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Upper Extremity

2020 Reimbursement Guide

Physician & Facility

WRIGHT
FOCUSED EXCELLENCE

Upper Extremity
Reimbursement Guide

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Physician Reimbursement

Medicare reimburses physicians according to the Medicare Physician Fee Schedule (MPFS), which is based on Relative Value Units (RVUs), and payment varies by geographic region.

CY 2020 FINAL PHYSICIAN PAYMENT

CPT® CODE[1]	Description	Facility (POS 21, 22 or 24)	
		RVUs	Medicare National Average Payment[2]
Elbow			
24340	Tenodesis of biceps tendon at elbow (separate procedure)	17.72	$640
24341	Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)	21.47	$775
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft	22.39	$808
24343	Repair lateral collateral ligament, elbow, with local tissue	20.42	$737
24344	Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)	31.57	$1,139
24346	Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)	31.77	$1,147
24363	Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)	41.99	$1,515
24370	Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component	44.64	$1,611
24371	Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component	51.50	$1,859
24999	Unlisted procedure, humerus or elbow	N/A	Carrier Priced
29830	Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)	13.16	$475
29834	Arthroscopy, elbow, surgical; with removal of loose body or foreign body	14.19	$512
29835	Arthroscopy, elbow, surgical; synovectomy, partial	14.67	$529
29836	Arthroscopy, elbow, surgical; synovectomy, complete	16.84	$608
29837	Arthroscopy, elbow, surgical; debridement, limited	15.20	$549
29838	Arthroscopy, elbow, surgical; debridement, extensive	17.07	$616
Forearm			
25355	Osteotomy, radius; middle or proximal third	22.08	$797
25360	Osteotomy; ulna	18.86	$681

CPT® CODE[1]	Description	Facility (POS 21, 22 or 24)	
		RVUs	Medicare National Average Payment[2]
Hand			
26530	Arthroplasty, metacarpophalangeal joint; each joint	15.52	$560
26531	Arthroplasty, metacarpophalangeal joint; with prosthetic implant, each joint	18.07	$652
26535	Arthroplasty, interphalangeal joint; each joint	12.48	$450
26536	Arthroplasty, interphalangeal joint; with prosthetic implant, each joint	20.83	$752
26548	Repair and reconstruction, finger, volar plate, interphalangeal joint	22.22	$802
29901	Arthroscopy, metacarpophalangeal joint, surgical; with debridement	15.45	$558
Shoulder			
23020	Capsular contracture release (eg, Sever type procedure)	19.92	$719
23120	Claviculectomy; partial	16.86	$608
23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release	17.68	$638
23170	Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle	16.20	$585
23334	Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component	30.82	$1,112
23335	Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid components (eg, total shoulder)	36.75	$1,326
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	23.68	$855
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	24.62	$889
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	28.07	$1,013
23455	Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)	28.72	$1,036
23460	Capsulorrhaphy, anterior, any type; with bone block	31.48	$1,136
23465	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block	32.33	$1,167
23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability	32.04	$1,156
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	34.72	$1,253
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	41.98	$1,515
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	46.83	$1,690
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	50.60	$1,826
23515	Open treatment of clavicular fracture, includes internal fixation, when performed	20.77	$750
23550	Open treatment of acromioclavicular dislocation, acute or chronic;	16.52	$596

CPT® CODE[1]	Description	Facility (POS 21, 22 or 24)	
		RVUs	Medicare National Average Payment[2]
23552	Open treatment of acromioclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)	18.84	$680
23800	Arthrodesis, glenohumeral joint;	29.66	$1,070
23929	Unlisted procedure, shoulder	N/A	Carrier Priced
29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)	13.55	$489
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy	30.54	$1,102
29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion	29.87	$1,078
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body	16.91	$610
29820	Arthroscopy, shoulder, surgical; synovectomy, partial	15.48	$559
29821	Arthroscopy, shoulder, surgical; synovectomy, complete	17.10	$617
29822	Arthroscopy, shoulder, surgical; debridement, limited	16.63	$600
29823	Arthroscopy, shoulder, surgical; debridement, extensive	18.10	$653
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including articular surface (Mumford procedure)	19.46	$702
29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation	16.91	$610
+29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)	5.05	$182
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	30.91	$1,116
29999	Unlisted procedure, arthroscopy	N/A	Carrier Priced
Wrist			
25210	Carpectomy; 1 bone	14.12	$510
25310	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon	17.85	$644
25447	Arthroplasty, interposition, intercarpal or carpometacarpal joints	23.88	$862
25449	Revision of arthroplasty, including removal of implant, wrist joint	29.87	$1,078
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	21.20	$765
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments	23.78	$858
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments	30.26	$1,092
25652	Open treatment of ulnar styloid fracture	17.93	$647

Outpatient Facility Reimbursement

Hospital outpatient services are reimbursed under Medicare's Outpatient Prospective Payment System (OPPS) based on the associated Ambulatory Payment Classification (APC). Procedures requiring similar resources are grouped into APCs and facilities are paid a lump sum payment for the services provided.

