stryker

Foot & Ankle

2022 Reimbursement Guide

Physician & Facility

Reimbursement helpline:
800-698-9985

Contents

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 2022 Final Physician Payment

CPT® code[1]	Description	Facility (POS 21, 22 or 24)		Non-Facility (POS 11)	
		RVUs	Medicare National Average Payment[2]	RVUs	Medicare National Average Payment[2]
Arthrodesis					
27870	Arthrodesis, ankle, open	29.98	$1,037	N/A	N/A
27871	Arthrodesis, tibiofibular joint, proximal or distal	20.52	$710	N/A	N/A
28705	Arthrodesis; pantalar	36.16	$1,251	N/A	N/A
28715	Arthrodesis; triple	27.84	$963	N/A	N/A
28725	Arthrodesis; subtalar	23.01	$796	N/A	N/A
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;	21.66	$750	N/A	N/A
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	23.14	$801	N/A	N/A
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	20.28	$702	N/A	N/A
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	18.24	$631	24.54	$849
28750	Arthrodesis, great toe; metatarsophalangeal joint	17.10	$592	23.26	$805
28755	Arthrodesis, great toe; interphalangeal joint	9.86	$341	15.02	$520
28760	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure)	16.71	$578	22.55	$780
Arthroplasty					
27700	Arthroplasty, ankle;	18.15	$628	N/A	N/A
27702	Arthroplasty, ankle; with implant (total ankle)	28.55	$988	N/A	N/A
27703	Arthroplasty, ankle; revision, total ankle	32.84	$1,136	N/A	N/A
27704	Removal of ankle implant	16.96	$587	N/A	N/A
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/ MRI images (List separately in addition to code for primary procedure)	0.00	Carrier Priced	0.00	Carrier Priced
Arthroscopy					
29891	Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect	19.87	$688	N/A	N/A

CPT® code[1]	Description	Facility (POS 21, 22 or 24)		Non-Facility (POS 11)	
		RVUs	Medicare National Average Payment[2]	RVUs	Medicare National Average Payment[2]
29894	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body	14.96	$518	N/A	N/A
29898	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive	16.63	$576	N/A	N/A
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis	30.11	$1,042	N/A	N/A
29906	Arthroscopy, subtalar joint, surgical; with debridement	19.35	$670	N/A	N/A
29907	Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis	26.05	$901	N/A	N/A
Bunionectomy/Ostectomy/Osteotomy					
28110	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)	8.54	$296	13.59	$470
28285	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)	11.28	$390	15.86	$549
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant	13.49	$467	20.34	$704
28291	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant	14.41	$499	20.93	$724
28292	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method	14.13	$489	20.51	$710
28295	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal metatarsal osteotomy, any method	18.21	$630	32.50	$1,125
28296	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method	15.04	$520	26.38	$913
28297	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method	17.80	$616	30.82	$1,067
28298	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method	14.78	$511	24.68	$854
28299	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method	17.30	$599	29.88	$1,034
28300	Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation	19.23	$665	N/A	N/A
28302	Osteotomy; talus	21.32	$738	N/A	N/A
28304	Osteotomy, tarsal bones, other than calcaneus or talus;	18.06	$625	24.49	$848
28305	Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (eg, Fowler type)	20.05	$694	N/A	N/A
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	11.88	$411	17.92	$620

CPT® code[1]	Description	Facility (POS 21, 22 or 24)		Non-Facility (POS 11)	
		RVUs	Medicare National Average Payment[2]	RVUs	Medicare National Average Payment[2]
28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	15.38	$532	23.43	$811
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	11.34	$392	16.86	$583
28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	26.35	$912	N/A	N/A
28310	Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)	10.63	$368	16.11	$558
28312	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe	9.67	$335	15.33	$531
28313	Reconstruction, angular deformity of toe, soft tissue procedures only (eg, overlapping second toe, fifth toe, curly toes)	10.58	$366	15.61	$540
Capsulotomy					
28264	Capsulotomy, midtarsal (eg, Heyman type procedure)	20.51	$710	26.80	$927
28270	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)	9.80	$339	14.38	$498
28272	Capsulotomy; interphalangeal joint, each joint (separate procedure)	7.35	$254	11.33	$392
Insertion/Removal					
0335T	Insertion of sinus tarsi implant	N/A	Carrier Priced	N/A	Carrier Priced
20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	12.39	$429	17.98	$622
Internal Fixation					
27814	Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed	22.74	$787	N/A	N/A
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	26.17	$906	N/A	N/A
27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	29.39	$1,017	N/A	N/A
27826	Open treatment of fracture of weight bearing articular surface/ portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	25.53	$884	N/A	N/A
27827	Open treatment of fracture of weight bearing articular surface/ portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only	33.41	$1,156	N/A	N/A
27828	Open treatment of fracture of weight bearing articular surface/ portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula	39.61	$1,371	N/A	N/A

CPT® code[1]	Description	Facility (POS 21, 22 or 24)		Non-Facility (POS 11)	
		RVUs	Medicare National Average Payment[2]	RVUs	Medicare National Average Payment[2]
28320	Repair, nonunion or malunion; tarsal bones	18.04	$624	N/A	N/A
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed;	33.45	$1,158	N/A	N/A
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	38.65	$1,338	N/A	N/A
28445	Open treatment of talus fracture, includes internal fixation, when performed	30.28	$1,048	N/A	N/A
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	18.89	$654	N/A	N/A
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	16.65	$576	N/A	N/A
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	14.72	$509	19.55	$677
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each	11.96	$414	16.86	$583
28531	Open treatment of sesamoid fracture, with or without internal fixation	5.30	$183	9.76	$338
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	19.48	$674	25.52	$883
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	24.55	$850	N/A	N/A
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	14.29	$495	19.24	$666
28675	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed	12.14	$420	17.09	$591
29892	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)	18.82	$651	N/A	N/A
Repair					
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon;	19.55	$677	N/A	N/A
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	19.51	$675	N/A	N/A
27654	Repair, secondary, Achilles tendon, with or without graft	21.13	$731	N/A	N/A
27698	Repair, secondary, disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)	18.89	$654	N/A	N/A
28200	Repair, tendon, flexor, foot; primary or secondary, w/ out free graft, each tendon	9.65	$334	14.70	$509
28202	Repair, tendon, flexor, foot; secondary with free graft, each tendon (includes obtaining graft)	12.57	$422	17.58	$608
28208	Repair, tendon, extensor, foot; primary or secondary, each tendon	9.41	$326	14.30	$495
28210	Repair, tendon, extensor, foot; primary or secondary with free graft, each tendon (includes obtaining graft)	12.32	$426	17.32	$599

