



## Elbow Arthroplasty Surgical Procedures

2009 Reimbursement  
and Coding Reference Guide  
for Physicians and Hospitals



This coding reference guide is intended to illustrate the common CPT®\* codes, ICD-9 CM procedure codes, and common MS-DRG, APC and ASC assignment for elbow arthroplasty surgical procedures performed in the inpatient hospital, outpatient hospital, and ambulatory surgery center settings. CPT® is a trademark of the American Medical Association (AMA).

Valid January 1, 2009 to September 30, 2009



## Common CPT Code\* Modifiers

Below are common CPT code modifiers that may be applicable to elbow arthroplasty surgical procedures. Reference should be made to the Current Procedural Terminology (CPT) 2008 Professional Edition (Appendix A) for complete modifier definitions, and for applicability with specific CPT procedure codes.

- 22 Increased Procedural Services:** When the service(s) provided is greater than that usually required for the listed procedure. A report may also be appropriate.
- 50 Bilateral Procedure:** Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative sessions should be identified by adding modifier 50 to the appropriate procedure code.
- 51 Multiple Procedures:** When multiple procedures, other than Evaluation and Management Services, physical medicine and rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same provider, 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). Modifier 51 should not be appended to designated CPT “add-on” codes.
- 52 Reduced Services:** Under certain circumstances a service or procedure is partially reduced or eliminated at the physician’s discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, indicating that the service is reduced.
- 53 Discontinued Procedure:** Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure due to extenuating circumstances that threaten the well being of the patient.
- 54 Surgical Care Only:** When one physician performs a surgical procedure and another provides pre-operative and/or post-operative management.
- 58 Staged or Related Procedure or Service by the Same Physician During a Post-operative Period:** The physician may need 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 diagnostic surgical procedure. This modifier is not used to report the treatment of a problem that requires a return to the operating room.
- 62 Two Surgeons:** When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associate add-on code(s) for that procedure.
- 66 Surgical Team:** Highly complex procedures requiring concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, and various types of complex equipment.
- 73 Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia:** Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure due to extenuating circumstances that threaten the well being of the patient prior to the administration of anesthesia (Facility use only).
- 74 Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After the Administration of Anesthesia:** Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure due to extenuating circumstances that threaten the well being of the patient after the administration of anesthesia (Facility use only).
- 76 Repeat Procedure by Same Physician:** The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service.
- 77 Repeat Procedure by Another Physician:** The physician may need to indicate that a procedure or service performed by another physician had to be repeated.
- 80 Assistant Surgeon:** Surgical assistant services.
- 81 Minimum Assistant Surgeon:** Minimum surgical assistant services.
- 82 Assistant Surgeon (when qualified resident surgeon not available):** The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82.
- 99 Multiple Modifiers:** Under certain circumstances, two or more modifiers may be necessary to completely delineate a service.

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## Common PHYSICIAN Procedure Codes for Elbow Arthroplasty Surgical Procedures

| CPT Code* | Code Description   | Medicare 2009                |                                       |
|-----------|--|------------------------------|---------------------------------------|
|           |  | Total Adjusted Facility RVUs | National Average Payment <sup>1</sup> |
| 24160     | Implant removal; elbow joint   | 15.41                        | \$556                                 |
| 24164     | radial head  | 12.58                        | \$454                                 |
| 24361     | Arthroplasty, elbow; with distal humeral prosthetic replacement  | 25.99                        | \$937                                 |
| 24362     | Arthroplasty, elbow; with implant and fascia lata ligament reconstruction  | 27.59                        | \$995                                 |
| 24363     | Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)   | 38.48                        | \$1,388                               |
| 24365     | Arthroplasty, radial head;   | 16.36                        | \$590                                 |
| 24366     | with implant   | 17.53                        | \$632                                 |
| +20985    | Computer-assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure) | 4.04                         | \$146                                 |

+ Add-on code

<sup>1</sup> Per CMS-1403-FC. Determined by multiplying the physician fee schedule conversion factor (\$36.0666) by the total adjusted facility RVUs. Represents national average with no geographic adjustment; individual physician reimbursement will vary.

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## Common INPATIENT HOSPITAL Procedure Codes and MS-DRG Assignment for Elbow Arthroplasty Surgical Procedures

| ICD-9-CM Procedure Codes | Code Description                                 | Common Medicare MS-DRG Assignment  | Medicare National Average Payment <sup>1,2</sup> |
|--------------------------|--|--|--|
| 78.63                    | Removal of implanted device from radius and ulna | 495 — Local Excision and Removal Internal Fixation Devices Except Hip and Femur with MCC       | \$17,625   |
|                          |  | 496 — Local Excision and Removal Internal Fixation Devices Except Hip and Femur with CC        | \$9,840  |
| 78.69                    | Removal of implanted device from other bone      | 497 — Local Excision and Removal Internal Fixation Devices Except Hip and Femur without CC/MCC | \$6,246  |
| 81.84                    | Total elbow replacement                          | 483 — Major Joint and Limb Reattachment Procedures of Upper Extremity with CC/MCC              | \$12,498   |
|                          |  | 484 — Major Joint and Limb Reattachment Procedures of Upper Extremity without CC/MCC           | \$9,685  |
| 81.85                    | Other repair of elbow                            | 507 — Major Shoulder or Elbow Joint Procedures with CC/MCC                                     | \$9,531  |
|                          |  | 508 — Major Shoulder or Elbow Joint Procedures without CC/MCC                                  | \$6,187  |
| 00.31                    | Computer assisted surgery with CT/CTA            | Additional procedures that might be coded along with the above procedures, if applicable       |  |
| 00.32                    | Computer assisted surgery with MR/MRA            |  |  |
| 00.33                    | Computer assisted surgery with fluoroscopy       |  |  |
| 00.34                    | Imageless computer assisted surgery              |  |  |
| 00.35                    | Computer assisted surgery with multiple datasets |  |  |
| 00.39                    | Other computer assisted surgery                  |  |  |

