DePuy Synthes 2020 Foot and Ankle Reimbursement Guide

Physician and Facility

DePuy Synthes

PART OF THE Johnson & Johnson FAMILY OF COMPANIES

Contents

This guide has been developed to assist physicians and facilities in coding for the use of the DePuy Synthes foot and ankle implants and devices.

These procedures may be a covered service if they meet all of the requirements established by Medicare and private payers. It is essential that each claim be coded properly and supported with appropriate documentation in the medical record.

Physician Services

Current Procedural Terminology (CPT®) codes and Medicare Physician Fee Schedule values for common foot and ankle procedures are indicated below. CPT® coding has been provided for the following anatomical and procedural groups:

- Forefoot
- Midfoot
- Hindfoot
- Ankle

- Excision
- Repair, Revision, and/or Reconstruction
- Fracture and/or Dislocation
- Arthrodesis

Procedure Codes for Forefoot

Excision

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
28108	Excision or curettage of bone cyst or benign tumor, phalanges of foot	8.29	$299
28110	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)	8.35	$301
28111	Ostectomy, complete excision; first metatarsal head	9.33	$337
28112	Ostectomy, complete excision; other metatarsal head (second, third or fourth)	9.00	$325
28113	Ostectomy, complete excision; fifth metatarsal head	12.18	$440
28114	Ostectomy, complete excision; all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (eg, Clayton type procedure)	23.83	$860
28124	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe	9.55	$345
28126	Resection, partial or complete, phalangeal base, each toe	7.11	$257
28140	Metatarsectomy	12.56	$453
28150	Phalangectomy, toe, each toe	8.01	$289
28153	Resection, condyle(s), distal end of phalanx, each toe	7.64	$276
28160	Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each	7.69	$278
28173	Radical resection of tumor; metatarsal	21.25	$767
28175	Radical resection of tumor; phalanx of toe	13.64	$492

Repair, Revision and/or Reconstruction

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
28285	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)	10.94	$395
28286	Correction, cock-up fifth toe, with plastic skin closure (eg, Ruiz-Mora type procedure)	8.56	$309
28288	Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head	12.46	$450
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant	13.22	$477
28291	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant	14.11	$509
28292	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method	13.93	$503
28295	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal metatarsal osteotomy, any method	16.16	$583
28296	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method	14.81	$534
28297	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method	17.40	$628
28298	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method	14.34	$518
28299	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method	16.80	$606
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	11.55	$417
28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	11.97	$432
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	10.92	$394
28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	25.48	$920
28310	Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)	10.35	$374
28312	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe	9.12	$329

Repair, Revision and/or Reconstruction

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
28315	Sesamoidectomy, first toe (separate procedure)	9.38	$339
28322	Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)	16.56	$598
28340	Reconstruction, toe, macrodactyly; soft tissue resection	11.86	$428
28341	Reconstruction, toe, macrodactyly; requiring bone resection	14.13	$510
28344	Reconstruction, toe(s); polydactyly	8.04	$290
28345	Reconstruction, toe(s); syndactyly, with or without skin graft(s), each web	10.50	$379
28360	Reconstruction, cleft foot	31.53	$1,138

Fracture and/or Dislocation

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	20.20	$729
28470	Closed treatment of metatarsal fracture; without manipulation, each	5.85	$211
28475	Closed treatment of metatarsal fracture; with manipulation, each	6.52	$235
28476	Percutaneous skeletal fixation of metatarsal fracture, with manipulation, each	10.56	$381
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	15.89	$573
28490	Closed treatment of fracture great toe, phalanx or phalanges; without manipulation	3.55	$128
28495	Closed treatment of fracture great toe, phalanx or phalanges; with manipulation	4.25	$153
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	14.32	$516
28510	Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each	3.41	$125
28515	Closed treatment of fracture, phalanx or phalanges, other than great toe; with manipulation, each	4.08	$147
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each	11.61	$419
28530	Closed treatment of sesamoid fracture	2.88	$104
28531	Open treatment of sesamoid fracture, with or without internal fixation	5.22	$188
28630	Closed treatment of metatarsophalangeal joint dislocation; without anesthesia	3.20	$115
28635	Closed treatment of metatarsophalangeal joint dislocation; requiring anesthesia	3.81	$138

Fracture and/or Dislocation

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
28636	Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation	5.74	$207
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	14.00	$505
28660	Closed treatment of interphalangeal joint dislocation; without anesthesia	2.62	$95
28665	Closed treatment of interphalangeal joint dislocation; requiring anesthesia	3.72	$134
28675	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed	11.62	$419

Arthrodesis

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
28750	Arthrodesis, great toe; metatarsophalangeal joint	16.81	$607
28755	Arthrodesis, great toe; interphalangeal joint	9.58	$346
28760	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure)	16.60	$599

Procedure Codes for Midfoot

Excision

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
28104	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus;	10.20	$368
28106	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with iliac or other autograft (includes obtaining graft)	12.34	$445
28107	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with allograft	10.01	$361
28116	Ostectomy, excision of tarsal coalition	16.62	$600
28122	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus	12.62	$455
28171	Radical resection of tumor; tarsal (except talus or calcaneus)	32.11	$1,159

Repair, Revision, and/or Reconstruction

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
28304	Osteotomy, tarsal bones, other than calcaneus or talus;	17.40	$628
28305	Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (eg, Fowler type)	19.30	$697
28320	Repair, nonunion or malunion; tarsal bones	17.66	$637