CPT® code[1]	Description	Facility (POS 21, 22 or 24)		Non-Facility (POS 11)	
		RVUs	Medicare National Average Payment[2]	RVUs	Medicare National Average Payment[2]
Unlisted					
27899	Unlisted procedure, leg or ankle	N/A	Carrier Priced	N/A	Carrier Priced
28899	Unlisted procedure, foot or toes	N/A	Carrier Priced	N/A	Carrier Priced
29999	Unlisted procedure, arthroscopy	N/A	Carrier Priced	N/A	Carrier Priced

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 2022 Final Hospital Outpatient And Ambulatory Surgical Center Payment

CPT® code[1]	Description	Hospital Outpatient (POS 22)		Ambulatory Surgical Center (POS 24)		
		APC	Medicare National Average Payment[3]	SI	Medicare National Average Payment[3]	PI
Arthrodesis						
27870	Arthrodesis, ankle, open	5115	$12,593	J1	$8,904	J8
27871	Arthrodesis, tibiofibular joint, proximal or distal	5115	$12,593	J1	$9,267	J8
28705	Arthrodesis; pantalar	5116	$16,513	J1	$12,372	J8
28715	Arthrodesis; triple	5115	$12,593	J1	$9,190	J8
28725	Arthrodesis; subtalar	5115	$12,593	J1	$8,695	J8
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;	5115	$12,593	J1	$9,230	J8
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	5115	$12,593	J1	$9,385	J8
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	5115	$12,593	J1	$9,139	J8
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	5114	$6,397	J1	$4,502	J8
28750	Arthrodesis, great toe; metatarsophalangeal joint	5114	$6,397	J1	$4,341	J8
28755	Arthrodesis, great toe; interphalangeal joint	5114	$6,397	J1	$3,001	A2
28760	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure)	5114	$6,397	J1	$3,905	J8

CPT® code[1]	Description	Hospital Outpatient (POS 22)		Ambulatory Surgical Center (POS 24)		
		APC	Medicare National Average Payment[3]	SI	Medicare National Average Payment[3]	PI
Arthroplasty						
27700	Arthroplasty, ankle;	5114	$6,397	J1	$3,895	J8
27702	Arthroplasty, ankle; with implant (total ankle)	5115	$12,593	J1	Not included on the ASC Covered Procedures List	N/A
27703	Arthroplasty, ankle; revision, total ankle	N/A	Carrier Priced	N/A	Not included on the ASC Covered Procedures List	N/A
27704	Removal of ankle implant	5113	$2,892	Q2	$1,362	A2
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)	N/A	Packaged	N	Packaged	N1
Arthroscopy						
29891	Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect	5113	$2,892	J1	$1,362	A2
29894	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body	5113	$2,892	J1	$1,362	A2
29898	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive	5113	$2,892	J1	$1,362	A2
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis	5114	$6,397	J1	$4,007	J8
29906	Arthroscopy, subtalar joint, surgical; with debridement	5113	$2,892	J1	$1,362	G2
29907	Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis	5115	$12,593	J1	$7,833	J8
Bunionectomy/Ostectomy/Osteotomy						
28110	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)	5113	$2,892	J1	$1,362	A2
28285	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)	5113	$2,892	J1	$1,362	A2
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant	5113	$2,892	J1	$1,362	A2
28291	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant	5114	$6,397	J1	$4,531	J8
28292	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method	5113	$2,892	J1	$1,362	A2
28295	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal metatarsal osteotomy, any method	5113	$2,892	J1	$1,362	G2
28296	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method	5113	$2,892	J1	$1,362	A2

CPT® code[1]	Description	Hospital Outpatient (POS 22)		Ambulatory Surgical Center (POS 24)		
		APC	Medicare National Average Payment[3]	SI	Medicare National Average Payment[3]	PI
28297	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method	5114	$6,397	J1	$4,387	J8
28298	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method	5114	$6,397	J1	$3,881	J8
28299	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method	5114	$6,397	J1	$3,918	J8
28300	Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation	5114	$6,397	J1	$4,230	J8
28302	Osteotomy; talus	5114	$6,397	J1	$3,905	J8
28304	Osteotomy, tarsal bones, other than calcaneus or talus;	5114	$6,397	J1	$3,001	A2
28305	Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (eg, Fowler type)	5114	$6,397	J1	$4,312	J8
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	5114	$6,397	J1	$3,001	A2
28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	5114	$6,397	J1	$3,001	A2
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	5113	$2,892	J1	$1,362	A2
28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	5114	$6,397	J1	$4,070	J8
28310	Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)	5114	$6,397	J1	$3,001	A2
28312	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe	5113	$2,892	J1	$1,362	A2
28313	Reconstruction, angular deformity of toe, soft tissue procedures only (eg, overlapping second toe, fifth toe, curly toes)	5113	$2,892	J1	$1,362	A2
Capsulotomy						
28264	Capsulotomy, midtarsal (eg, Heyman type procedure)	5112	$1,423	J1	$742	A2
28270	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)	5113	$2,892	J1	$1,362	A2
28272	Capsulotomy; interphalangeal joint, each joint (separate procedure)	5112	$1,423	J1	$238	P3
Insertion/Removal						
0335T	Insertion of sinus tarsi implant	5114	$6,397	J1	$4,543	J8
20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	5073	$2,422	Q2	$1,020	A2

