail joint, left shoulder
M25.219	Flail joint, unspecified shoulder
M25.411	Effusion, right shoulder
M25.412	Effusion, left shoulder
M25.419	Effusion, unspecified shoulder
Z47.1	Aftercare following joint replacement surgery
Z47.31	Aftercare following explantation of shoulder joint prosthesis
M05.01	Felty's syndrome, shoulder
M05.011	Felty's syndrome, right shoulder
M05.012	Felty's syndrome, left shoulder
M05.019	Felty's syndrome, unspecified shoulder
M05.11	Rheumatoid lung disease with rheumatoid arthritis of shoulder
M05.111	Rheumatoid lung disease with rheumatoid arthritis of right shoulder
M05.112	Rheumatoid lung disease with rheumatoid arthritis of left shoulder
M25.811	Other specified joint disorders, right shoulder
M25.812	Other specified joint disorders, left shoulder
M25.819	Other specified joint disorders, unspecified shoulder
T84.018	Broken internal joint prosthesis, other site

Diagnosis Codes for Shoulder

ICD-10-CM	Description
T84.018A	Broken internal joint prosthesis, other site initial encounter
T84.018D	Broken internal joint prosthesis, other site subsequent encounter
T84.018S	Broken internal joint prosthesis, other site sequela
T84.028	Dislocation of other internal joint prosthesis
T84.028A	Dislocation of other internal joint prosthesis initial encounter
T84.028D	Dislocation of other internal joint prosthesis subsequent encounter
T84.028S	Dislocation of other internal joint prosthesis sequela
T84.038	Mechanical loosening of other internal prosthetic joint
T84.038A	Mechanical loosening of other internal prosthetic joint initial encounter
T84.038D	Mechanical loosening of other internal prosthetic joint subsequent encounter
T84.038S	Mechanical loosening of other internal prosthetic joint sequela
T84.058	Periprosthetic osteolysis of other internal prosthetic joint
T84.058A	Periprosthetic osteolysis of other internal prosthetic joint initial encounter
T84.058D	Periprosthetic osteolysis of other internal prosthetic joint subsequent encounter
T84.058S	Periprosthetic osteolysis of other internal prosthetic joint sequela
T84.068	Wear of articular bearing surface of other internal prosthetic joint
T84.068A	Wear of articular bearing surface of other internal prosthetic joint initial encounter
T84.068D	Wear of articular bearing surface of other internal prosthetic joint subsequent encounter
T84.068S	Wear of articular bearing surface of other internal prosthetic joint sequela
T84.098	Other mechanical complication of other internal joint prosthesis
T84.098A	Other mechanical complication of other internal joint prosthesis initial encounter
T84.098D	Other mechanical complication of other internal joint prosthesis subsequent encounter
T84.098S	Other mechanical complication of other internal joint prosthesis sequela

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 Joint Reconstruction products.

HCPCS Code	Description
C1776	Joint Device (Implantable)

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 Joint Reconstruction procedures are listed in the following table.

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

Modifiers

The modifiers outlined below may be used to report special circumstance during Joint Reconstruction surgery. These include some of the most common modifiers used in conjunction with Joint Reconstruction 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.
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>
62	<p>Two Surgeons: When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.</p>
76	<p>Repeat Procedure or Service by the Same Physician or Other Healthcare Professional: It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.</p>
77	<p>Repeat Procedure by Another Physician or Other Qualified Healthcare Professional: It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.</p>
78	<p>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.)</p>
79	<p>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.)</p>
80	<p>Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).</p>
81	<p>Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.</p>
82	<p>Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).</p>

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 2020 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.

Status Indicator (SI) Definitions

J1 - Hospital Part B services paid through a Comprehensive APC. **N** - Items and Services Packaged into APC Rates. Paid under OPPS; payment is packaged into payment for other services. **Q1** - Packaged APC payment if billed on same date of service as a HCPCS assigned status indicator S, T, V or X; otherwise payment is made through a separate APC payment. **Q2** - Payment is packaged if billed on the same date of service as a HCPCS code assigned a status indicator "T"; otherwise payment is made through a separate APC payment.

Carriers priced code. Carriers/MACS will establish RVUs and payment amounts for these services, generally on an individual case-by-case basis following review of documentation such as an operative report.

Restricted coverage. Special coverage instructions apply.

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 nonfacility PE RVUs; payment based on OPPS relative payment weight. **Z2** - Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.

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Please refer to the instructions for use for a complete list of indications, contraindications, warnings and precautions