Fracture and/or Dislocation

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
28450	Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each	5.47	$197
28455	Treatment of tarsal bone fracture (except talus and calcaneus); with manipulation, each	7.40	$267
28456	Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus), with manipulation, each	9.74	$352
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	18.18	$656
28540	Closed treatment of tarsal bone dislocation, other than talotarsal; without anesthesia	5.01	$181
28545	Closed treatment of tarsal bone dislocation, other than talotarsal; requiring anesthesia	7.62	$275
28546	Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation	9.85	$355
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	18.75	$677
28600	Closed treatment of tarsometatarsal joint dislocation; without anesthesia	5.30	$191
28605	Closed treatment of tarsometatarsal joint dislocation; requiring anesthesia	8.57	$309
28606	Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation	11.19	$404
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	23.43	$846

Arthrodesis

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse	21.21	$765
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	22.38	$808
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	19.89	$718
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	17.90	$646

Procedure Codes for Hindfoot

Excision

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus;	11.98	$432
28102	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with iliac or other autograft (includes obtaining graft)	17.54	$633
28103	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with allograft	11.24	$406
28118	Ostectomy, calcaneus;	12.04	$435
28119	Ostectomy, calcaneus; for spur, with or without plantar fascial release	10.39	$375
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	14.33	$517
28130	Talectomy (astragalectomy)	18.21	$657

Repair, Revision, and/or Reconstruction

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
28300	Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation	18.78	$678
28302	Osteotomy; talus	20.66	$746

Fracture and/or Dislocation

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
28400	Closed treatment of calcaneal fracture; without manipulation	6.55	$236
28405	Closed treatment of calcaneal fracture; with manipulation	10.08	$364
28406	Percutaneous skeletal fixation of calcaneal fracture, with manipulation	15.58	$562
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed;	32.28	$1,165
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	37.10	$1,339
28430	Closed treatment of talus fracture; without manipulation	6.03	$218
28435	Closed treatment of talus fracture; with manipulation	9.31	$336
28436	Percutaneous skeletal fixation of talus fracture, with manipulation	13.45	$485
28445	Open treatment of talus fracture, includes internal fixation, when performed	29.91	$1,079
28570	Closed treatment of talotarsal joint dislocation; without anesthesia	5.52	$199
28575	Closed treatment of talotarsal joint dislocation; requiring anesthesia	9.57	$345
28576	Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation	11.14	$402
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed	19.62	$708

Procedure Codes for Ankle

Arthrodesis

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
27870	Arthrodesis, ankle, open	29.51	$1,065
27871	Arthrodesis, tibiofibular joint, proximal or distal	19.88	$717
28705	Arthrodesis; pantalar	35.47	$1,280
28715	Arthrodesis; triple	27.12	$979
28725	Arthrodesis; subtalar	22.47	$811
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis	29.77	$1,074

Fracture and/or Dislocation

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	18.66	$673
27814	Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli,or medial and posterior malleoli), includes internal fixation, when performed	22.13	$799
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	24.98	$902
27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	28.26	$1,020
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	24.55	$886
27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only	32.05	$1,157
27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula	38.10	$1,375
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	20.20	$729

Other Procedures

CPT® Code	Description	2020 Total RVUs	2020 Medicare National Average Payment
20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	12.14	$438
20900	Bone graft, any donor area; minor or small (eg, dowel or button)	5.33	$192
28899	Unlisted procedure, foot or toes	N/A	N/A

Facility Services

Outpatient Services

Medicare reimburses outpatient hospital and Ambulatory Surgery Center (ASC) services under the Outpatient Prospective Payment System (OPPS), which bases payment on Ambulatory Payment Classifications (APCs) and ASC Payment Groups. Services are reported with CPT® codes. The Medicare national average payments for common foot and ankle procedures in the outpatient setting are listed below.

Procedure Codes for Forefoot

Excision

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
28108	Excision or curettage of bone cyst or benign tumor, phalanges of foot	J1	5112	$1,355	A2	$713
28110	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)	J1	5113	$2,737	A2	$1,286
28111	Ostectomy, complete excision; first metatarsal head	J1	5113	$2,737	A2	$1,286
28112	Ostectomy, complete excision; other metatarsal head (second, third or fourth)	J1	5113	$2,737	A2	$1,286
28113	Ostectomy, complete excision; fifth metatarsal head	J1	5113	$2,737	A2	$1,286
28114	Ostectomy, complete excision; all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (eg, Clayton type procedure)	J1	5113	$2,737	A2	$1,286
28124	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe	J1	5113	$2,737	P3	$302
28126	Resection, partial or complete, phalangeal base, each toe	J1	5113	$2,737	A2	$1,286
28140	Metatarsectomy	J1	5113	$2,737	A2	$1,286
28150	Phalangectomy, toe, each toe	J1	5113	$2,737	A2	$1,286

Excision

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	**Description**	**SI**	**APC**	**2020 Medicare National Average Payment**	**PI**	**2020 Medicare National Average Payment**
28153	Resection, condyle(s), distal end of phalanx, each toe	J1	5113	$2,737	A2	$1,286
28160	Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each	J1	5113	$2,737	A2	$1,286
28173	Radical resection of tumor; metatarsal	J1	5113	$2,737	A2	$1,286
28175	Radical resection of tumor; phalanx of toe	J1	5112	$1,355	A2	$713