CPT® code[1]	Description	Hospital Outpatient (POS 22)		Ambulatory Surgical Center (POS 24)		
		APC	Medicare National Average Payment[3]	SI	Medicare National Average Payment[3]	PI
Internal Fixation						
27814	Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed	5114	$6,397	J1	$4,029	J8
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	5114	$6,397	J1	$4,033	J8
27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	5114	$6,397	J1	$3,991	J8
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	5114	$6,397	J1	$3,995	J8
27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only	5115	$12,593	J1	$8,560	J8
27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula	5115	$12,593	J1	$8,502	J8
28320	Repair, nonunion or malunion; tarsal bones	5115	$12,593	J1	$8,828	J8
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed;	5114	$6,397	J1	$4,229	J8
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	5115	$12,593	J1	$8,303	J8
28445	Open treatment of talus fracture, includes internal fixation, when performed	5114	$6,397	J1	$4,204	J8
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	5114	$6,397	J1	$3,966	J8
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	5114	$6,397	J1	$4,036	J8
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	5113	$2,892	J1	$1,362	A2
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each	5113	$2,892	J1	$1,362	A2
28531	Open treatment of sesamoid fracture, with or without internal fixation	5114	$6,397	J1	$3,001	A2
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	5114	$6,397	J1	$3,977	J8
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	5114	$6,397	J1	$4,105	J8

CPT® code[1]	Description	Hospital Outpatient (POS 22)		Ambulatory Surgical Center (POS 24)		
		APC	Medicare National Average Payment[3]	SI	Medicare National Average Payment[3]	PI
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	5113	$2,892	J1	$1,362	A2
28675	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed	5113	$2,892	J1	$1,362	A2
29892	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)	5114	$6,397	J1	$3,001	A2
Repair						
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon;	5114	$6,397	J1	$3,001	A2
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	5114	$6,397	J1	$4,230	J8
27654	Repair, secondary, Achilles tendon, with or without graft	5114	$6,397	J1	$3,905	J8
27698	Repair, secondary, disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)	5114	$6,397	J1	$3,904	J8
28200	Repair, tendon, flexor, foot; primary or secondary, w/out free graft, each tendon	5113	$2,892	J1	$1,362	A2
28202	Repair, tendon, flexor, foot; secondary with free graft, each tendon (includes obtaining graft)	5114	$6,397	J1	$3,884	J8
28208	Repair, tendon, extensor, foot; primary or secondary, each tendon	5113	$2,892	J1	$1,362	A2
28210	Repair, tendon, extensor, foot; primary or secondary with free graft, each tendon (includes obtaining graft)	5114	$6,397	J1	$3,947	J8
Unlisted						
27899	Unlisted procedure, leg or ankle	5111	$211	T	Not included on the ASC Covered Procedures List	N/A
28899	Unlisted procedure, foot or toes	5111	$211	T	Not included on the ASC Covered Procedures List	N/A
29999	Unlisted procedure, arthroscopy	5111	$211	T	Not included on the ASC Covered Procedures List	N/A

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.

HCPCS code	Description
C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)
C1734	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue to bone (implantable)
C1769	Guide Wire
C1776	Joint device (implantable)
C1889	Implantable/insertable device, not otherwise classified
L8641	Metatarsal joint implant
L8642	Hallux implant
L8699	Prosthetic implant, not otherwise specified

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 below4	
XE	**Separate Encounter:** A service that is distinct because it occurred during a separate encounter. Only use XE to describe separate encounters on the same date of service.
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 Lower Extremity procedures:

ICD-10-PCS code	ICD-10-PCS Description
0JCQ0ZZ	Extirpation of Matter from Right Foot Subcutaneous Tissue and Fascia, Open Approach
0JCQ3ZZ	Extirpation of Matter from Right Foot Subcutaneous Tissue and Fascia, Percutaneous Approach
0JCR0ZZ	Extirpation of Matter from Left Foot Subcutaneous Tissue and Fascia, Open Approach
0JCR3ZZ	Extirpation of Matter from Left Foot Subcutaneous Tissue and Fascia, Percutaneous Approach
0K8V0ZZ	Division of Right Foot Muscle, Open Approach
0K8V3ZZ	Division of Right Foot Muscle, Percutaneous Approach
0K8V4ZZ	Division of Right Foot Muscle, Percutaneous Endoscopic Approach
0K8W0ZZ	Division of Left Foot Muscle, Open Approach
0K8W3ZZ	Division of Left Foot Muscle, Percutaneous Approach
0K8W4ZZ	Division of Left Foot Muscle, Percutaneous Endoscopic Approach
0LMT0ZZ	Reattachment of Left Ankle Tendon, Open Approach
0LQV0ZZ	Repair Right Foot Tendon, Open Approach
0LQV3ZZ	Repair Right Foot Tendon, Percutaneous Approach
0LQV4ZZ	Repair Right Foot Tendon, Percutaneous Endoscopic Approach
0LQW0ZZ	Repair Left Foot Tendon, Open Approach
0LQW3ZZ	Repair Left Foot Tendon, Percutaneous Approach
0LQW4ZZ	Repair Left Foot Tendon, Percutaneous Endoscopic Approach
0MQQ0ZZ	Repair Right Ankle Bursa and Ligament, Open Approach
0MQQ3ZZ	Repair Right Ankle Bursa and Ligament, Percutaneous Approach
0MQR0ZZ	Repair Left Ankle Bursa and Ligament, Open Approach
0MQR3ZZ	Repair Left Ankle Bursa and Ligament, Percutaneous Approach
0MQS0ZZ	Repair Right Foot Bursa and Ligament, Open Approach
0MQS3ZZ	Repair Right Foot Bursa and Ligament, Percutaneous Approach
0MQS4ZZ	Repair Right Foot Bursa and Ligament, Percutaneous Endoscopic Approach
0MQT0ZZ	Repair Left Foot Bursa and Ligament, Open Approach
0MQT3ZZ	Repair Left Foot Bursa and Ligament, Percutaneous Approach