CY 2020 FINAL HOSPITAL OUTPATIENT AND AMBULATORY SURGICAL CENTER PAYMENT

CPT® CODE	Description	Hospital Outpatient (POS 22)		Ambulatory Surgical Center (POS 24)		
		APC	Medicare National Average Payment[3]	SI	Medicare National Average Payment[3]	PI
Elbow						
24340	Tenodesis of biceps tendon at elbow (separate procedure)	5114	$5,982	J1	$2,803	A2
24341	Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)	5114	$5,982	J1	$2,803	A2
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft	5114	$5,982	J1	$2,803	A2
24343	Repair lateral collateral ligament, elbow, with local tissue	5113	$2,737	J1	$1,286	G2
24344	Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)	5114	$5,982	J1	$2,803	G2
24346	Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)	5115	$11,901	J1	$5,727	G2
24363	Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)	5116	$15,946	J1	$12,204	J8
24370	Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component	5115	$11,901	J1	$8,443	J8
24371	Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component	5116	$15,946	J1	$10,938	J8
24999	Unlisted procedure, humerus or elbow	5111	$216	T	Not on ASC allowable list	N/A
29830	Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)	5113	$2,737	J1	$1,286	A2
29834	Arthroscopy, elbow, surgical; with removal of loose body or foreign body	5113	$2,737	J1	$1,286	A2
29835	Arthroscopy, elbow, surgical; synovectomy, partial	5113	$2,737	J1	$1,286	A2
29836	Arthroscopy, elbow, surgical; synovectomy, complete	5114	$5,982	J1	$2,803	A2
29837	Arthroscopy, elbow, surgical; debridement, limited	5113	$2,737	J1	$1,286	A2
29838	Arthroscopy, elbow, surgical; debridement, extensive	5113	$2,737	J1	$1,286	A2
Forearm						
25355	Osteotomy, radius; middle or proximal third	5113	$2,737	J1	$1,286	A2
25360	Osteotomy; ulna	5114	$5,982	J1	$3,847	J8
Hand						
26530	Arthroplasty, metacarpophalangeal joint; each joint	5114	$5,982	J1	$2,803	A2
26531	Arthroplasty, metacarpophalangeal joint; with prosthetic implant, each joint	5114	$5,982	J1	$4,021	J8
26535	Arthroplasty, interphalangeal joint; each joint	5113	$2,737	J1	$1,286	A2

CPT® CODE	Description	Hospital Outpatient (POS 22)		Ambulatory Surgical Center (POS 24)		
		APC	Medicare National Average Payment[3]	SI	Medicare National Average Payment[3]	PI
26536	Arthroplasty, interphalangeal joint; with prosthetic implant, each joint	5114	$5,982	J1	$3,721	J8
26548	Repair and reconstruction, finger, volar plate, interphalangeal joint	5113	$2,737	J1	$1,286	A2
29901	Arthroscopy, metacarpophalangeal joint, surgical; with debridement	5113	$2,737	J1	$1,286	A2
Shoulder						
23020	Capsular contracture release (eg, Sever type procedure)	5113	$2,737	J1	$1,286	A2
23120	Claviculectomy; partial	5113	$2,737	J1	$1,286	A2
23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release	5113	$2,737	J1	$1,286	A2
23170	Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle	5113	$2,737	J1	$1,286	A2
23334	Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component	5073	$2,319	J1	$994	G2
23335	Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid components (eg, total shoulder)	N/A	Inpatient Procedure	C	Excluded from payment in ASC	N/A
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	5114	$5,982	J1	$2,803	A2
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	5114	$5,982	J1	$2,803	A2
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	5114	$5,982	J1	$2,803	A2
23455	Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)	5114	$5,982	J1	$2,803	A2
23460	Capsulorrhaphy, anterior, any type; with bone block	5114	$5,982	J1	$2,803	A2
23465	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block	5114	$5,982	J1	$2,803	G2
23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability	5114	$5,982	J1	$2,803	A2
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	5115	$11,901	J1	Not on ASC allowable list	N/A
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	N/A	Inpatient Procedure	C	Excluded from payment in ASC	N/A
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	5115	$11,901	J1	Not on ASC allowable list	N/A
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	N/A	Inpatient Procedure	C	Excluded from payment in ASC	N/A
23515	Open treatment of clavicular fracture, includes internal fixation, when performed	5114	$5,982	J1	$3,847	J8
23550	Open treatment of acromioclavicular dislocation, acute or chronic;	5114	$5,982	J1	$2,803	A2
23552	Open treatment of acromioclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)	5114	$5,982	J1	$3,822	J8
23800	Arthrodesis, glenohumeral joint;	5114	$5,982	J1	$2,803	G2