Repair, Revision, and/or Reconstruction

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	**Description**	**SI**	**APC**	**2020 Medicare National Average Payment**	**PI**	**2020 Medicare National Average Payment**
28285	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)	J1	5113	$2,737	A2	$1,286
28286	Correction, cock-up fifth toe, with plastic skin closure (eg, Ruiz-Mora type procedure)	J1	5113	$2,737	A2	$1,286
28288	Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head	J1	5113	$2,737	A2	$1,286
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant	J1	5113	$2,737	A2	$1,286
28291	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant	J1	5114	$5,981	J8	$4,300
28292	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method	J1	5113	$2,737	A2	$1,286
28295	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal metatarsal osteotomy, any method	J1	5113	$2,737	G2	$1,286
28296	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method	J1	5113	$2,737	A2	$1,286

Repair, Revision, and/or Reconstruction

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	**Description**	**SI**	**APC**	**2020 Medicare National Average Payment**	**PI**	**2020 Medicare National Average Payment**
28297	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method	J1	5114	$5,981	J8	$4,021
28298	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method	J1	5114	$5,981	A2	$2,803
28299	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method	J1	5113	$5,981	A2	$2,803
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	J1	5114	$5,981	A2	$2,803
28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	J1	5113	$5,981	A2	$2,803
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	J1	5113	$2,737	A2	$1,286
28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	J1	5114	$5,981	A2	$2,803
28310	Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)	J1	5113	$5,981	A2	$2,803
28312	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe	J1	5113	$2,737	A2	$1,286

Repair, Revision, and/or Reconstruction

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	**Description**	**SI**	**APC**	**2020 Medicare National Average Payment**	**PI**	**2020 Medicare National Average Payment**
28315	Sesamoidectomy, first toe (separate procedure)	J1	5113	$2,737	A2	$1,286
28322	Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)	J1	5114	$5,981	J8	$3.824
28340	Reconstruction, toe, macrodactyly; soft tissue resection	J1	5113	$2,737	A2	$1,286
28341	Reconstruction, toe, macrodactyly; requiring bone resection	J1	5113	$2,737	A2	$1,286
28344	Reconstruction, toe(s); polydactyly	J1	5113	$2,737	A2	$1,286
28345	Reconstruction, toe(s); syndactyly, with or without skin graft(s), each web	J1	5112	$1,355	A2	$713
28360	Reconstruction, cleft foot	J1	5114	$5,981	N/A	N/A

Fracture and/or Dislocation

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	**Description**	**SI**	**APC**	**2020 Medicare National Average Payment**	**PI**	**2020 Medicare National Average Payment**
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	J1	5114	$5,981	A2	$2,803
28470	Closed treatment of metatarsal fracture; without manipulation, each	T	5111	$216	P2	$109
28475	Closed treatment of metatarsal fracture; with manipulation, each	T	5111	$216	P2	$109
28476	Percutaneous skeletal fixation of metatarsal fracture, with manipulation, each	J1	5113	$2,737	A2	$1,286
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	J1	5114	$5,981	J8	$3,732
28490	Closed treatment of fracture great toe, phalanx or phalanges; without manipulation	T	5111	$216	P3	$99
28495	Closed treatment of fracture great toe, phalanx or phalanges; with manipulation	T	5111	$216	P2	$109
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	J1	5113	$2,737	A2	$1,286

Fracture and/or Dislocation

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	**Description**	**SI**	**APC**	**2020 Medicare National Average Payment**	**PI**	**2020 Medicare National Average Payment**
28510	Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each	T	5111	$216	P3	$78
28515	Closed treatment of fracture, phalanx or phalanges, other than great toe; with manipulation, each	T	5111	$216	P3	$106
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each	J1	5113	$2,737	A2	$1,286
28530	Closed treatment of sesamoid fracture	T	5111	$216	P3	$75
28531	Open treatment of sesamoid fracture, with or without internal fixation	J1	5114	$5,981	A2	$2,803
28630	Closed treatment of metatarsophalangeal joint dislocation; without anesthesia	T	5111	$216	P3	$89
28635	Closed treatment of metatarsophalangeal joint dislocation; requiring anesthesia	J1	5112	$1,355	A2	$713
28636	Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation	J1	5113	$2,737	A2	$1,286
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	J1	5113	$2,737	A2	$1,286
28660	Closed treatment of interphalangeal joint dislocation; without anesthesia	T	5111	$216	P3	$69
28665	Closed treatment of interphalangeal joint dislocation; requiring anesthesia	T	5102	$230	A2	$116
28675	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed	J1	5113	$2,737	A2	$1,286

Arthrodesis

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	**Description**	**SI**	**APC**	**2020 Medicare National Average Payment**	**PI**	**2020 Medicare National Average Payment**
28750	Arthrodesis, great toe; metatarsophalangeal joint	J1	5114	$5,981	J8	$4,068
28755	Arthrodesis, great toe; interphalangeal joint	J1	5114	$5,981	A2	$2,803
28760	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure)	J1	5114	$5,981	A2	$2,803

