DualCompression Hindfoot Nail

2024 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about arthroscopic, endoscopic, or surgical procedures completed with the products described in this guide, the following information is shared for educational and strategic planning purposes only. Information described in this guide is intended solely for use as a resource tool to assist physician office and ambulatory surgical center billing staff regarding potential reimbursement challenges. It is the sole responsibility of the treating health care professional to diagnose and treat the patient, and to confirm coverage, coding, and claim submission guidance with the patient's health insurance plan to ensure claims are accurate, complete, and supported documentation in the patient's medical record. Any determination regarding if and how to seek reimbursement should be made only by the appropriate members of the staff, in consultation with the physician, and in consideration of the procedure performed or therapy provided to a specific patient. Arthrex does not recommend or endorse the use of any particular diagnosis or procedure code(s) and makes no determination if or how reimbursement may be available. Of important note, reimbursement codes and payment, as well as health policy and legislation, are subject to continual change.

Regulatory Clearance

The Arthrex DualCompression Hindfoot Fusion Nail Implant System is intended to facilitate tibiotalocalcaneal arthrodesis to treat severe foot/ankle deformity, arthritis, instability, and skeletal defects after tumor resection. These include neuro-osteoarthropathy (Charcot's Foot), avascular necrosis of the talus, failed joint replacement, failed ankle fusion, distal tibia fracture non-unions, osteoarthritis, rheumatoid arthritis, and pseudoarthrosis (K221031, November 2022).

Value Analysis Significance

The Arthrex DualCompression hindfoot nail differentiates itself from static and dynamized IM nails by the use of tensioning of the stainless-steel cable, providing intraoperative compression and further stretching the superelastic nitinol core for a maximum combined total sustained compression of 8 mm (180 mm nail) or 10 mm (210 mm, 240 mm, and 300 mm nails).[1]

Physician's Professional Fee

The primary open surgical procedure determined by the surgeon may include:

2024 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		**Physician**[b] **Medicare National Average**		**Hospital Outpatient**[c]		**ASC**[d]
CPT®[a] Code HCPCS Code	Code Description	Facility Setting (HOPD and ASC)	Non-Facility Setting (Office)	APC & APC Description	Medicare National Average	Medicare National Average
Foot/Ankle						
27870	Arthrodesis ankle, open	$966.41	N/A	5115-Level 5 Musculoskeletal (MSK) Procedure	$12,552.87	$9300.00
28725	Arthrodesis subtalar	$771.45	N/A	5115-Level 5 MSK Procedure	$12,552.87	$9005.07
28715	Triple arthrodesis	$929.61	N/A	5115-Level 5 MSK Procedure	$12,552.87	$9821.71
28705	Pantalar arthrodesis	$1202.37	N/A	5116-Level 6 MSK Procedure	$17,774.76	$12,699.07

[a] CPT (Current Procedural Terminology) is a registered trademark of the American Medical Association. Health care providers and their professional coders must closely review this primary citation along with the patient's medical record before selecting the appropriate code.

[b] AMA CPT 2024 and CMS PFS 2024 Final Rule

[c] CMS 2024 OPPS Final Rule @ www.cms.gov

[d] CMS 2024 ASC Final Rule @ www.cms.gov

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HCPCS Code	Code Description	Notes
C1713	**Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)**	For Medicare, anchors/screws/joint devices are not separately reimbursed in any setting of care (eg, hospital, ASC). These costs are absorbed by the facility via the appropriate reimbursement mechanism (eg, MS-DRG, APC, etc)
L8699	**Prosthetic implant, no otherwise specified** This code reports prosthetic implants that are not otherwise described in more specific HCPCS Level II codes.	For non-Medicare (eg, commercial) patients, depending on contractual terms and general stipulations of the payer, direct invoicing by the facility may be allowed. Contact the patient's insurance company or the facility's payer contract for further information.
A4649	**Surgical supplies; miscellaneous** This code reports miscellaneous surgical supplies and should only be reported if a more specific HCPCS Level II or CPT code is not available.	
List of Pass-Through Payment Device Category Codes (Updated September 2022) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment		

Inpatient Billing

For inpatient procedures, the following steps are applied to generate a reimbursement payment.

1. ICD-10 diagnosis codes are assigned based on the patient diagnoses. Multiple codes may be assigned to a patient if multiple diagnoses exist. For example, both ICD10 diagnosis codes E08.40 (diabetes) and M12.579 (arthropathy) are comorbidities commonly associated with patients who are treated with the Arthrex DualCompression hindfoot nail.

