

2012 Knee Reimbursement Fact Sheet

SURGEON CPT CODE ¹	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT ²
27440	Arthroplasty, knee, tibial plateau	\$ 788
27441	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy	814
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee	869
27443	Arthroplasty, femoral condyles or tibial plateau(s) knee; with debridement and partial synovectomy	815
27445	Arthroplasty, knee, hinge prosthesis	1,255
27446	Arthroplasty, knee, condyle and plateau; medial or lateral compartment	1,109
27447	Arthroplasty, knee, condyle and plateau; medial and lateral components with or without patella resurfacing (total knee arthroplasty)	1,544
27486	Revision of total knee arthroplasty, with or without allograft; one component	1,412
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	1,768
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure)	148
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving), including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	574
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving), including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	550
0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)	Carrier Priced
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)	Carrier Priced

OUTPATIENT FACILITY

Hospital Outpatient Department

APC	APC DESCRIPTION	MEDICARE PAYMENT ³
0041	Level I Arthroscopy (CPT codes: 29880, 29881)	\$2,075
0047	Arthroplasty without Prosthesis (CPT codes: 27440, 27441, 27442, 27443)	2,884
0425	Level II Arthroplasty or implantation with prosthesis (CPT code: 27446)	9,294

Freestanding Ambulatory Surgery Center

CPT CODE ¹	DESCRIPTION	MEDICARE PAYMENT ⁴
27440	Arthroplasty, knee, tibial plateau	\$1,664
27441	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy	1,664
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee	1,664
27446	Arthroplasty, knee, condyle and plateau; medial or lateral compartment	7,756
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving), including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	1,197
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving), including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	1,197

INPATIENT FACILITY

ICD-9 CODE ⁵	DESCRIPTION		
00.31	Computer assisted surgery with CT/CTA	00.81	Revision of knee replacement; tibial component
00.32	Computer assisted surgery with MR/MRA	00.82	Revision of knee replacement; femoral component
00.33	Computer assisted surgery with fluoroscopy	00.83	Revision of knee replacement; patellar component
00.34	Imageless computer assisted surgery	00.84	Revision of knee replacement; tibial insert (liner)
00.35	Computer assisted surgery with multiple datasets	81.54	Total knee replacement
00.39	Other computer assisted surgery	81.55	Revision of knee replacement; not otherwise specified
00.80	Revision of knee replacement; total (all components)		

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) ⁶	NATIONAL AVERAGE DRG PAYMENT ⁶
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
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

¹ 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.

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

³ Federal Register, Vol. 76, No. 230, Wednesday, November 30, 2011/ Rules and Regulations; Final Hospital Outpatient Payment.

⁴ Federal Register, Vol. 76, No. 230, Wednesday, November 30, 2011/ Rules and Regulations; Final ASC Reimbursement.

⁵ Hospital ICD-9-CM 2010 Volumes 1, 2 & 3, 9th Revision-Clinical Modification, American Medical Association. Copyright © 2011 Saunders, an imprint of Elsevier, Inc.

⁶ 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.

The information contained in this document is provided to help you understand the reimbursement process. It is not intended to increase or maximize reimbursement by any payor. We strongly recommend that providers consult their payor organization with regard to local reimbursement policies. The information contained in this document is provided for information purposes only and represents no statement, promise or guarantee by Ethicon Endo-Surgery, Inc. concerning levels of reimbursement, payment or charge. Similarly, all CPT, HCPCS and ICD-9 codes are supplied for information purposes only and represent no statement, promise or guarantee by Ethicon Endo-Surgery, Inc. that these codes will be appropriate or that reimbursement will be made. ICD-9 is based on the official version of the World Health Organization's Ninth Revision, International Classification of Diseases. CPT codes and descriptions only are copyright 2011 American Medical Association. All Rights Reserved. CPT does not include fee schedules, relative values or related listings. The source for this information is the Centers for Medicare and Medicaid Services and various commercial payors. The content provided by the Centers for Medicare and Medicaid Services is updated frequently. It is the responsibility of the health services provider to confirm the appropriate coding required by their local Medicare carriers, fiscal intermediaries and commercial payors.