Procedure Codes for Midfoot

Excision

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
28104	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus;	J1	5113	$2,737	A2	$1,286
28106	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with iliac or other autograft (includes obtaining graft)	J1	5114	$5,981	A2	$2,803
28107	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with allograft	J1	5114	$5,981	A2	$2,803
28116	Ostectomy, excision of tarsal coalition	J1	5113	$2,737	A2	$1,286
28122	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus	J1	5113	$2,737	A2	$1,286
28171	Radical resection of tumor; tarsal (except talus or calcaneus)	J1	5113	$2,737	A2	$1,286

Repair, Revision, and/or Reconstruction

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
28304	Osteotomy, tarsal bones, other than calcaneus or talus;	J1	5114	$5,981	A2	$2,803
28305	Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (eg, Fowler type)	J1	5114	$5,981	G2	$4,037
28320	Repair, nonunion or malunion; tarsal bones	J1	5115	$11,899	J8	$8,877

Fracture and/or dislocation

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	**Description**	**SI**	**APC**	**2020 Medicare National Average Payment**	**PI**	**2020 Medicare National Average Payment**
28450	Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each	T	5111	$216	P2	$109
28455	Treatment of tarsal bone fracture (except talus and calcaneus); with manipulation, each	J1	5112	$1,355	P3	$168
28456	Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus), with manipulation, each	J1	5114	$5,981	A2	$2,803
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	J1	5114	$5,981	J8	$3,831
28540	Closed treatment of tarsal bone dislocation, other than talotarsal; without anesthesia	T	5111	$216	P2	$109
28545	Closed treatment of tarsal bone dislocation, other than talotarsal; requiring anesthesia	J1	5113	$2,737	G2	$1,286
28546	Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation	J1	5112	$1,355	A2	$713
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	J1	5114	$5,981	J8	$2,803
28600	Closed treatment of tarsometatarsal joint dislocation; without anesthesia	T	5111	$216	P2	$109
28605	Closed treatment of tarsometatarsal joint dislocation; requiring anesthesia	T	5111	$216	P2	$109
28606	Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation	J1	5113	$2,737	A2	$1,286
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	J1	5114	$5,981	J8	$3,655

Arthrodesis

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse	J1	5115	$11,899	J8	$8,734
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	J1	5115	$11,899	J8	$8,822
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	J1	5115	$11,899	J8	$8,386
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	J1	5114	$5,981	J8	$4,144

Procedure Codes for Hindfoot

Excision

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus;	J1	5113	$2,737	A2	$1,286
28102	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with iliac or other autograft (includes obtaining graft)	J1	5114	$5,981	J8	$2,803
28103	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with allograft	J1	5114	$5,981	A2	$2,803
28118	Ostectomy, calcaneus;	J1	5113	$2,737	A2	$1,286
28119	Ostectomy, calcaneus; for spur, with or without plantar fascial release	J1	5113	$2,737	A2	$1,286
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	J1	5113	$2,737	A2	$1,286
28130	Talectomy (astragalectomy)	J1	5113	$5,981	A2	$4,183

Repair, Revision and/or Reconstruction

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
28300	Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation	J1	5114	$5,981	J8	$3,749
28302	Osteotomy; talus	J1	5114	$5,981	A2	$2,803

Fracture and/or Dislocation

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
28400	Closed treatment of calcaneal fracture; without manipulation	T	5111	$216	A2	$109
28405	Closed treatment of calcaneal fracture; with manipulation	T	5111	$216	A2	$109
28406	Percutaneous skeletal fixation of calcaneal fracture, with manipulation	J1	5114	$5,931	A2	$2,803
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed;	J1	5114	$5,931	J8	$3,875
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	J1	5115	$11,899	J8	$8,250
28430	Closed treatment of talus fracture; without manipulation	T	5111	$216	P2	$109
28435	Closed treatment of talus fracture; with manipulation	J1	5112	$1,355	A2	$713
28436	Percutaneous skeletal fixation of talus fracture, with manipulation	J1	5114	$5,981	G2	$2,803
28445	Open treatment of talus fracture, includes internal fixation, when performed	J1	5114	$5,981	A2	$3,638
28570	Closed treatment of talotarsal joint dislocation; without anesthesia	T	5111	$216	P2	$109
28575	Closed treatment of talotarsal joint dislocation; requiring anesthesia	J1	5113	$2,737	A2	$1,286
28576	Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation	J1	5113	$5,981	A2	$2,803
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed	J1	5114	$5,981	J8	$4,134

Procedure Codes for Ankle

Arthrodesis

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
27870	Arthrodesis, ankle, open	J1	5115	$11,899	J8	$8,448
27871	Arthrodesis, tibiofibular joint, proximal or distal	J1	5115	$11,899	J8	$8,142
28705	Arthrodesis; pantalar	J1	5116	$15,944	J8	$11,578
28715	Arthrodesis; triple	J1	5115	$11,899	J8	$8,838
28725	Arthrodesis; subtalar	J1	5115	$11,899	J8	$8,118
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis	J1	5114	$5,981	J8	$3,635

Fracture and/or Dislocation

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	J1	5114	$5,981	J8	$3,705
27814	Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli,or medial and posterior malleoli), includes internal fixation, when performed	J1	5114	$5,981	J8	$3,764
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	J1	5114	$5,981	J8	$3,748
27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	J1	5114	$5,981	J8	$3,735
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	J1	5114	$5,981	J8	$3,916
27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only	J1	5115	$11,899	J8	$8,017

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula	J1	5115	$11,899	J8	$8,157
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	J1	5114	$5,981	A2	$2,803
27870	Arthrodesis, ankle, open	J1	5115	$11,899	J8	$8,448

