



Knee Arthroplasty Surgical Procedures

2010 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 knee arthroplasty surgical procedures performed in the inpatient hospital, outpatient hospital, and ambulatory surgical center settings. CPT® is a trademark of the American Medical Association (AMA).

Valid January 1, 2010 to September 30, 2010.



Common CPT* Code Modifiers

Below are common CPT code modifiers that may be applicable to knee surgical procedures. Reference should be made to the Current Procedural Terminology (CPT) 2010 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 Knee Arthroplasty Surgical Procedures

CPT Code*	Code Description
27437	Arthroplasty, patella; without prosthesis
27438	Arthroplasty, patella; with prosthesis
27440	Arthroplasty, knee, tibial plateau;
27441	with debridement and partial synovectomy
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;
27443	with debridement and partial synovectomy
27445	Arthroplasty, knee, hinge prosthesis
27446	Arthroplasty, knee, condyle and plateau; medial <u>OR</u> lateral compartments
27447	Arthroplasty, knee, condyle and plateau; medial <u>AND</u> lateral compartments with or without patella resurfacing (TKA)
27486	Revision of total knee arthroplasty, with or without allograft; one component
27487	femoral and entire tibial component
27488	Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee
27599 ¹	Unlisted procedure, femur or knee
+20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure)

+ Add-on code

1 Use of unlisted codes may require payer operative note review and/or pre-authorization. The physician typically sets relative fee based on similar CPT procedure codes; reimbursement by payers may vary.

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The final 2010 Medicare National Payment Rates are pending congressional action. Inquiries regarding 2010 payment rates may be directed to the physician's Medicare Part B carrier or to appropriate payer.

Common INPATIENT HOSPITAL Billing Codes for Knee Arthroplasty Surgical Procedures

ICD-9-CM Procedure Codes	Code Description	Common Medicare MS-DRG Assignment	Medicare National Average Payment ^{1,2}
00.80	Revision of knee replacement, total (all components)	461 – Bilateral or Multiple Major Joint Procedures of Lower Extremity with MCC	\$25,783
		462 – Bilateral or Multiple Major Joint Procedures of Lower Extremity without MCC	\$18,119
		466 – Revision of Hip or Knee Replacement with MCC	\$26,395
		467 – Revision of Hip or Knee Replacement with CC	\$17,640
		468 – Revision of Hip or Knee Replacement without CC/MCC	\$14,225
00.81	Revision of knee replacement, tibial component	466 – Revision of Hip or Knee Replacement with MCC	\$26,395
00.82	Revision of knee replacement, femoral component	467 – Revision of Hip or Knee Replacement with CC	\$17,640
		468 – Revision of Hip or Knee Replacement without CC/MCC	\$14,225
00.83	Revision of knee replacement, patellar component	485 – Knee Procedures with Principal Diagnosis of Infection with MCC	\$17,450
		486 – Knee Procedures with Principal Diagnosis of Infection with CC	\$11,620
		487 – Knee Procedures with Principal Diagnosis of Infection without CC/MCC	\$8,104
00.84	Revision of total knee replacement, tibial insert, liner	488 – Knee Procedures without Principal Diagnosis of Infection with CC/MCC	\$9,481
		489 – Knee Procedures without Principal Diagnosis of Infection without CC/MCC	\$6,687
81.47	Other repair of knee	485 – Knee Procedures with Principal Dx of Infection with MCC	\$17,450
		486 – Knee Procedures with Principal Dx of Infection with CC	\$11,620
		487 – Knee Procedures with Principal Dx of Infection without CC/MCC	\$8,104
		488 – Knee Procedures with Principal Dx of Infection with CC/MCC	\$9,481
		489 – Knee Procedures w/o Principal Dx of Infection without CC/MCC	\$6,687
81.54	Total knee replacement	461 – Bilateral or Multiple Major Joint Procedures of Lower Extremity with MCC	\$25,783
		462 – Bilateral or Multiple Major Joint Procedures of Lower Extremity without MCC	\$18,119
		469 – Major Joint Replacement or Reattachment of Lower Extremity with MCC	\$18,812
		470 – Major Joint Replacement or Reattachment of Lower Extremity without MCC	\$11,652

1 FY 2010 Medicare Inpatient Prospective Payment System final rule (CMS-1406-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).

