

# 2012 Hip Reimbursement Fact Sheet

SURGEON CPT CODE <sup>1</sup>	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT <sup>2</sup>
<b>Traditional Open Procedure</b>		
27125	Hemiarthroplasty, hip, partial	\$ 1,133
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty)	1,446
27132	Conversion of previous hip surgery to total hip arthroplasty; with or without autograft or allograft	1,684
27134	Revision of total hip arthroplasty, both components; with or without autograft or allograft	1,930
27137	Revision of total hip arthroplasty, acetabular component only; with or without autograft or allograft	1,481
27138	Revision of total hip arthroplasty, femoral component only; with or without autograft or allograft	1,541
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure)	148
0054T	Computer-assisted surgical navigational procedure for musculoskeletal procedures; with image guidance based on intraoperatively obtained images (e.g., fluoroscopy, ultrasound) (List separately in addition to code for primary procedure)	Carrier Priced
0055T	Computer-assisted surgical navigational procedure for musculoskeletal procedures; with image guidance based on preoperative images (e.g. CT or MRI) (List separately in addition to code for primary procedure)	Carrier Priced
27299	Unlisted procedure; pelvis or hip joint	Carrier Priced

**NOTE:** Hip autoplasty procedures are not covered by Medicare in the Hospital Outpatient or Ambulatory Surgical sites of service.

## OUTPATIENT FACILITY

### Hospital Outpatient Department

APC	APC DESCRIPTION	MEDICARE PAYMENT <sup>3</sup>
0129	Level I Closed Treatment Fracture (CPT codes: 27299)	\$105

## INPATIENT FACILITY

ICD-9 CODE <sup>5</sup>	DESCRIPTION
00.31	Computer assisted surgery with CT/CTA
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
00.70	Revision of hip replacement; both acetabular and femoral components
00.71	Revision of hip replacement; acetabular component
00.72	Revision of hip replacement; femoral component
00.73	Revision of hip replacement; acetabular liner and/or femoral head only
00.74	Hip bearing surface; metal-on-polyethylene
00.75	Hip bearing surface; metal-on-metal
00.76	Hip bearing surface; ceramic-on-ceramic
00.77	Hip bearing surface; ceramic-on-polyethylene
81.51	Total hip replacement
81.52	Partial hip replacement
81.53	Revision of hip replacement; not otherwise specified

**NOTE:** ICD-9 codes are grouped into Diagnoses Related Groups (DRGs) for Medicare reimbursement using a patient's diagnoses, procedures performed, age, sex and discharge status. One DRG is assigned to each inpatient stay.



INPATIENT FACILITY			
DRG	DESCRIPTION	AVERAGE LENGTH OF STAY (DAYS) <sup>5</sup>	NATIONAL AVERAGE DRG PAYMENT <sup>6</sup>
461	Bilateral or multiple major joint procedures of lower extremity with MCC	8.6	\$30,400
462	Bilateral or multiple major joint procedures of lower extremity without MCC	3.9	18,785
466	Revision of hip or knee replacement with MCC	8.8	28,050
467	Revision of hip or knee replacement with CC	4.8	18,266
468	Revision of hip or knee replacement without CC/MCC	3.4	14,472
469	Major joint replacement or reattachment of lower extremity with MCC	7.7	19,381
470	Major joint replacement or reattachment of lower extremity without MCC	3.6	11,750
628	Other endocrine, nutritional and metabolic O.R. procedures with MCC	9.8	18,316
629	Other endocrine, nutritional and metabolic O.R. procedures with CC	7.8	12,432
630	Other endocrine nutritional and metabolic O.R. procedures without CC/MCC	4.3	7,393
907	Other O.R. procedures for injuries with MCC	11.3	22,334
908	Other O.R. procedures for injuries with CC	6.0	10,867
909	Other O.R. procedures for injuries without CC/MCC	3.3	6,539
956	Limb reattachment, hip and femur procedures for multiple significant trauma	8.5	20,453

<sup>1</sup> All Current Procedural Terminology (CPT) five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines and other material are copyright 2011 American Medical Association. All Rights Reserved.

<sup>2</sup> Federal Register, Vol. 76, No. 228, Monday, November 28, 2011/ Rules and Regulations. The 2012 Final Physician Reimbursement Conversion Factor = \$34.0376.

<sup>3</sup> Hospital ICD-9-CM 2010 Volumes 1, 2 & 3, 9th Revision-Clinical Modification, American Medical Association. Copyright © 2011 Saunders, an imprint of Elsevier, Inc.

<sup>4</sup> Federal Register, Vol. 76, No. 160, Thursday, August 18, 2011/ Rules and Regulations; Final National Average DRG Payment.

Physicians should refer to their provider Carrier Manual for their geographic payments.

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