Other Procedures

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2020 Medicare National Average Payment	PI	2020 Medicare National Average Payment
20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	Q2	5073	$2,318	A2	$994
20900	Bone graft, any donor area; minor or small (eg, dowel or button)	J1	5114	$5,981	A2	$2,803
28899	Unlisted procedure, foot or toes	T	511	$216	N/A	Not on ASC Allowable List

Hospital Inpatient Services

Medicare reimburses inpatient hospital services under the Inpatient Prospective Payment System (IPPS), which bases payment on MS-DRGs (Medicare Severity Diagnosis Related Groups). The MS-DRGs and Medicare national average payments for foot and ankle procedures are provided below:

MS-DRGs for Foot and Ankle Procedures

MS-DRG	Description	2020 Relative Weight	2020 Medicare National Average Payment
492	Lower extremity and humerus procedures except hip, foot and femur with MCC	3.4453	$21,580
493	Lower extremity and humerus procedures except hip, foot and femur with CC	2.3020	$14,419
494	Lower extremity and humerus procedures except hip, foot and femur without CC/MCC	1.8114	$11,346
495	Local excision and removal of internal fixation devices except hip and femur with MCC	3.4326	$21,501
496	Local excision and removal of internal fixation devices except hip and femur with CC	2.0405	$12,781
497	Local excision and removal of internal fixation devices except hip and femur without CC/MCC	1.4693	$9,203
503	Foot procedures with MCC	2.7166	$17,016
504	Foot procedures with CC	1.7365	$10,877
505	Foot procedures without CC/MCC	1.6815	$10,532
515	Other musculoskeletal system and connective tissue O.R. procedures with MCC	3.1540	$19,756
516	Other musculoskeletal system and connective tissue O.R. procedures with CC	1.9391	$12,146
517	Other musculoskeletal system and connective tissue O.R. procedures without CC/MCC	1.4153	$8,865
907	Other O.R. procedures for injuries with MCC	3.9896	$24,990
908	Other O.R. procedures for injuries with CC	2.0631	$12,923
909	Other O.R. procedures for injuries without CC/MCC	1.3187	$8,260
957	Other O.R. procedures for multiple significant trauma with MCC	7.5337	$47,189
958	Other O.R. procedures for multiple significant trauma with CC	4.1909	$26,251
959	Other O.R. procedures for multiple significant trauma without CC/MCC	2.8005	$17,542

***MCC=Major Complications or Comorbidities**

****CC=Complications or Comorbidities**

Procedure Codes

Medicare uses The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and Procedure Coding System (PCS) codes to identify diagnoses and procedures in the hospital inpatient setting. Hospitals must report the principal diagnosis using the appropriate ICD-10-CM code, as well as any secondary diagnoses – some of which may be considered CCs or MCCs for MS-DRG assignment. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." The circumstances of inpatient admission always govern the selection of principal diagnosis.

For patient admissions involving procedures, hospitals must also report ICD-10-PCS procedure code(s) for the surgical and other procedures as well as ICD-10-CM diagnosis codes.

Listed below are the ICD-10-PCS procedure codes associated with common foot and ankle procedures. Please determine the appropriate ICD-10-PCS code section based on the general descriptions in the right hand column. The first three characters outline the section, body system and operation. Once you have identified the section, the code can be coded to greater specificity by choosing the most appropriate body part, approach, device and qualifier within the brackets.

ICD-10-PCS	Description (See current ICD-10-PCS book for complete descriptions)
0Q8[L,M,N,P,Q,R]0ZZ	Division of Tarsal, Metatarsal, Toe Phalanx
0QB[L,M,N,P,Q,R]0ZZ	Excision of Tarsal, Metatarsal, Toe Phalanx
0QP[G,H,L,M,N,P,Q,R]04Z	Removal of Internal Fixation Device
0QQ[L,M,N,P,Q,R]0ZZ	Repair Tarsal, Metatarsal, Toe Phalanx
0QS[G,H,J,K,L,M,N,P,Q,R]0[4,Z]Z	Reposition Tarsal, Metatarsal, Toe Phalanx, Tibia, Fibula, Ankle
0SB[F,G,H,J,K,L,M,N,P,Q][0,3,4]ZZ	Excision of Ankle, Tarsal, Tarsometatarsal, Metatarsal-Phalangeal, Toe, Phalangeal Joints
0SG[F,G,H,J,L,M,N,P,Q][0,3,4][4,5,7,J,K]Z	Fusion of Ankle, Tarsal, Tarsometatarsal, Metatarsal-Phalangeal, Toe, Phalangeal Joints
0SH[F,G,H,J,K,L,M,N,P,Q][0,3,4]4Z	Insertion of Internal Fixation Device into Ankle, Tarsal, Tarsometatarsal, Metatarsal-Phalangeal, Toe, Phalangeal Joints
0SH[F,G,H,J,K,L,M,N,P,Q]08Z	Insertion of Spacer into Ankle, Tarsal, Tarsometatarsal, Metatarsal-Phalangeal, Toe, Phalangeal Joints
0SP[F,G,H,J,K,L,M,N,P,Q]08Z	Removal of Spacer from Ankle, Tarsal, Tarsometatarsal, Metatarsal-Phalangeal, Toe, Phalangeal Joints
0SS[F,G,H,J,K,L,M,N,P,Q]0[4,Z]Z	Reposition Ankle, Tarsal, Tarsometatarsal, Metatarsal-Phalangeal, Toe, Phalangeal Joints
0SS[F,G]0ZZ	Reposition Ankle Joint, Open Approach
0YQ[K,L,M,N,P,Q,R,S,T,U,V,W,X,Y]0ZZ	Repair Ankle, Foot and Toes, Open Approach
2W3[S,T,U,V]X[1,3,Z,Y]Z	Immobilization of Foot and Toe