Common INPATIENT HOSPITAL Billing Codes for Knee Arthroplasty Surgical Procedures (continued)

ICD-9-CM Procedure Codes	Code Description	Common Medicare MS-DRG Assignment	Medicare National Average Payment ^{1,2}
81.55	Revision of knee replacement, not otherwise specified	466 — Revision of Hip or Knee Replacement with MCC	\$26,395
		467 — Revision of Hip or Knee Replacement with CC	\$17,640
		468 — Revision of Hip or Knee Replacement without CC/MCC	\$14,225
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 Knee Arthroplasty Surgical Procedures

CPT* Code	Code Description	Estimated 2010 Adjusted ASC Payment Rate ³
27437	Arthroplasty, patella; without prosthesis	\$1,349
27438	Arthroplasty, patella; with prosthesis	\$1,917
27440	Arthroplasty, knee, tibial plateau;	\$1,598
27441	with debridement and partial synovectomy	\$1,370
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;	\$1,370
27443	with debridement and partial synovectomy	\$1,370
27446	Arthroplasty, knee, condyle and plateau; medial <u>OR</u> lateral compartments	\$6,627

1 FY 2010 Medicare Inpatient Prospective Payment System final rule (CMS-1406-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).

3 Represents unadjusted payment rate as published in Addendum BB, CMS-1414-FC; individual ASC reimbursement will vary.

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Common OUTPATIENT HOSPITAL APCs for Knee Arthroplasty Surgical Procedures

CPT*/ HCPCS Code	Code Description	Medicare APC Assignment	Status Indicator ¹	Unadjusted Payment Rate ²
27437	Arthroplasty, patella; without prosthesis	0047 – Arthroplasty without prosthesis	T	\$2,689
27438	Arthroplasty, patella; with prosthesis	0048 – Level I Arthroplasty with prosthesis	T	\$3,915
27440	Arthroplasty, knee, tibial plateau;	0047 – Arthroplasty without prosthesis	T	\$2,689
27441	with debridement and partial synovectomy	0047 – Arthroplasty without prosthesis	T	\$2,689
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;	0047 – Arthroplasty without prosthesis	T	\$2,689
27443	with debridement and partial synovectomy	0047 – Arthroplasty without prosthesis	T	\$2,689
27446	Arthroplasty, knee, condyle and plateau; medial <u>OR</u> lateral compartments	0681 – Knee Arthroplasty	T	\$8,006
27599	Unlisted procedure, femur or knee	0129 – Level 1 Closed Treatment Fracture Finger/Toe/Trunk	T	\$112
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

1 Per addendum B, CMS-1414-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-1414-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, 2009.
- 42 CFR Parts 410, 411, 414 et al. Medicare Program [CMS-1413-FC]; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010; Final Rule; Medicare Program; Solicitation of Independent Accrediting Organizations To Participate in the Advanced Diagnostic Imaging Supplier Accreditation Program; Notice, November 25, 2009.
- 42 CFR Parts 410, 411, 414, 415, 485, and 498 Medicare Program [CMS-1413-CN3]; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010; Corrections, December 10, 2009.
- 42 CFR Parts 410, 416, and 419 Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates [CMS-1414-FC]; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates; Final Rule, November 20, 2009.
- 42 CFR Parts 410, 416, and 419 Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates [CMS-1414-CN]; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates; Final Rule, December 31, 2009
- 42 CFR Parts 412, 413, 415, et al. Medicare Program [CMS-1406-F]; Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates; and Changes to the Long Term Care Hospital Prospective Payment System and Rate Years 2010 and 2009 Rates; Final Rule, August 27, 2009.
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