ICD-10-PCS code	ICD-10-PCS Description
0MQT4ZZ	Repair Left Foot Bursa and Ligament, Percutaneous Endoscopic Approach
0Q8L0ZZ	Division of Right Tarsal, Open Approach
0Q8L3ZZ	Division of Right Tarsal, Percutaneous Approach
0Q8L4ZZ	Division of Right Tarsal, Percutaneous Endoscopic Approach
0Q8M0ZZ	Division of Left Tarsal, Open Approach
0Q8M3ZZ	Division of Left Tarsal, Percutaneous Approach
0Q8M4ZZ	Division of Left Tarsal, Percutaneous Endoscopic Approach
0QBN0Z2	Excision of Right Metatarsal, Sesamoid Bone(s) 1st Toe, Open Approach
0QBN0ZZ	Excision of Right Metatarsal, Open Approach
0QBN3Z2	Excision of Right Metatarsal, Sesamoid Bone(s) 1st Toe, Percutaneous Approach
0QBN3ZZ	Excision of Right Metatarsal, Percutaneous Approach
0QBN4Z2	Excision of Right Metatarsal, Sesamoid Bone(s) 1st Toe, Percutaneous Endoscopic Approach
0QBN4ZZ	Excision of Right Metatarsal, Percutaneous Endoscopic Approach
0QBP0Z2	Excision of Left Metatarsal, Sesamoid Bone(s) 1st Toe, Open Approach
0QBP0ZZ	Excision of Left Metatarsal, Open Approach
0QBP3Z2	Excision of Left Metatarsal, Sesamoid Bone(s) 1st Toe, Percutaneous Approach
0QBP3ZZ	Excision of Left Metatarsal, Percutaneous Approach
0QBP4Z2	Excision of Left Metatarsal, Sesamoid Bone(s) 1st Toe, Percutaneous Endoscopic Approach
0QBP4ZZ	Excision of Left Metatarsal, Percutaneous Endoscopic Approach
0QBQ0ZZ	Excision of Right Toe Phalanx, Open Approach
0QBQ3ZZ	Excision of Right Toe Phalanx, Percutaneous Approach
0QBQ4ZZ	Excision of Right Toe Phalanx, Percutaneous Endoscopic Approach
0QBR0ZZ	Excision of Left Toe Phalanx, Open Approach
0QBR4ZZ	Excision of Left Toe Phalanx, Percutaneous Endoscopic Approach
0QHL04Z	Insertion of Internal Fixation Device into Right Tarsal, Open Approach
0QHL34Z	Insertion of Internal Fixation Device into Right Tarsal, Percutaneous Approach
0QHL44Z	Insertion of Internal Fixation Device into Right Tarsal, Percutaneous Endoscopic Approach
0QHM04Z	Insertion of Internal Fixation Device into Left Tarsal, Open Approach
0QHM34Z	Insertion of Internal Fixation Device into Left Tarsal, Percutaneous Approach
0QHM44Z	Insertion of Internal Fixation Device into Left Tarsal, Percutaneous Endoscopic Approach

ICD-10-PCS code	ICD-10-PCS Description
0QPL04Z	Removal of Internal Fixation Device from Right Tarsal, Open Approach
0QPL05Z	Removal of External Fixation Device from Right Tarsal, Open Approach
0QPM04Z	Removal of Internal Fixation Device from Left Tarsal, Open Approach
0QPM05Z	Removal of External Fixation Device from Left Tarsal, Open Approach
0QPN04Z	Removal of Internal Fixation Device from Right Metatarsal, Open Approach
0QPN05Z	Removal of External Fixation Device from Right Metatarsal, Open Approach
0QPP04Z	Removal of Internal Fixation Device from Left Metatarsal, Open Approach
0QPP05Z	Removal of External Fixation Device from Left Metatarsal, Open Approach
0QPQ04Z	Removal of Internal Fixation Device from Right Toe Phalanx, Open Approach
0QPQ05Z	Removal of External Fixation Device from Right Toe Phalanx, Open Approach
0QPR04Z	Removal of Internal Fixation Device from Left Toe Phalanx, Open Approach
0QPR05Z	Removal of External Fixation Device from Left Toe Phalanx, Open Approach
0QQL0ZZ	Repair Right Tarsal, Open Approach
0QQL3ZZ	Repair Right Tarsal, Percutaneous Approach
0QQL4ZZ	Repair Right Tarsal, Percutaneous Endoscopic Approach
0QQLXZZ	Repair Right Tarsal, External Approach
0QQM0ZZ	Repair Left Tarsal, Open Approach
0QQM3ZZ	Repair Left Tarsal, Percutaneous Approach
0QQM4ZZ	Repair Left Tarsal, Percutaneous Endoscopic Approach
0QQMXZZ	Repair Left Tarsal, External Approach
0QRL07Z	Replacement of Right Tarsal with Autologous Tissue Substitute, Open Approach
0QRL0KZ	Replacement of Right Tarsal with Nonautologous Tissue Substitute, Open Approach
0QRL37Z	Replacement of Right Tarsal with Autologous Tissue Substitute, Percutaneous Approach
0QRL3KZ	Replacement of Right Tarsal with Nonautologous Tissue Substitute, Percutaneous Approach
0QRL47Z	Replacement of Right Tarsal with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0QRL4KZ	Replacement of Right Tarsal with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0QRM07Z	Replacement of Left Tarsal with Autologous Tissue Substitute, Open Approach
0QRM0KZ	Replacement of Left Tarsal with Nonautologous Tissue Substitute, Open Approach
0QRM37Z	Replacement of Left Tarsal with Autologous Tissue Substitute, Percutaneous Approach
0QRM3KZ	Replacement of Left Tarsal with Nonautologous Tissue Substitute, Percutaneous Approach