Diagnosis Codes

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes entered on hospital and physician claims are important in conveying information about the patient's condition to payers. All healthcare providers must report the principal diagnosis using the appropriate ICD- 10-CM code, as well as any secondary diagnoses. Payers use this information to evaluate the medical necessity for the episode of care and the appropriateness of the treatment the patient received.

Diagnosis codes should be reported to the highest level of specificity available – a code is invalid if it has not been coded to the full number of digits required for that code.

The table below includes examples only of ICD-10-CM diagnosis codes associated with foot and ankle conditions:

ICD-10-CM	Description (See current ICD-10-CM Diagnosis book for complete descriptions)
A52.16	Charcot's arthropathy (tabetic)
C49.20-C49.22	Malignant neoplasm of connective and soft tissue of lower limb
D16.30-D16.32	Benign neoplasm of short bones of lower limb
D49.2	Neoplasm of unspecified behavior of bone, soft tissue, and skin
E10.52-E10.610	Type 1 diabetes mellitus
E11.52-E11.610	Type 2 diabetes mellitus
E13.52-E13.52	Other specified diabetes mellitus
M00.071-M00.079	Staphylococcal arthritis
M00.171-M00.179	Pneumococcal arthritis
M00.271-M00.279	Other streptococcal arthritis
M05.40-M06.9	Rheumatoid Arthritis
M14.671-M14.679	Charcot's joint
M19.071-M19.90	Osteoarthritis
M20.10-M20.22	Hallux valgus
M20.30-M20.12	Hallux varus
M20.40-M20.42	Other hammer toe(s)
M20.5X1-M20.5X9	Other deformities of toe(s)
M21.071-M21.079	Valgus deformity, not elsewhere classified
M21.171-M21.179	Varus deformity, not elsewhere classified
M21.371-M21.379	Foot drop
M21.40-M21.42	Flat foot
M21.541-M21.549	Clubfoot
M21.611-M21.629	Bunion
M21.6X1-M21.6X9	Other acquired deformities of the foot
M25.271-M25.279	Flail joint, ankle
M25.371-M25.376	Other instability, ankle
M25.70-M25.776	Osteophyte, ankle

ICD-10-CM	Description (See current ICD-10-CM Diagnosis book for complete descriptions)
M80.00XK-M80.079P	Age-related osteoporosis with current pathological fracture
M80.80XK-M80.879P	Other osteoporosis with current pathological fracture
M84.30XA-M84.38XP	Stress fracture
M84.40XK-M84.68XP	Pathological fracture
M89.70-M89.79	Major osseous defect
M92.60-M92.70	Juvenile osteochondrosis
M93.20-M93.29	Osteochondritis dissecans
Q70.20-Q70.23	Fused toes
S82.421A-S82.66XC	Displaced and non-displaced fibula fractures
S82.871A-S82.873R	Displaced pilon fracture
S82.874A-S82.876R	Nondisplaced pilon fracture
S82.841-S82.846C	Bimalleolar fracture
S82.851-S82.856C	Trimalleolar fracture
S89.111K-S89.149P	Salter-Harris Type I, II, III, IV physeal fracture of lower end of tibia
S89.191A-S89.199P	Other physeal fracture of lower end of tibia
S92.001A-S92.009K	Unspecified fracture of calcaneus
S92.011A-S92.013P	Displaced fracture of body of calcaneus
S92.014A-S92.016K	Nondisplaced fracture of body of calcaneus
S92.021A-S92.023P	Displaced fracture of anterior process of calcaneus
S92.024A-S92.026P	Nondisplaced fracture of anterior process of calcaneus
S92.031A-S92.033P	Displaced avulsion fracture of tuberosity of calcaneus
S92.034A-S92.036P	Nondisplaced avulsion fracture of tuberosity
S92.041A-S92.043P	Displaced other fracture of tuberosity
S92.044A-S92.046P	Nondisplaced other fracture of tuberosity of calcaneus
S92.051A-S92.053P	Displaced other extra-articular fracture of calcaneus
S92.054A-S92.056P	Nondisplaced other extra-articular fracture of calcaneus
S92.061A-S92.063P	Displaced intraarticular fracture of calcaneus
S92.064A-S92.066P	Nondisplaced intraarticular fracture of calcaneus
S92.101A-S92.109P	Unspecified fracture of talus
S92.111A-S92.113P	Displaced fracture of neck of talus
S92.114A-S92.116P	Nondisplaced fracture of neck of talus
S92.121A-S92.123P	Displaced fracture of body of talus
S92.124A-S92.126P	Nondisplaced fracture of body of talus