CPT® CODE	Description	Hospital Outpatient (POS 22)		Ambulatory Surgical Center (POS 24)		
		APC	Medicare National Average Payment[3]	SI	Medicare National Average Payment[3]	PI
23929	Unlisted procedure, shoulder	5111	$216	T	Not on ASC allowable list	N/A
29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)	5113	$2,737	J1	$1,286	A2
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy	5114	$5,982	J1	$2,803	A2
29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion	5114	$5,982	J1	$2,803	A2
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body	5113	$2,737	J1	$1,286	A2
29820	Arthroscopy, shoulder, surgical; synovectomy, partial	5114	$5,982	J1	$2,803	A2
29821	Arthroscopy, shoulder, surgical; synovectomy, complete	5113	$2,737	J1	$1,286	A2
29822	Arthroscopy, shoulder, surgical; debridement, limited	5113	$2,737	J1	$1,286	A2
29823	Arthroscopy, shoulder, surgical; debridement, extensive	5113	$2,737	J1	$1,286	A2
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including articular surface (Mumford procedure)	5113	$2,737	J1	$1,286	A2
29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation	5113	$2,737	J1	$1,286	A2
+29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)	N/A	Packaged	N	Packaged	N1
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	5114	$5,982	J1	$2,803	A2
29999	Unlisted procedure, arthroscopy	5111	$216	T	Not on ASC allowable list	N/A
Wrist						
25210	Carpectomy; 1 bone	5113	$2,737	J1	$1,286	A2
25310	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon	5113	$2,737	J1	$1,286	A2
25447	Arthroplasty, interposition, intercarpal or carpometacarpal joints	5113	$2,737	J1	$1,286	A2
25449	Revision of arthroplasty, including removal of implant, wrist joint	5114	$5,982	J1	$2,803	A2
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	5114	$5,982	J1	$4,037	J8
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments	5114	$5,982	J1	$4,020	J8
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments	5114	$5,982	J1	$4,036	J8
25652	Open treatment of ulnar styloid fracture	5114	$5,982	J1	$2,803	G2

HCPCS Codes

Relevant HCPCS Level II codes are reported for materials, products and devices utilized in procedures for tracking and/or reimbursement purposes. Please review each payer's guidelines for reporting and payment.

Please consult the HCPCS Level II Product Coding Guide for more information.

HCPCS Code	Description
L8699	Prosthetic implant, not otherwise specified
C1889	Implantable/insertable device for device intensive procedure, not otherwise classified

Modifiers

Modifiers indicate that a reported service has been altered by a specific circumstance but that the code description has not changed. Some of the modifiers will impact reimbursement while others are informational only.

Modifier	Description
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant surgery.
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.
26	**Professional Component:** Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.
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.
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.
59	**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.

Effective January 1, 2015 CMS established four new modifiers to define specific subsets of the 59 modifier. Modifier 59 is still recognized but should not be used when a more descriptive modifier is available. The X{EPSU} modifiers are below[4]

Modifier	Description
XE	**Separate Encounter:** A service that is distinct because it occurred during a separate encounter
XS	**Separate Structure:** A service that is distinct because it was performed on a separate organ/structure
XP	**Separate Practitioner:** A service that is distinct because it was performed by a different practitioner
XU	**Unusual Non-Overlapping Service:** The use of a service that is distinct because it does not overlap usual components of the main service
80	**Assistant Surgeon:** Surgical assistant services may be identified by adding the modifier 80 to the usual procedure numbers. This modifier should be reported to identify surgical assistant services performed in a non-teaching setting or in a teaching setting when a resident was available, but the surgeon opted not to use the resident. In the latter case, the service is generally not covered by Medicare. .

Inpatient Facility Reimbursement

ICD-10-PCS Procedure Codes

Medicare uses the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) to identify procedures in the hospital inpatient setting.

The following table lists commonly used ICD-10-PCS codes for Upper Extremity procedures:

ICD-10-PCS Code	ICD-10-PCS Description
0LQ10ZZ	Repair Right Shoulder Tendon, Open Approach
0LQ14ZZ	Repair Right Shoulder Tendon, Percutaneous Endoscopic Approach
0MQ14ZZ	Repair Right Shoulder Bursa and Ligament, Percutaneous Endoscopic Approach
0PB90ZZ	Excision of Right Clavicle, Open Approach
0RRJ0J6	Replacement of Right Shoulder Joint with Synthetic Substitute, Humeral Surface, Open Approach
0RRJ0KZ	Replacement of Right Shoulder Joint with Nonautologous Tissue Substitute, Open Approach
0RRJ0J7	Replacement of Right Shoulder Joint with Synthetic Substitute, Glenoid Surface, Open Approach
0RGE0ZZ	Fusion of Right Sternoclavicular Joint, Open Approach
0RGG0ZZ	Fusion of Right Acromioclavicular Joint, Open Approach
0RGJ0ZZ	Fusion of Right Shoulder Joint, Open Approach
0MU10KZ	Supplement Right Shoulder Bursa and Ligament with Nonautologous Tissue Substitute, Open Approach
0MU14KZ	Supplement Right Shoulder Bursa and Ligament with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0LM10ZZ	Reattachment of Right Shoulder Tendon, Open Approach
0LM20ZZ	Reattachment of Left Shoulder Tendon, Open Approach
0LM30ZZ	Reattachment of Right Upper Arm Tendon, Open Approach
0LM40ZZ	Reattachment of Left Upper Arm Tendon, Open Approach
0LQ10ZZ	Repair Right Shoulder Tendon, Open Approach
0LQ13ZZ	Repair Right Shoulder Tendon, Percutaneous Approach
0LQ20ZZ	Repair Left Shoulder Tendon, Open Approach
0LQ23ZZ	Repair Left Shoulder Tendon, Percutaneous Approach
0LQ30ZZ	Repair Right Upper Arm Tendon, Open Approach
0LQ40ZZ	Repair Left Upper Arm Tendon, Open Approach
0LR107Z	Replace of Right Shoulder Tendon with Autologous Tissue Substitute, Open Approach
0LR10JZ	Replace of Right Shoulder Tendon with Synthetic Substitute, Open Approach
0LR10KZ	Replace of Right Shoulder Tendon with Nonautologous Tissue Substitute, Open Approach
0LR147Z	Replace Right Shoulder Tendon with Autologous Tissue Substitute, Percutaneous Endoscopic Approach

ICD-10-PCS Code	ICD-10-PCS Description
0LR14JZ	Replace Right Shoulder Tendon with Synthetic Substitute, Percutaneous Endoscopic Approach
0LR14KZ	Replace Right Shoulder Tendon with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0LR207Z	Replace of Left Shoulder Tendon with Autologous Tissue Substitute, Open Approach
0LR20JZ	Replace of Left Shoulder Tendon with Synthetic Substitute, Open Approach
0LR20KZ	Replace of Left Shoulder Tendon with Nonautologous Tissue Substitute, Open Approach
0P8J0ZZ	Division of Left Radius, Open Approach
0P8J3ZZ	Division of Left Radius, Percutaneous Approach
0P8J4ZZ	Division of Left Radius, Percutaneous Endoscopic Approach
0P8K0ZZ	Division of Right Ulna, Open Approach
0P8K3ZZ	Division of Right Ulna, Percutaneous Approach
0P8K4ZZ	Division of Right Ulna, Percutaneous Endoscopic Approach
0P8L0ZZ	Division of Left Ulna, Open Approach
0P8L3ZZ	Division of Left Ulna, Percutaneous Approach
0P8L4ZZ	Division of Left Ulna, Percutaneous Endoscopic Approach
0PC90ZZ	Extirpation of Matter from Right Clavicle, Open Approach
0PC93ZZ	Extirpation of Matter from Right Clavicle, Percutaneous Approach
0PC94ZZ	Extirpation of Matter from Right Clavicle, Percutaneous Endoscopic Approach
0PCB0ZZ	Extirpation of Matter from Left Clavicle, Open Approach
0PCB3ZZ	Extirpation of Matter from Left Clavicle, Percutaneous Approach
0PCB4ZZ	Extirpation of Matter from Left Clavicle, Percutaneous Endoscopic Approach
0PP74JZ	Removal of Synthetic Substitute from Right Glenoid Cavity, Percutaneous Endoscopic Approach
0PP84JZ	Removal of Synthetic Substitute from Left Glenoid Cavity, Percutaneous Endoscopic Approach
0PSH04Z	Reposition Right Radius with Internal Fixation Device, Open Approach
0PSH06Z	Reposition Right Radius with Intramedullary Fixation Device, Open Approach
0PSH0ZZ	Reposition Right Radius, Open Approach
0PSH34Z	Reposition Right Radius with Internal Fixation Device, Percutaneous Approach
0PSH35Z	Reposition Right Radius with External Fixation Device, Percutaneous Approach
0PSH36Z	Reposition Right Radius with Intramedullary Fixation Device, Percutaneous Approach
0PSH3BZ	Reposition Right Radius with Monoplanar External Fixation Device, Percutaneous Approach
0PSH3CZ	Reposition Right Radius with Ring External Fixation Device, Percutaneous Approach
0PSH3DZ	Reposition Right Radius with Hybrid External Fixation Device, Percutaneous Approach