ICD-10-PCS code	ICD-10-PCS Description
0QRM47Z	Replacement of Left Tarsal with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0QRM4KZ	Replacement of Left Tarsal with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0QRQ07Z	Replacement of Right Toe Phalanx with Autologous Tissue Substitute, Open Approach
0QRQ0JZ	Replacement of Right Toe Phalanx with Synthetic Substitute, Open Approach
0QRQ0KZ	Replacement of Right Toe Phalanx with Nonautologous Tissue Substitute, Open Approach
0QRQ37Z	Replacement of Right Toe Phalanx with Autologous Tissue Substitute, Percutaneous Approach
0QRQ3JZ	Replacement of Right Toe Phalanx with Synthetic Substitute, Percutaneous Approach
0QRQ3KZ	Replacement of Right Toe Phalanx with Nonautologous Tissue Substitute, Percutaneous Approach
0QRQ47Z	Replacement of Right Toe Phalanx with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0QRQ4JZ	Replacement of Right Toe Phalanx with Synthetic Substitute, Percutaneous Endoscopic Approach
0QRQ4KZ	Replacement of Right Toe Phalanx with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0QRR07Z	Replacement of Left Toe Phalanx with Autologous Tissue Substitute, Open Approach
0QRR0JZ	Replacement of Left Toe Phalanx with Synthetic Substitute, Open Approach
0QRR0KZ	Replacement of Left Toe Phalanx with Nonautologous Tissue Substitute, Open Approach
0QRR37Z	Replacement of Left Toe Phalanx with Autologous Tissue Substitute, Percutaneous Approach
0QRR3JZ	Replacement of Left Toe Phalanx with Synthetic Substitute, Percutaneous Approach
0QRR3KZ	Replacement of Left Toe Phalanx with Nonautologous Tissue Substitute, Percutaneous Approach
0QRR47Z	Replacement of Left Toe Phalanx with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0QRR4JZ	Replacement of Left Toe Phalanx with Synthetic Substitute, Percutaneous Endoscopic Approach
0QRR4KZ	Replacement of Left Toe Phalanx with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0QSG04Z	Reposition Right Tibia with Internal Fixation Device, Open Approach
0QSG06Z	Reposition Right Tibia with Intramedullary Internal Fixation Device, Open Approach
0QSG0ZZ	Reposition Right Tibia, Open Approach
0QSG3ZZ	Reposition Right Tibia, Percutaneous Approach
0QSG4ZZ	Reposition Right Tibia, Percutaneous Endoscopic Approach
0QSH04Z	Reposition Left Tibia with Internal Fixation Device, Open Approach
0QSH06Z	Reposition Left Tibia with Intramedullary Internal Fixation Device, Open Approach
0QSH0ZZ	Reposition Left Tibia, Open Approach
0QSH3ZZ	Reposition Left Tibia, Percutaneous Approach
0QSH4ZZ	Reposition Left Tibia, Percutaneous Endoscopic Approach

ICD-10-PCS code	ICD-10-PCS Description
0QSJ04Z	Reposition Right Fibula with Internal Fixation Device, Open Approach
0QSJ06Z	Reposition Right Fibula with Intramedullary Internal Fixation Device, Open Approach
0QSK04Z	Reposition Left Fibula with Internal Fixation Device, Open Approach
0QSK06Z	Reposition Left Fibula with Intramedullary Internal Fixation Device, Open Approach
0QSL04Z	Reposition Right Tarsal with Internal Fixation Device, Open Approach
0QSL05Z	Reposition Right Tarsal with External Fixation Device, Open Approach
0QSL0ZZ	Reposition Right Tarsal, Open Approach
0QSL44Z	Reposition Right Tarsal with Internal Fixation Device, Percutaneous Endoscopic Approach
0QSM04Z	Reposition Left Tarsal with Internal Fixation Device, Open Approach
0QSM05Z	Reposition Left Tarsal with External Fixation Device, Open Approach
0QSM0ZZ	Reposition Left Tarsal, Open Approach
0QSM44Z	Reposition Left Tarsal with Internal Fixation Device, Percutaneous Endoscopic Approach
0QSN04Z	Reposition Right Metatarsal with Internal Fixation Device, Open Approach
0QSP04Z	Reposition Left Metatarsal with Internal Fixation Device, Open Approach
0QSQ04Z	Reposition Right Toe Phalanx with Internal Fixation Device, Open Approach
0QSQ0ZZ	Reposition Right Toe Phalanx, Open Approach
0QSR04Z	Reposition Left Toe Phalanx with Internal Fixation Device, Open Approach
0QSR0ZZ	Reposition Left Toe Phalanx, Open Approach
0S5F0ZZ	Destruction of Right Ankle Joint, Open Approach
0S5F3ZZ	Destruction of Right Ankle Joint, Percutaneous Approach
0S5F4ZZ	Destruction of Right Ankle Joint, Percutaneous Endoscopic Approach
0S5G0ZZ	Destruction of Left Ankle Joint, Open Approach
0S5G3ZZ	Destruction of Left Ankle Joint, Percutaneous Approach
0S5G4ZZ	Destruction of Left Ankle Joint, Percutaneous Endoscopic Approach
0SBF0ZZ	Excision of Right Ankle Joint, Open Approach
0SBF3ZZ	Excision of Right Ankle Joint, Percutaneous Approach
0SBF4ZZ	Excision of Right Ankle Joint, Percutaneous Endoscopic Approach
0SBG0ZZ	Excision of Left Ankle Joint, Open Approach
0SBG3ZZ	Excision of Left Ankle Joint, Percutaneous Approach
0SBG4ZZ	Excision of Left Ankle Joint, Percutaneous Endoscopic Approach