ICD-10-CM	Description (See current ICD-10-CM Diagnosis book for complete descriptions)
S92.131A-S92.133P	Displaced fracture of posterior process of talus
S92.134A-S92.136P	Nondisplaced fracture of posterior process talus
S92.141A-S92.143P	Displaced dome fracture of talus
S92.144A-S92.146P	Nondisplaced dome fracture of talus
S92.151A-S92.153P	Displaced avulsion fracture (chip fracture) of talus
S92.154A-S92.156P	Nondisplaced avulsion fracture (chip fracture) of talus
S92.191A-S92.199P	Other fracture of talus
S92.201A-S92.209S	Fracture of unspecified tarsal bone(s)
S92.211A-S92.213P	Displaced fracture of cuboid bone of left foot
S92.214A-S92.216P	Nondisplaced fracture of cuboid bone
S92.221A-S92.223P	Displaced fracture of lateral cuneiform
S92.224A-S92.226P	Nondisplaced fracture of lateral cuneiform
S92.231A-S92.233P	Displaced fracture of intermediate cuneiform
S92.201A-S92.209S	Fracture of unspecified tarsal bone(s)
S92.211A-S92.213P	Displaced fracture of cuboid bone of left foot
S92.214A-S92.216P	Nondisplaced fracture of cuboid bone
S92.221A-S92.223P	Displaced fracture of lateral cuneiform
S92.224A-S92.226P	Nondisplaced fracture of lateral cuneiform
S92.231A-S92.233P	Displaced fracture of intermediate cuneiform
S92.234A-S92.236P	Nondisplaced fracture of intermediate cuneiform
S92.241A-S92.243P	Displaced fracture of medial cuneiform
S92.244A-S92.246P	Nondisplaced fracture of medial cuneiform of foot
S92.251A-S92.253P	Displaced fracture of navicular [scaphoid] of foot
S92.254A-S92.256P	Nondisplaced fracture of navicular [scaphoid] of foot
S92.301A-S92.309P	Fracture of unspecified metatarsal bone(s)
S92.311K-S92.313P	Displaced fracture of first metatarsal bone
S92.314K-S92.316P	Nondisplaced fracture of first metatarsal bone
S92.321K-S92.323P	Displaced fracture of second metatarsal bone
S92.324K-S92.326P	Nondisplaced fracture of second metatarsal bone
S92.331K-S92.333P	Displaced fracture of third metatarsal bone
S92.334K-S92.336P	Nondisplaced fracture of third metatarsal bone
S92.341K-S92.343P	Displaced fracture of fourth metatarsal bone

ICD-10-CM	Description (See current ICD-10-CM Diagnosis book for complete descriptions)
S92.344K-S92.346P	Nondisplaced fracture of fourth metatarsal bone
S92.351K-S92.353P	Displaced fracture of fifth metatarsal bone
S92.354K-S92.356P	Nondisplaced fracture of fifth metatarsal bone
S92.401A-S92.403K	Displaced unspecified fracture of great toe
S92.404A-S92.406P	Nondisplaced unspecified fracture of great toe
S92.411A-S92.413P	Displaced fracture of proximal phalanx of great toe
S92.414K-S92.416P	Nondisplaced fracture of proximal phalanx of great toe
S92.421K-S92.423P	Displaced fracture of distal phalanx of great toe
S92.424K-S92.426P	Nondisplaced fracture of distal phalanx of great toe
S92.491K-S92.499P	Other fracture of great toe
S92.501A-S92.503P	Displaced unspecified fracture of lesser toe(s)
S92.504A-S92.506P	Nondisplaced unspecified fracture of lesser toe(s)
S92.511A-S92.513P	Displaced fracture of proximal phalanx of lesser toe(s)
S92.514K-S92.516P	Nondisplaced fracture of proximal phalanx of lesser toe(s)
S92.521K-S92.523P	Displaced fracture of middle phalanx of lesser toe(s)
S92.524K-S92.526P	Nondisplaced fracture of middle phalanx of lesser toe(s)
S92.531K-S92.533P	Displaced fracture of distal phalanx of lesser toe(s)
S92.534K-S92.536P	Nondisplaced fracture of distal phalanx of lesser toe(s)
S92.591K-S92.592P	Other fracture of lesser toes
S92.811A-S92.819P	Other fracture of foot
S92.901A-S92.919P	Unspecified fracture of foot
S93.01XA-S93.03XA	Subluxation of ankle joint
S93.01XA-S93.03XS	Subluxation of ankle joint
S93.04XA-S93.06XS	Dislocation of ankle joint
S93.04XA-S93.119A	Dislocation of ankle joint
S93.121A-S93.129A	Dislocation of metatarsophalangeal joint
S93.131A-S93.139A	Subluxation of interphalangeal joint
S93.141A-S93.149A	Subluxation of metatarsophalangeal joint
S93.311A-S93.316A	Subluxation of tarsal joint
S93.321A-S93.323A	Subluxation or tarsometatarsal joint
S97.00XA-S97.82XA	Crushing injury of foot
S99.001A-S99.009A	Unspecified physeal fracture of calcaneus

ICD-10-CM	Description (See current ICD-10-CM Diagnosis book for complete descriptions)
S99.011A-S99.049A	Salter-Harris Type I, II, III, IV physeal fracture of calcaneus
S99.091A-S99.092A	Other physeal fracture of calcaneus
S99.101K-S99.109P	Unspecified physeal fracture of metatarsal
S99.111K-S99.149P	Salter-Harris Type II, III, IV physeal fracture of metatarsal
S99.191K-S99.199P	Other physeal fracture of metatarsal
T84.50XA	Infection and inflammatory reaction due to unspecified internal joint prosthesis, initial encounter
T84.69XA	Infection and inflammatory reaction due to internal fixation device of other site, initial encounter
T84.7XXA	Infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts, initial encounter

HCPCS Codes and Revenue Codes

Medicare uses HCPCS (C-codes) to track device cost information for future APC rate-setting purposes. No additional payment will be provided to the facility. All appropriate C-codes should be added to the hospital's chargemaster to report device costs used in the outpatient setting. CMS will return a hospital claim if the appropriate tracking code is not identified on the claim when a device-dependent procedure is performed. The tables below may be referenced when reporting various DePuy Synthes foot and ankle products.