ICD-10-PCS Code	ICD-10-PCS Description
0PSH44Z	Reposition Right Radius with Internal Fixation Device, Percutaneous Endoscopic Approach
0PSH45Z	Reposition Right Radius with External Fixation Device, Percutaneous Endoscopic Approach
0PSH4BZ	Reposition Right Radius with Monoplanar External Fixation Device, Percutaneous Endoscopic Approach
0PSH4CZ	Reposition Right Radius with Ring External Fixation Device, Percutaneous Endoscopic Approach
0PSH4DZ	Reposition Right Radius with Hybrid External Fixation Device, Percutaneous Endoscopic Approach
0PSHXZZ	Reposition Right Radius, External Approach
0PSJ04Z	Reposition Left Radius with Internal Fixation Device, Open Approach
0PSJ06Z	Reposition Left Radius with Intramedullary Fixation Device, Open Approach
0PSJ0ZZ	Reposition Left Radius, Open Approach
0PSJ34Z	Reposition Left Radius with Internal Fixation Device, Percutaneous Approach
0PSJ35Z	Reposition Left Radius with External Fixation Device, Percutaneous Approach
0PSJ36Z	Reposition Left Radius with Intramedullary Fixation Device, Percutaneous Approach
0PSJ3BZ	Reposition Left Radius with Monoplanar External Fixation Device, Percutaneous Approach
0PSJ3CZ	Reposition Left Radius with Ring External Fixation Device, Percutaneous Approach
0PSJ3DZ	Reposition Left Radius with Hybrid External Fixation Device, Percutaneous Approach
0PSJ44Z	Reposition Left Radius with Internal Fixation Device, Percutaneous Endoscopic Approach
0PSJ45Z	Reposition Left Radius with External Fixation Device, Percutaneous Endoscopic Approach
0PSJ46Z	Reposition Left Radius with Intramedullary Fixation Device, Percutaneous Endoscopic Approach
0PSJ4CZ	Reposition Left Radius with Ring External Fixation Device, Percutaneous Endoscopic Approach
0PSJ4DZ	Reposition Left Radius with Hybrid External Fixation Device, Percutaneous Endoscopic Approach
0PSK04Z	Reposition Right Ulna with Internal Fixation Device, Open Approach
0PSK06Z	Reposition Right Ulna with Intramedullary Fixation Device, Open Approach
0PSK0ZZ	Reposition Right Ulna, Open Approach
0PSK34Z	Reposition Right Ulna with Internal Fixation Device, Percutaneous Approach
0PSK36Z	Reposition Right Ulna with Intramedullary Fixation Device, Percutaneous Approach
0PSK44Z	Reposition Right Ulna with Internal Fixation Device, Percutaneous Endoscopic Approach
0PSK46Z	Reposition Right Ulna with Intramedullary Fixation Device, Percutaneous Endoscopic Approach
0PSKXZZ	Reposition Right Ulna, External Approach
0PSL04Z	Reposition Left Ulna with Internal Fixation Device, Open Approach
0PSL06Z	Reposition Left Ulna with Intramedullary Fixation Device, Open Approach
0PSL0ZZ	Reposition Left Ulna, Open Approach

ICD-10-PCS Code	ICD-10-PCS Description
0PSL34Z	Reposition Left Ulna with Internal Fixation Device, Percutaneous Approach
0PSL36Z	Reposition Left Ulna with Intramedullary Fixation Device, Percutaneous Approach
0PSL44Z	Reposition Left Ulna with Internal Fixation Device, Percutaneous Endoscopic Approach
0PSL46Z	Reposition Left Ulna with Intramedullary Fixation Device, Percutaneous Endoscopic Approach
0PSLXZZ	Reposition Left Ulna, External Approach
0RBJ0ZX	Excision of Right Shoulder Joint, Open Approach, Diagnostic
0RBJ3ZX	Excision of Right Shoulder Joint, Percutaneous Approach, Diagnostic
0RBJ4ZX	Excision of Right Shoulder Joint, Percutaneous Endoscopic Approach, Diagnostic
0RBK0ZX	Excision of Left Shoulder Joint, Open Approach, Diagnostic
0RBK3ZX	Excision of Left Shoulder Joint, Percutaneous Approach, Diagnostic
0RBK4ZX	Excision of Left Shoulder Joint, Percutaneous Endoscopic Approach, Diagnostic
0RGJ04Z	Fusion of Right Shoulder Joint with Internal Fixation Device, Open Approach
0RGJ07Z	Fusion of Right Shoulder Joint with Autologous Tissue Substitute, Open Approach
0RGJ0JZ	Fusion of Right Shoulder Joint with Synthetic Substitute, Open Approach
0RGJ0KZ	Fusion of Right Shoulder Joint with Nonautologous Tissue Substitute, Open Approach
0RGJ34Z	Fusion of Right Shoulder Joint with Internal Fixation Device, Percutaneous Approach
0RGJ37Z	Fusion of Right Shoulder Joint with Autologous Tissue Substitute, Percutaneous Approach
0RGJ3JZ	Fusion of Right Shoulder Joint with Synthetic Substitute, Percutaneous Approach
0RGJ3KZ	Fusion of Right Shoulder Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0RGJ44Z	Fusion of Right Shoulder Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0RGJ47Z	Fusion of Right Shoulder Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGJ4JZ	Fusion of Right Shoulder Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0RGJ4KZ	Fusion of Right Shoulder Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGK04Z	Fusion of Left Shoulder Joint with Internal Fixation Device, Open Approach
0RRW07Z	Replace of Right Finger Phalanx Joint with Autologous Tissue Substitute, Open Approach
0RGJ04Z	Fusion of Right Shoulder Joint with Internal Fixation Device, Open Approach
0RGJ07Z	Fusion of Right Shoulder Joint with Autologous Tissue Substitute, Open Approach
0RGJ0JZ	Fusion of Right Shoulder Joint with Synthetic Substitute, Open Approach
0RGJ0KZ	Fusion of Right Shoulder Joint with Nonautologous Tissue Substitute, Open Approach
0RGJ34Z	Fusion of Right Shoulder Joint with Internal Fixation Device, Percutaneous Approach
0RGJ37Z	Fusion of Right Shoulder Joint with Autologous Tissue Substitute, Percutaneous Approach

