



Knee 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 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, 2009 to September 30, 2009



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) 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.

* Current Procedural Terminology ©2008 American Medical Association. All Rights Reserved.

Common PHYSICIAN Procedure Codes for Knee Arthroplasty Surgical Procedures

CPT Code*	Code Description	Medicare 2009	
		Total Adjusted Facility RVUs	National Average Payment ¹
27437	Arthroplasty, patella; without prosthesis	16.91	\$610
27438	Arthroplasty, patella; with prosthesis	21.70	\$783
27440	Arthroplasty, knee, tibial plateau;	19.83	\$715
27441	with debridement and partial synovectomy	20.48	\$739
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;	22.50	\$811
27443	with debridement and partial synovectomy	21.05	\$759
27445	Arthroplasty, knee, hinge prosthesis	32.86	\$1,185
27446	Arthroplasty, knee, condyle and plateau; medial <u>OR</u> lateral compartments	29.16	\$1,052
27447	Arthroplasty, knee, condyle and plateau; medial <u>AND</u> lateral compartments with or without patella resurfacing (TKA)	40.38	\$1,456
27486	Revision of total knee arthroplasty, with or without allograft; one component	36.80	\$1,327
27487	femoral and entire tibial component	46.49	\$1,677
27488	Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee	31.09	\$1,121
27599 ³	Unlisted procedure, femur or knee	N/A ²	N/A ²
+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

¹ 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.

² 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.

* *Current Procedural Terminology* ©2008 American Medical Association. All Rights Reserved.

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	\$25,220
		462 — Bilateral or Multiple Major Joint Procedures of Lower Extremity without MCC	\$17,456
		466 — Revision of Hip or Knee Replacement with MCC	\$25,226
		467 — Revision of Hip or Knee Replacement with CC	\$17,008
		468 — Revision of Hip or Knee Replacement without CC/MCC	\$13,604
00.81	Revision of knee replacement, tibial component	466 — Revision of Hip or Knee Replacement with MCC	\$25,226
00.82	Revision of knee replacement, femoral component	467 — Revision of Hip or Knee Replacement with CC	\$17,008
		468 — Revision of Hip or Knee Replacement without CC/MCC	\$13,604
00.83	Revision of knee replacement, patellar component	485 — Knee Procedures with Principal Diagnosis of Infection with MCC	\$18,300
		486 — Knee Procedures with Principal Diagnosis of Infection with CC	\$11,989
		487 — Knee Procedures with Principal Diagnosis of Infection without CC/MCC	\$8,628
00.84	Revision of total knee replacement, tibial insert, liner	488 — Knee Procedures without Principal Diagnosis of Infection with CC/MCC	\$9,331
		489 — Knee Procedures without Principal Diagnosis of Infection without CC/MCC	\$6,442
81.54	Total knee replacement	461 — Bilateral or Multiple Major Joint Procedures of Lower Extremity with MCC	\$25,220
		462 — Bilateral or Multiple Major Joint Procedures of Lower Extremity without MCC	\$17,456
		469 — Major Joint Replacement or Reattachment of Lower Extremity with MCC	\$18,268
		470 — Major Joint Replacement or Reattachment of Lower Extremity without MCC	\$11,148
81.55	Revision of knee replacement, not otherwise specified	466 — Revision of Hip or Knee Replacement with MCC	\$25,226
		467 — Revision of Hip or Knee Replacement with CC	\$17,008
		468 — Revision of Hip or Knee Replacement without CC/MCC	\$13,604

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)).

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

ICD-9-CM Procedure Codes

Code Description	Common Medicare MS-DRG Assignment
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 2009 Adjusted ASC Payment Rate ¹
27437	Arthroplasty, patella; without prosthesis	\$1,071
27438	Arthroplasty, patella; with prosthesis	\$1,422
27440	Arthroplasty, knee, tibial plateau;	\$1,527
27441	with debridement and partial synovectomy	\$1,113
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;	\$1,113
27443	with debridement and partial synovectomy	\$1,113
27446	Arthroplasty, knee, condyle and plateau; medial <u>OR</u> lateral compartments	\$10,921

¹ Represents unadjusted payment rate calculated per CMS-1404-FC Individual ASC reimbursement will vary.

* *Current Procedural Terminology* ©2008 American Medical Association. All Rights Reserved.

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	\$2,499
27438	Arthroplasty, patella; with prosthesis	0048 – Level I Arthroplasty with prosthesis	T	\$3,512
27440	Arthroplasty, knee, tibial plateau;	0047 – Arthroplasty without prosthesis	T	\$2,499
27441	with debridement and partial synovectomy	0047 – Arthroplasty without prosthesis	T	\$2,499
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;	0047 – Arthroplasty without prosthesis	T	\$2,499
27443	with debridement and partial synovectomy	0047 – Arthroplasty without prosthesis	T	\$2,499
27446	Arthroplasty, knee, condyle and plateau; medial <u>OR</u> lateral compartments	0681 – Knee Arthroplasty	T	\$12,322
27599	Unlisted procedure, femur or knee	0129 – Level 1 Closed Treatment Fracture Finger/Toe/Trunk	T	\$106
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-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.

* *Current Procedural Terminology* ©2008 American Medical Association. All Rights Reserved.

Zimmer Coding Reference Guide Disclaimer — Limitation on Coverage and Payment

The information in this document was obtained from third party sources and is subject to change without notice, including as a result in changes in reimbursement laws, regulations, rules and policies. All content in this document is informational only, general in nature and does not cover all situations or all payers' rules or policies. The service and the product must be reasonable and necessary for the care of the patient to support reimbursement. Providers should report the procedure and related codes that most accurately describe the patients' medical condition, procedures performed and the products used. This document represents no promise or guarantee by Zimmer regarding coverage or payment for products or procedures by Medicare or other payers. Providers should check Medicare bulletins, manuals, program memoranda, and Medicare guidelines to ensure compliance with Medicare requirements. Inquiries can be directed to the hospital's Medicare Part A fiscal intermediary, the physician's Medicare Part B carrier, or to appropriate payers. Zimmer specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on information in this document.

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.

Current Procedural Terminology (CPT) is copyright 2008 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

This Coding Reference Guide is valid January 1, 2009 – September 30, 2009.



+H124972100307001/\$090114R4A090

97-2100-307-00 Rev. 4 2ML Printed in USA ©2006, 2007, 2008, 2009 Zimmer, Inc.

Contact the Zimmer Reimbursement Hotline at 866-946-0444
or visit us at www.reimbursement.zimmer.com



zimmer | health economics