HCPCS Code	Description
A4649	Surgical Supply, Miscellaneous
C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable). Implantable pins and/or screws that are used to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone. Screws oppose tissues via drilling as follows: soft tissue-to-bone, tendon-to-bone, or bone-to-bone fixation. Pins are inserted or drilled into bone, principally with the intent to facilitate stabilization or oppose bone-to-bone. This may include orthopedic plates with accompanying washers and nuts. **This category also applies to synthetic bone substitutes that may be used to fill bony void or gaps (i.e., bone substitute implanted into a bony defect created from trauma or surgery).**
C1889	Implantable/insertable device for device intensive procedure, not otherwise classified
C1776	Joint device (implantable)
L8699	Prosthetic Implant, Not otherwise specified
L8641	Metatarsal joint implant
L8642	Hallux implant
L8699	Prosthetic implant, not otherwise specified

Revenue codes allow hospitals to categorize services provided by revenue center for cost reporting. For Medicare, revenue codes must be included for each service on a CMS 1450 (UB-04) claim form. Sample revenue codes that hospital facilities may use to track costs for services associated with foot and ankle procedures are listed in the following table.

Revenue Code	Description
0270	Medical/Surgical Supplies
0271	Medical/Surgical Supplies: Non-sterile
0272	Medical/Surgical Supplies: Sterile
0278	Medical/Surgical Supplies: Other Implants

Modifiers

The modifiers outlined below may be used to report special circumstance during foot and ankle surgery. These include some of the most common modifiers used in conjunction with foot and ankle surgery and do not represent a full listing. Please refer to the most up to date version of the AMA CPT® Code book for a complete listing.

Modifiers	Description
22	**Increased Procedural Services:** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.
47	**Anesthesia by Surgeon:** Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures.
50	**Bilateral Procedure:** Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code.
51	**Multiple Procedures:** When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, 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). Note: This modifier should not be appended to designated "add-on" codes (see Appendix D).
52	**Reduced Services:** Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).
53	**Discontinued Procedure:** Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).
54	**Surgical Care Only:** When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.
55	**Postoperative Management Only:** When 1 physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.
56	**Preoperative Management Only:** When 1 physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

Modifiers	Description
58	**Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period:** It may be necessary 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 surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.
59	**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.
62	**Two Surgeons:** When 2 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 associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.
76	**Repeat Procedure or Service by the Same Physician or Other Healthcare Professional:** It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.
77	**Repeat Procedure by Another Physician or Other Qualified Healthcare Professional:** It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.
78	**Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Healthcare Professional Following Initial Procedure for a Related Procedure During the Postoperative Period:** It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)
79	**Unrelated Procedure or Service by the Same Physician During the Postoperative Period:** The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)
80	**Assistant Surgeon:** Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).
81	**Minimum Assistant Surgeon:** Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.
82	**Assistant Surgeon (when qualified resident surgeon not available):** The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)
T5	Right foot, great toe
TA	Left foot, great toe

Notes

Not all codes provided are applicable for the recommended uses of DePuy Synthes products. The most appropriate code for the patient's clinical presentation must be selected. CPT® copyright 2019 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT®, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Sources

Calendar Year 2020 Medicare Outpatient Prospective Payment System, Final Rule [CMS-1717-FC], Federal Register, November 12, 2019 and its associated addenda. Medicare payment allowable rates shown above do not reflect the automatic payment cuts required under the sequestration process of the 2011 Budget Control Act. Calendar Year 2020 Medicare Physician Fee Schedule, Final Rule [CMS-1715-F]. Federal Register, November 15, 2019. No geographic adjustments have been made to the reported payment rates. Calendar Year 2020 Medicare Inpatient Final Rule, Final Rule [CMS-1716-F]. Federal Register, August 16, 2019. No geographic adjustments have been made to the reported payment rates. Final National Average DRG Payment.

Status Indicator (SI) Definitions

J1 - Hospital Part B services paid through a Comprehensive APC. **Q2** - Payment is packaged if billed on the same date of service as a HCPCS code assigned a status indicator "T"; otherwise payment is made through a separate APC payment. **T** -Significant procedure subject to multiple procedure discounting.

Carriers priced code. Carriers/MACS will establish RVUs and payment amounts for these services, generally on an individual case-by-case basis following review of documentation such as an operative report.

Restricted coverage. Special coverage instructions apply.

Payment Indicator (PI) Definitions

A2 - Surgical procedure on ASC list in CY 2007, payment based on OPPS relative payment weight; **G2** - Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight; **J8** - Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate. **N1**- Packaged service/item; no separate payment made. **P2** - Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight. **P3** - Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.

FOR ADDITIONAL QUESTIONS OR INFORMATION CONTACT

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