ICD-10-PCS Code	ICD-10-PCS Description
0RGJ3JZ	Fusion of Right Shoulder Joint with Synthetic Substitute, Percutaneous Approach
0RGJ3KZ	Fusion of Right Shoulder Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0RGJ44Z	Fusion of Right Shoulder Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0RGJ47Z	Fusion of Right Shoulder Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGJ4JZ	Fusion of Right Shoulder Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0RGK07Z	Fusion of Left Shoulder Joint with Autologous Tissue Substitute, Open Approach
0RGK0JZ	Fusion of Left Shoulder Joint with Synthetic Substitute, Open Approach
0RGK0KZ	Fusion of Left Shoulder Joint with Nonautologous Tissue Substitute, Open Approach
0RGK34Z	Fusion of Left Shoulder Joint with Internal Fixation Device, Percutaneous Approach
0RGK37Z	Fusion of Left Shoulder Joint with Autologous Tissue Substitute, Percutaneous Approach
0RGK3JZ	Fusion of Left Shoulder Joint with Synthetic Substitute, Percutaneous Approach
0RGK3KZ	Fusion of Left Shoulder Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0RGK44Z	Fusion of Left Shoulder Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0RGK47Z	Fusion of Left Shoulder Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGK4JZ	Fusion of Left Shoulder Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0RGK4KZ	Fusion of Left Shoulder Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0RHJ43Z	Insertion of Infusion Device in Right Shoulder Joint, Percutaneous Endoscopic Approach
0RHK43Z	Insert of Infusion Device in Left Shoulder Joint, Percutaneous Endoscopic Approach
0RHK44Z	Insertion of Internal Fixation Device into Left Shoulder Joint, Percutaneous Endoscopic Approach
0RPJ0JZ	Removal of Synthetic Substitute from Right Shoulder Joint, Open Approach
0RPJ3JZ	Removal of Synthetic Substitute from Right Shoulder Joint, Percutaneous Approach
0RPK0JZ	Removal of Synthetic Substitute from Left Shoulder Joint, Open Approach
0RPK3JZ	Removal of Synthetic Substitute from Left Shoulder Joint, Percutaneous Approach
0RQJ0ZZ	Repair Right Shoulder Joint, Open Approach
0RQJ3ZZ	Repair Right Shoulder Joint, Percutaneous Approach
0RQJXZZ	Repair Right Shoulder Joint, External Approach
0RQK0ZZ	Repair Left Shoulder Joint, Open Approach
0RQK3ZZ	Repair Left Shoulder Joint, Percutaneous Approach
0RQKXZZ	Repair Left Shoulder Joint, External Approach
0RQW0ZZ	Repair Right Finger Phalangeal Joint, Open Approach
0RQW3ZZ	Repair Right Finger Phalangeal Joint, Percutaneous Approach