ICD-10-PCS code	ICD-10-PCS Description
0SBH0ZZ	Excision of Right Tarsal Joint, Open Approach
0SBH3ZZ	Excision of Right Tarsal Joint, Percutaneous Approach
0SBH4ZZ	Excision of Right Tarsal Joint, Percutaneous Endoscopic Approach
0SBJ0ZZ	Excision of Left Tarsal Joint, Open Approach
0SBJ3ZZ	Excision of Left Tarsal Joint, Percutaneous Approach
0SBJ4ZZ	Excision of Left Tarsal Joint, Percutaneous Endoscopic Approach
0SGF04Z	Fusion of Right Ankle Joint with Internal Fixation Device, Open Approach
0SGF05Z	Fusion of Right Ankle Joint with External Fixation Device, Open Approach
0SGF07Z	Fusion of Right Ankle Joint with Autologous Tissue Substitute, Open Approach
0SGF0JZ	Fusion of Right Ankle Joint with Synthetic Substitute, Open Approach
0SGF0KZ	Fusion of Right Ankle Joint with Nonautologous Tissue Substitute, Open Approach
0SGF34Z	Fusion of Right Ankle Joint with Internal Fixation Device, Percutaneous Approach
0SGF35Z	Fusion of Right Ankle Joint with External Fixation Device, Percutaneous Approach
0SGF37Z	Fusion of Right Ankle Joint with Autologous Tissue Substitute, Percutaneous Approach
0SGF3JZ	Fusion of Right Ankle Joint with Synthetic Substitute, Percutaneous Approach
0SGF3KZ	Fusion of Right Ankle Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0SGF44Z	Fusion of Right Ankle Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0SGF45Z	Fusion of Right Ankle Joint with External Fixation Device, Percutaneous Endoscopic Approach
0SGF47Z	Fusion of Right Ankle Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0SGF4JZ	Fusion of Right Ankle Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0SGF4KZ	Fusion of Right Ankle Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0SGG04Z	Fusion of Left Ankle Joint with Internal Fixation Device, Open Approach
0SGG05Z	Fusion of Left Ankle Joint with External Fixation Device, Open Approach
0SGG07Z	Fusion of Left Ankle Joint with Autologous Tissue Substitute, Open Approach
0SGG0JZ	Fusion of Left Ankle Joint with Synthetic Substitute, Open Approach
0SGG0KZ	Fusion of Left Ankle Joint with Nonautologous Tissue Substitute, Open Approach
0SGG34Z	Fusion of Left Ankle Joint with Internal Fixation Device, Percutaneous Approach
0SGG35Z	Fusion of Left Ankle Joint with External Fixation Device, Percutaneous Approach
0SGG37Z	Fusion of Left Ankle Joint with Autologous Tissue Substitute, Percutaneous Approach
0SGG3JZ	Fusion of Left Ankle Joint with Synthetic Substitute, Percutaneous Approach

ICD-10-PCS code	ICD-10-PCS Description
0SGG3KZ	Fusion of Left Ankle Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0SGG44Z	Fusion of Left Ankle Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0SGG47Z	Fusion of Left Ankle Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0SGG4JZ	Fusion of Left Ankle Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0SGG4KZ	Fusion of Left Ankle Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0SGH04Z	Fusion of Right Tarsal Joint with Internal Fixation Device, Open Approach
0SGH05Z	Fusion of Right Tarsal Joint with External Fixation Device, Open Approach
0SGH07Z	Fusion of Right Tarsal Joint with Autologous Tissue Substitute, Open Approach
0SGH0JZ	Fusion of Right Tarsal Joint with Synthetic Substitute, Open Approach
0SGH0KZ	Fusion of Right Tarsal Joint with Nonautologous Tissue Substitute, Open Approach
0SGH34Z	Fusion of Right Tarsal Joint with Internal Fixation Device, Percutaneous Approach
0SGH35Z	Fusion of Right Tarsal Joint with External Fixation Device, Percutaneous Approach
0SGH37Z	Fusion of Right Tarsal Joint with Autologous Tissue Substitute, Percutaneous Approach
0SGH3JZ	Fusion of Right Tarsal Joint with Synthetic Substitute, Percutaneous Approach
0SGH3KZ	Fusion of Right Tarsal Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0SGH44Z	Fusion of Right Tarsal Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0SGH45Z	Fusion of Right Tarsal Joint with External Fixation Device, Percutaneous Endoscopic Approach
0SGH47Z	Fusion of Right Tarsal Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0SGH4JZ	Fusion of Right Tarsal Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0SGH4KZ	Fusion of Right Tarsal Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0SGJ04Z	Fusion of Left Tarsal Joint with Internal Fixation Device, Open Approach
0SGJ05Z	Fusion of Left Tarsal Joint with External Fixation Device, Open Approach
0SGJ07Z	Fusion of Left Tarsal Joint with Autologous Tissue Substitute, Open Approach
0SGJ0JZ	Fusion of Left Tarsal Joint with Synthetic Substitute, Open Approach
0SGJ0KZ	Fusion of Left Tarsal Joint with Nonautologous Tissue Substitute, Open Approach
0SGJ34Z	Fusion of Left Tarsal Joint with Internal Fixation Device, Percutaneous Approach
0SGJ35Z	Fusion of Left Tarsal Joint with External Fixation Device, Percutaneous Approach
0SGJ37Z	Fusion of Left Tarsal Joint with Autologous Tissue Substitute, Percutaneous Approach
0SGJ3JZ	Fusion of Left Tarsal Joint with Synthetic Substitute, Percutaneous Approach
0SGJ3KZ	Fusion of Left Tarsal Joint with Nonautologous Tissue Substitute, Percutaneous Approach