## Common AMBULATORY SURGERY CENTER (ASC) Payment Rates for Elbow Arthroplasty Surgical Procedures

| CPT Code* | Code Description   | Estimated 2009 Adjusted ASC Payment Rate <sup>3</sup> |
|-----------|--|---|
| 24160     | Implant removal; elbow joint   | \$820   |
| 24164     | radial head  | \$852   |
| 24361     | Arthroplasty, elbow; with distal humeral prosthetic replacement                                      | \$6,086   |
| 24362     | Arthroplasty, elbow; with implant and fascia lata ligament reconstruction                            | \$1,422   |
| 24363     | Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow) | \$6,221   |
| 24365     | Arthroplasty, radial head;   | \$1,113   |
| 24366     | with implant   | \$6,086   |

1 FY 2009 Medicare Inpatient Prospective Payment System final rule (CMS-1390-F), Table 5.

2 Assumes payment for a large urban hospital with wage index >1 and full update. Medicare payment = MS-DRG relative weight x (labor standardized amount + non-labor standardized amount + national capital rate (\$5,552.58)).

3 Represents unadjusted payment rate calculated per CMS-1404-FC. Individual ASC reimbursement will vary.

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## Common OUTPATIENT HOSPITAL APCs for Elbow Arthroplasty Surgical Procedures

| CPT*/<br>HCPCS Code | Code Description   | Medicare APC Assignment   | Status<br>Indicator <sup>1</sup> | Unadjusted<br>Payment Rate <sup>2</sup> |
|---------------------|--|---|----------------------------------|---|
| 24160               | Implant removal; elbow joint   | 0050 – Level II Musculoskeletal Procedures Except Hand and Foot | T                                | \$1,974                                 |
| 24164               | radial head  | 0050 – Level II Musculoskeletal Procedures Except Hand and Foot | T                                | \$1,974                                 |
| 24361               | Arthroplasty, elbow; with distal humeral prosthetic replacement  | 0425 – Level II Arthroplasty with Prosthesis                    | T                                | \$8,044                                 |
| 24362               | Arthroplasty, elbow; with implant and fascia lata ligament reconstruction  | 0048 – Level I Arthroplasty with Prosthesis                     | T                                | \$3,512                                 |
| 24363               | Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)   | 0425 – Level II Arthroplasty with Prosthesis                    | T                                | \$8,044                                 |
| 24365               | Arthroplasty, radial head;   | 0047 – Arthroplasty without Prosthesis                          | T                                | \$2,499                                 |
| 24366               | with implant   | 0425 – Level II Arthroplasty with Prosthesis                    | T                                | \$8,044                                 |
| 20985               | Computer-assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure) | N/A   | N                                | N/A                                     |
| C1776               | Joint device (implantable)   | N/A   | N                                | N/A                                     |

**Note: Surgical procedures for implantable prosthetic devices, performed in an inpatient or outpatient hospital setting, include the cost of the device in the Diagnosis Related Group (DRG) or Ambulatory Payment Classification (APC) rate.**

1 Per addendum B, CMS-1404-FC; Status Indicator:

N = Items and services packaged into APC rates - no separate APC payment

T = Significant Procedure, multiple surgical reduction applies

2 Represents unadjusted payment rate as published in Addendum B, CMS-1404-FC. Individual facility reimbursement will vary.

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### Data Sources

- ICD-9-CM Official Guidelines For Coding and Reporting, U.S. Department of Health and Human Services, Effective October 1, 2007.
- 42 CFR Parts 405, 409, 410, 411, et. al. [CMS-1403-FC]; Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; and Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).
- 42 CFR Parts 411, 412, 413, 422, and 489 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates; Payments for Graduate Medical Education in Certain Emergency Situations; Changes to Disclosure of Physician Ownership in Hospitals and Physician Self-Referral Rules; Updates to the Long-Term Care Prospective Payment System; Updates to Certain IPPS-Excluded Hospitals; and Collection of Information Regarding Financial Relationships Between Hospitals; Final Rule, August 19, 2008.
- 42 CFR Parts 410, 416, and 419 [CMS-1404-FC]; Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2009 Payment Rates; Hospital Conditions of Participation: Requirements for Approval and Re-Approval of Transplant Centers to Perform Organ Transplants--Clarification of Provider and Supplier Termination Policy Medicare and Medicaid Programs: Changes to the Ambulatory Surgical Center Conditions for Coverage.

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