ICD-10-PCS Code	ICD-10-PCS Description
0RQW4ZZ	Repair Right Finger Phalangeal Joint, Percutaneous Endoscopic Approach
0RQX0ZZ	Repair Left Finger Phalangeal Joint, Open Approach
0RQX3ZZ	Repair Left Finger Phalangeal Joint, Percutaneous Approach
0RQX4ZZ	Repair Left Finger Phalangeal Joint, Percutaneous Endoscopic Approach
0RRJ00Z	Replacement of Right Shoulder Joint with Reverse Ball & Socket Synthetic Substitute, Open Approach
0RRJ07Z	Replacement of Right Shoulder Joint with Autologous Tissue Substitute, Open Approach
0RRJ0J6	Replace Right Shoulder Joint with Synthetic Substitute, Humeral, Open Approach
0RRJ0J6	Replacement of Right Shoulder Joint with Synthetic Substitute, Humeral Surface, Open Approach
0RRJ0KZ	Replacement of Right Shoulder Joint with Nonautologous Tissue Substitute, Open Approach
0RRJ0J7	Replacement of Right Shoulder Joint with Synthetic Substitute, Glenoid Surface, Open Approach
0RGE0ZZ	Fusion of Right Sternoclavicular Joint, Open Approach
0RGG0ZZ	Fusion of Right Acromioclavicular Joint, Open Approach
0RGJ0ZZ	Fusion of Right Shoulder Joint, Open Approach
0RRJ0J7	Replacement of Right Shoulder Joint with Synthetic Substitute, Glenoid, Open Approach
0RRJ0JZ	Replacement of Right Shoulder Joint with Synthetic Substitute, Open Approach
0RRJ0KZ	Replacement of Right Shoulder Joint with Nonautologous Tissue Substitute, Open Approach
0RRK00Z	Replacement of Left Shoulder Joint with Reverse Ball & Socket Synthetic Substitute, Open Approach
0RRK07Z	Replacement of Left Shoulder Joint with Autologous Tissue Substitute, Open Approach
0RRK0J6	Replacement of Left Shoulder Joint with Synthetic Substitute, Humeral, Open Approach
0RRK0J7	Replacement of Left Shoulder Joint with Synthetic Substitute, Glenoid, Open Approach
0RRK0JZ	Replacement of Left Shoulder Joint with Synthetic Substitute, Open Approach
0RRK0KZ	Replacement of Left Shoulder Joint with Nonautologous Tissue Substitute, Open Approach
0RRL0JZ	Replacement of Right Elbow Joint with Synthetic Substitute, Open Approach
0RRL0KZ	Replacement of Right Elbow Joint with Nonautologous Tissue Substitute, Open Approach
0RRM0JZ	Replacement of Left Elbow Joint with Synthetic Substitute, Open Approach
0RRM0KZ	Replacement of Left Elbow Joint with Nonautologous Tissue Substitute, Open Approach
0RRQ07Z	Replacement of Right Carpal Joint with Autologous Tissue Substitute, Open Approach
0RRQ0JZ	Replacement of Right Carpal Joint with Synthetic Substitute, Open Approach
0RRQ0KZ	Replacement of Right Carpal Joint with Nonautologous Tissue Substitute, Open Approach
0RRR07Z	Replacement of Left Carpal Joint with Autologous Tissue Substitute, Open Approach
0RRR0JZ	Replacement of Left Carpal Joint with Synthetic Substitute, Open Approach

ICD-10-PCS Code	ICD-10-PCS Description
0RRR0KZ	Replacement of Left Carpal Joint with Nonautologous Tissue Substitute, Open Approach
0RRS07Z	Replacement of Right Carpometacarpal Joint with Autologous Tissue Substitute, Open Approach
0RRS0JZ	Replacement of Right Carpometacarpal Joint with Synthetic Substitute, Open Approach
0RRS0KZ	Replacement of Right Carpometacarpal Joint with Nonautologous Tissue Substitute, Open Approach
0RRT07Z	Replacement of Left Carpometacarpal Joint with Autologous Tissue Substitute, Open Approach
0RRT0JZ	Replacement of Left Carpometacarpal Joint with Synthetic Substitute, Open Approach
0RRT0KZ	Replacement of Left Carpometacarpal Joint with Nonautologous Tissue Substitute, Open Approach
0RRU07Z	Replacement of Right Metacarpophalangeal Joint with Autologous Tissue Substitute, Open Approach
0RRU0JZ	Replacement of Right Metacarpophalangeal Joint with Synthetic Substitute, Open Approach
0RRU0KZ	Replacement of Right Metacarpophalangeal Joint with Nonautologous Tissue Substitute, Open Approach
0RRV07Z	Replacement of Left Metacarpophalangeal Joint with Autologous Tissue Substitute, Open Approach
0RRV0JZ	Replacement of Left Metacarpophalangeal Joint with Synthetic Substitute, Open Approach
0RRV0KZ	Replacement of Left Metacarpophalangeal Joint with Nonautologous Tissue Substitute, Open Approach
0RRW07Z	Replacement of Right Finger Phalangeal Joint with Autologous Tissue Substitute, Open Approach
0RRW0JZ	Replacement of Right Finger Phalangeal Joint with Synthetic Substitute, Open Approach
0RRW0KZ	Replacement of Right Finger Phalangeal Joint with Nonautologous Tissue Substitute, Open Approach
0RRX07Z	Replacement of Left Finger Phalangeal Joint with Autologous Tissue Substitute, Open Approach
0RRX0KZ	Replacement of Left Finger Phalangeal Joint with Nonautologous Tissue Substitute, Open Approach
0RUW07Z	Supplement Right Finger Phalangeal Joint with Autologous Tissue Substitute, Open Approach
0RUW0JZ	Supplement Right Finger Phalangeal Joint with Synthetic Substitute, Open Approach
0RUW0KZ	Supplement Right Finger Phalangeal Joint with Nonautologous Tissue Substitute, Open Approach
0RUW37Z	Supplement Right Finger Phalangeal Joint with Autolologous Tissue Substitute, Percutaneous Approach
0RUW3JZ	Supplement Right Finger Phalangeal Joint with Synthetic Substitute, Percutaneous Approach
0RUW3KZ	Supplement Right Finger Phalangeal Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0RUW47Z	Supplement Right Finger Phalangeal Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0RUW4JZ	Supplement Right Finger Phalangeal Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0RUW4KZ	Supplement Right Finger Phalangeal Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0RUX07Z	Supplement Left Finger Phalangeal Joint with Autologous Tissue Substitute, Open Approach
0RUX0JZ	Supplement Left Finger Phalangeal Joint with Synthetic Substitute, Open Approach
0RUX0KZ	Supplement Left Finger Phalangeal Joint with Nonautologous Tissue Substitute, Open Approach