ICD-10-PCS code	ICD-10-PCS Description
0SGJ44Z	Fusion of Left Tarsal Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0SGJ45Z	Fusion of Left Tarsal Joint with External Fixation Device, Percutaneous Endoscopic Approach
0SGJ47Z	Fusion of Left Tarsal Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0SGJ4JZ	Fusion of Left Tarsal Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0SGJ4KZ	Fusion of Left Tarsal Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0SGK04Z	Fusion of Right Tarsometatarsal Joint with Internal Fixation Device, Open Approach
0SGK05Z	Fusion of Right Tarsometatarsal Joint with External Fixation Device, Open Approach
0SGK34Z	Fusion of Right Tarsometatarsal Joint with Internal Fixation Device, Percutaneous Approach
0SGK35Z	Fusion of Right Tarsometatarsal Joint with External Fixation Device, Percutaneous Approach
0SGK44Z	Fusion Right Tarsometatarsal Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0SGK45Z	Fusion Right Tarsometatarsal Joint with External Fixation Device, Percutaneous Endoscopic Approach
0SGL04Z	Fusion of Left Tarsometatarsal Joint with Internal Fixation Device, Open Approach
0SGL05Z	Fusion of Left Tarsometatarsal Joint with External Fixation Device, Open Approach
0SGL44Z	Fusion Left Tarsometatarsal Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0SGL45Z	Fusion Left Tarsometatarsal Joint with External Fixation Device, Percutaneous Endoscopic Approach
0SGM04Z	Fusion of Right Metatarsal-Phalangeal Joint with Internal Fixation Device, Open Approach
0SGM05Z	Fusion of Right Metatarsal-Phalangeal Joint with External Fixation Device, Open Approach
0SGN04Z	Fusion of Left Metatarsal-Phalangeal Joint with Internal Fixation Device, Open Approach
0SGN05Z	Fusion of Left Metatarsal-Phalangeal Joint with External Fixation Device, Open Approach
0SGP04Z	Fusion of Right Toe Phalanx Joint with Internal Fixation Device, Open Approach
0SGP05Z	Fusion of Right Toe Phalanx Joint with External Fixation Device, Open Approach
0SGQ04Z	Fusion of Left Toe Phalanx Joint with Internal Fixation Device, Open Approach
0SGQ05Z	Fusion of Left Toe Phalanx Joint with External Fixation Device, Open Approach
0SHH44Z	Insertion of Internal Fixation Device into Right Tarsal Joint, Percutaneous Endoscopic Approach
0SHH45Z	Insertion of External Fixation Device into Right Tarsal Joint, Percutaneous Endoscopic Approach
0SHH48Z	Insertion of Spacer into Right Tarsal Joint, Percutaneous Endoscopic Approach
0SHJ44Z	Insertion of Internal Fixation Device into Left Tarsal Joint, Percutaneous Endoscopic Approach
0SHJ45Z	Insertion of External Fixation Device into Left Tarsal Joint, Percutaneous Endoscopic Approach
0SHJ48Z	Insertion of Spacer into Left Tarsal Joint, Percutaneous Endoscopic Approach
0SNM0ZZ	Release Right Metatarsal-Phalangeal Joint, Open Approach

ICD-10-PCS code	ICD-10-PCS Description
0SNM3ZZ	Release Right Metatarsal-Phalangeal Joint, Percutaneous Approach
0SNM4ZZ	Release Right Metatarsal-Phalangeal Joint, Percutaneous Endoscopic Approach
0SNN0ZZ	Release Left Metatarsal-Phalangeal Joint, Open Approach
0SNN3ZZ	Release Left Metatarsal-Phalangeal Joint, Percutaneous Approach
0SNN4ZZ	Release Left Metatarsal-Phalangeal Joint, Percutaneous Endoscopic Approach
0SNP0ZZ	Release Right Toe Phalangeal Joint, Open Approach
0SNP3ZZ	Release Right Toe Phalangeal Joint, Percutaneous Approach
0SNP4ZZ	Release Right Toe Phalangeal Joint, Percutaneous Endoscopic Approach
0SNQ0ZZ	Release Left Toe Phalangeal Joint, Open Approach
0SNQ3ZZ	Release Left Toe Phalangeal Joint, Percutaneous Approach
0SNQ4ZZ	Release Left Toe Phalangeal Joint, Percutaneous Endoscopic Approach
0SPF0JZ	Removal of Synthetic Substitute from Right Ankle Joint, Open Approach
0SPF3JZ	Removal of Synthetic Substitute from Right Ankle Joint, Percutaneous Approach
0SPF44Z	Removal of Internal Fixation Device from Right Ankle Joint, Percutaneous Endoscopic Approach
0SPF45Z	Removal of External Fixation Device from Right Ankle Joint, Percutaneous Endoscopic Approach
0SPF47Z	Removal of Autologous Tissue Substitute from Right Ankle Joint, Percutaneous Endoscopic Approach
0SPF48Z	Removal of Spacer from Right Ankle Joint, Percutaneous Endoscopic Approach
0SPF4JZ	Removal of Synthetic Substitute from Right Ankle Joint, Percutaneous Endoscopic Approach
0SPF4KZ	Removal of Nonautologous Tissue Substitute from Right Ankle Joint, Percutaneous Endoscopic Approach
0SPG0JZ	Removal of Synthetic Substitute from Left Ankle Joint, Open Approach
0SPG3JZ	Removal of Synthetic Substitute from Left Ankle Joint, Percutaneous Approach
0SPG40Z	Removal of Drainage Device from Left Ankle Joint, Percutaneous Endoscopic Approach
0SPG43Z	Removal of Infusion Device from Left Ankle Joint, Percutaneous Endoscopic Approach
0SPG44Z	Removal of Internal Fixation Device from Left Ankle Joint, Percutaneous Endoscopic Approach
0SPG45Z	Removal of External Fixation Device from Left Ankle Joint, Percutaneous Endoscopic Approach
0SPG47Z	Removal of Autologous Tissue Substitute from Left Ankle Joint, Percutaneous Endoscopic Approach
0SPG48Z	Removal of Spacer from Left Ankle Joint, Percutaneous Endoscopic Approach
0SPG4JZ	Removal of Synthetic Substitute from Left Ankle Joint, Percutaneous Endoscopic Approach
0SPG4KZ	Removal of Nonautologous Tissue Substitute from Left Ankle Joint, Percutaneous Endoscopic Approach
0SQF0ZZ	Repair Right Ankle Joint, Open Approach