Diagnosis Code	Description	Non-CC	CC	MCC
E08.40	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified	✓		
M12.579	Traumatic arthropathy, unspecified ankle and foot	✓		
M14.60	Charcot's joint, unspecified site	✓		
M19.079	Primary osteoarthritis, unspecified ankle and foot	✓		
M19.279	Secondary osteoarthritis, unspecified ankle and foot	✓		
M21.6X9	Other acquired deformities of ankle and foot	✓		
M89.70	Major osseous defect, unspecified site	✓		
Z47.2	Encounter for removal of internal fixation device	✓		
M87.276	Osteonecrosis due to previous trauma, unspecified foot		✓	
M96.0	Pseudarthrosis after fusion or arthrodesis		✓	
S92.909K	Unspecified fracture of unspecified foot, subsequent encounter for fracture with nonunion		✓	
S92.909P	Unspecified fracture of unspecified foot, subsequent encounter for fracture with malunion		✓	
T84.498A	Other mechanical complication of other orthopedic devices, implants and grafts, initial encounter		✓	
T84.84XA	Pain due to internal orthopedic prosthetic devices, implants and grafts, initial encounter		✓	
T86.831	Bone graft failure		✓	
Z68.41	Body mass index (BMI) 40.0-44.9, adult		✓	
N18.6	End stage renal disease			✓

The ICD-10 diagnosis codes are designated as noncomplication/comorbidity (Non-CC), complications and comorbidities (CC), and major complications and comorbidities (MCC). These classifications correlate to what MS-DRG code and subsequent payment is generated. Additional codes that may be applicable can be found in the Appendices.

2. An ICD-10-PCS procedure code is assigned based on the procedures performed to address the diagnosis.
3. The ICD-10 procedure code is matched with all ICD-10 diagnosis codes. The combined codes will generate the corresponding MS-DRG codes.

Procedure	Procedure Code	Description
Ankle Fusion	0SGF03Z	Fusion of right ankle joint with sustained compression internal fixation device, open approach
	0SGF33Z	Fusion of right ankle joint with sustained compression internal fixation device, percutaneous approach
	0SGF43Z	Fusion of right ankle joint with sustained compression internal fixation device, percutaneous endoscopic approach
	0SGG03Z	Fusion of left ankle joint with sustained compression internal fixation device, open approach
	0SGG33Z	Fusion of left ankle joint with sustained compression internal fixation device, percutaneous approach
Triple Arthrodesis and Subtalar Fusion	0SGG43Z	Fusion of left ankle joint with sustained compression internal fixation device, percutaneous endoscopic approach
	0SGH03Z	Fusion of right tarsal joint with sustained compression internal fixation device, open approach
	0SGH33Z	Fusion of right tarsal joint with sustained compression internal fixation device, percutaneous approach
	0SGH43Z	Fusion of right tarsal joint with sustained compression internal fixation device, percutaneous endoscopic approach
	0SGJ03Z	Fusion of left tarsal joint with sustained compression internal fixation device, open approach
	0SGJ33Z	Fusion of left tarsal joint with sustained compression internal fixation device, percutaneous approach
	0SGJ33Z	Fusion of left tarsal joint with sustained compression internal fixation device, percutaneous endoscopic approach

4. MS-DRG codes are submitted and used to determine payment amounts. A DRG code will take into account multiple conditions that may apply to a given patient. An example CC would be an implant removal (ICD-10 code T84.498A) in combination with another primary diagnosis.

Procedure	Procedure Code	Description
492	Lower extremity and humeral procedure except hip, foot, femur with MCC	$24,240.24
493	Lower extremity and humeral procedure except hip, foot, femur with CC	$16,815.74
494	Lower extremity and humeral procedure except hip, foot, femur without CC/MCC	$13,087.39

The payment numbers listed are based on national average unadjusted Medicare payments. It is also important to note that both Medicare and private payer reimbursement varies regionally and by facility.

For more information about the primary procedure, please speak with your admitting surgeon. You may also call the Arthrex Coding Helpline at 1-844-604-6359 or email arthrexRSP@arthrex.com.

The content provided in this guide is for informational purposes only. The Arthrex Coding Helpline does not guarantee reimbursement by third-party payers.

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Reference

1. Arthrex, Inc. Data on file (c10818). Naples, FL; 2020.

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