MS-DRGs

Medicare assigns a hospital inpatient stay to a Medicare Severity-Diagnosis Related Group (MS-DRG) based on the reported ICD-10 diagnoses and procedure codes. Hospitals generally receive a fixed, predetermined payment for each MS-DRG, which includes all costs associated with the patient's hospital stay. Private payers may have carve-outs for implants.

FY 2020 FINAL HOSPITAL INPATIENT PAYMENT

MS-DRG	Description	Relative Weight	Medicare National Average Payment[5]
483	Major Joint/Limb Reattachment Procedure of Upper Extremities	2.3921	$14,972
500	Soft Tissue Procedures with MCC	3.0152	$18,872
501	Soft Tissue Procedures with CC	1.6780	$10,503
502	Soft Tissue Procedures without CC/MCC	1.3207	$8,266
507	Major Shoulder or Elbow Joint Procedures with CC/MCC	2.1000	$13,144
508	Major Shoulder or Elbow Joint Procedures without CC/MCC	1.5584	$9,754
509	Arthroscopy	1.3917	$8,711
510	Shoulder, Elbow or Forearm Procedure, Except Major Joint Procedure with MCC	2.7880	$17,450
511	Shoulder, Elbow or Forearm Procedure, Except Major Joint Procedure with CC	1.8842	$11,793
512	Shoulder, Elbow or Forearm Procedure, Except Major Joint Procedure without CC/MCC	1.5138	$9,475
513	Hand or Wrist Procedure, Except Major Thumb or Joint Procedure with CC/MCC	1.5771	$9,871
514	Hand or Wrist Procedure, Except Major Thumb or Joint Procedure without CC/MCC	1.0668	$6,677
515	Other Musculoskeletal System and Connective Tissue O.R. Procedure with MCC	3.1540	$19,741
516	Other Musculoskeletal System and Connective Tissue O.R. Procedures with CC	1.9391	$12,137
517	Other Musculoskeletal System and Connective Tissue O.R. Procedures without CC/MCC	1.4153	$8,858
957	Other O.R. Procedures for Multiple Significant Trauma with MCC	7.5337	$47,153
958	Other O.R. Procedures for Multiple Significant Trauma with CC	4.1909	$26,231
959	Other O.R. Procedures for Multiple Significant Trauma without CC/MCC	2.8005	$17,528
987	Nonextensive O.R. Procedure Unrelated to Principal Diagnosis with MCC	3.3337	$20,865
988	Nonextensive O.R. Procedure Unrelated to Principal Diagnosis with CC	1.7183	$10,755
989	Nonextensive O.R. Procedure Unrelated to Principal Diagnosis without CC/MCC	1.1524	$7,213

CC=Complications or Comorbidities MCC=Major Complications or Comorbidities

Access Wright Reimbursement Helpline staff can assist with the following:

- General coding and reimbursement questions
- Patient-specific insurance verifications
- Prior authorization and pre-determination support
- Medicare unadjusted national average payment rates

For assistance with coding and reimbursement, please contact our

Fax: 240.238.9836 or 860.645.3988

Email: Reimbursement@Wright.com

8:30am EST – 7:00pm EST, Monday through Friday
(except holidays and unexpected closures)

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References:

1. Current Procedural Terminology 2020. CPT® copyright 2019 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS apply.
2. Calendar Year 2020 Medicare Physician Fee Schedule, Final Rule [CMS-1715-F]. Federal Register, November 15, 2019. Medicare national average physician payment rates listed in this document are based on the conversion factor of $36.0896. No geographic adjustments have been made to the reported payment rates.
3. Calendar Year 2020 Medicare Outpatient Prospective Payment System, Final Rule [CMS-1717-FC], Federal Register, November 12, 2019, its associated addenda posted on the Centers for Medicare and Medicaid Services web site on November 1, 2019, and Correction Notice [CMS-1717-CN] posted on December 18, 2019.
4. MLN Matters® Number MM8863 HYPERLINK "https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8863.pdf" (Accessed December 2019).
5. Fiscal Year 2020 Medicare Inpatient Prospective Payment System, Final Rule [CMS-1716-F], Federal Register, August 16, 2019 and Correction Notice [CMS-1716-CN], Federal Register October 7, 2019. Rates were calculated with a hospital Medicare base rate of $6,258.96.

Status Indicator (SI) Definitions: C - Not paid under OPPS. Admit patient. Bill as inpatient; **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; **T** - Significant procedure, multiple procedure reduction applies.

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.

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