ICD-10-PCS code	ICD-10-PCS Description
0SQF3ZZ	Repair Right Ankle Joint, Percutaneous Approach
0SQF4ZZ	Repair Right Ankle Joint, Percutaneous Endoscopic Approach
0SQFXZZ	Repair Right Ankle Joint, External Approach
0SQG0ZZ	Repair Left Ankle Joint, Open Approach
0SQG3ZZ	Repair Left Ankle Joint, Percutaneous Approach
0SQG4ZZ	Repair Left Ankle Joint, Percutaneous Endoscopic Approach
0SQGXZZ	Repair Left Ankle Joint, External Approach
0SRF07Z	Replacement of Right Ankle Joint with Autologous Tissue Substitute, Open Approach
0SRF0J9	Replacement of Right Ankle Joint with Synthetic Substitute, Cemented, Open Approach
0SRF0JA	Replacement of Right Ankle Joint with Synthetic Substitute, Uncemented, Open Approach
0SRF0JZ	Replacement of Right Ankle Joint with Synthetic Substitute, Open Approach
0SRF0KZ	Replacement of Right Ankle Joint with Nonautologous Tissue Substitute, Open Approach
0SRG07Z	Replacement of Left Ankle Joint with Autologous Tissue Substitute, Open Approach
0SRG0J9	Replacement of Left Ankle Joint with Synthetic Substitute, Cemented, Open Approach
0SRG0JA	Replacement Left Ankle Joint with Synthetic Substitute, Uncemented, Open Approach
0SRG0JZ	Replacement of Left Ankle Joint with Synthetic Substitute, Open Approach
0SRG0KZ	Replacement of Left Ankle Joint with Nonautologous Tissue Substitute, Open Approach
0SSF04Z	Reposition Right Ankle Joint with Internal Fixation Device, Open Approach
0SSF0ZZ	Reposition Right Ankle Joint, Open Approach
0SSF3ZZ	Reposition Right Ankle Joint, Percutaneous Approach
0SSF44Z	Reposition Right Ankle Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0SSF4ZZ	Reposition Right Ankle Joint, Percutaneous Endoscopic Approach
0SSG04Z	Reposition Left Ankle Joint with Internal Fixation Device, Open Approach
0SSG0ZZ	Reposition Left Ankle Joint, Open Approach
0SSG3ZZ	Reposition Left Ankle Joint, Percutaneous Approach
0SSG44Z	Reposition Left Ankle Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0SSH04Z	Reposition Right Tarsal Joint with Internal Fixation Device, Open Approach
0SSJ04Z	Reposition Left Tarsal Joint with Internal Fixation Device, Open Approach
0SSK04Z	Reposition Right Tarsometatarsal Joint with Internal Fixation Device, Open Approach
0SSL04Z	Reposition Left Tarsometatarsal Joint with Internal Fixation Device, Open Approach

ICD-10-PCS code	ICD-10-PCS Description
0SSM04Z	Reposition Right Metatarsal-Phalangeal Joint with Internal Fixation Device, Open Approach
0SWF0JZ	Revision of Synthetic Substitute in Right Ankle Joint, Open Approach
0SWF3JZ	Revision of Synthetic Substitute in Right Ankle Joint, Percutaneous Approach
0SWF4JZ	Revision of Synthetic Substitute in Right Ankle Joint, Percutaneous Endoscopic Approach
0SWG0JZ	Revision of Synthetic Substitute in Left Ankle Joint, Open Approach
0SWG3JZ	Revision of Synthetic Substitute in Left Ankle Joint, Percutaneous Approach
0SWG4JZ	Revision of Synthetic Substitute in Left Ankle Joint, Percutaneous Endoscopic 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.

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MS-DRG	Description	Relative Weight	Medicare National Average Payment[5]
469	Major Hip and Knee Joint Replacement OR Reattachment of Lower Extremity with MCC OR Total Ankle Replacement	3.0859	$20,349
470	Major Hip and Knee Joint Replacement OR Reattachment of Lower Extremity without MCC	1.9003	$12,531
492	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with MCC	3.4700	$22,882
493	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with CC	2.3258	$15,337
494	Lower Extremity and Humerus Procedures without CC/MCC	1.8517	$12,211
495	Local Excision and Removal of Internal Fixation Devices Except Hip and Femur with MCC	3.6419	$24,016
496	Local Excision and Removal of Internal Fixation Devices Except Hip and Femur with CC	1.9864	$13,099
497	Local Excision and Removal of Internal Fixation Devices Except Hip and Femur without CC/MCC	1.4515	$9,572
500	Soft Tissue Procedures with MCC	3.1895	$21,032
501	Soft Tissue Procedures with CC	1.7541	$11,567
502	Soft Tissue Procedures without CC/MCC	1.3328	$8,789
503	Foot Procedures with MCC	2.6406	$17,413
504	Foot Procedures with CC	1.7750	$11,705
505	Foot Procedures without CC/MCC	1.7750	$11,705
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC	3.1406	$20,710
516	Other Musculoskeletal System and Connective Tissue O.R. Procedures with CC	1.9628	$12,943
517	Other Musculoskeletal System and Connective Tissue O.R. Procedures without CC/MCC	1.3982	$9,220

CC=Complication or Comorbidity MCC=Major Complication or Comorbidity

The Stryker Reimbursement Helpline staff can assist with the following:

- General coding and reimbursement questions
- Prior authorization and pre-determination questions
- Medicare unadjusted national average payment rates

For assistance with coding and reimbursement, please contact:

Reimbursement helpline: 800-698-9985

Fax: 949-449-8699
Email: orthoreimbursement@stryker.com

9 a.m. - 5 p.m. CT,
Monday through Friday
(except holidays and unexpected closures)

Visit us at www.stryker.com.

Status Indicator (SI) Definitions: C - Not paid under OPPS. inpatient only procedure; **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; **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; **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; **P3** - Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on based on MPFS non-facility PE RVUs.

References:

1. Current Procedural Terminology 2022. CPT® copyright 2020 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.Applicable FARS/DFARS apply.

2. Calendar Year 2022 Medicare Physician Fee Schedule, Final Rule [CMS-1751-F]. Federal Register, November 19, 2021. PPRRVU January 2022 update December 15, 2021. Medicare national average physician payment rates listed in this document are based on the conversion factor of $34.6062. No geographic adjustments have been made to the reported payment rates.

3. Calendar Year 2022 Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, Final Rule [CMS-1753-FC], Federal Register, November 16, 2021 and its associated addenda posted on theCenters for Medicare and Medicaid Services web site on November 1, 2021.

4. MLN Matters® Fact Sheet. Proper Use of Modifiers 59 & -X{EPSU}. https://www.cms.gov/files/document/proper-use-modifiers-59-xepsu.pdf. (Accessed November 2021).

5. Fiscal Year 2022 Medicare Inpatient Prospective Payment System, Final Rule [CMS-1752-F], Federal Register, August 13, 2021 and Correcting Amendment [CMS-1752-F2], Federal Register October 20, 2021. Rates were calculated with a hospital Medicare base rate of $6,594.24.

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