PHYSICIAN & FACILITY CODING & BILLING GUIDE

KNEE ARTHROPLASTY

2019 Medicare National Average Payments

Physician Reimbursement

CPT[1] Code	CPT Code	RVUs[A]	2019 Payment
	Arthroplasty		
27440	Arthroplasty, knee, tibial plateau	22.92	$826
27441	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy	23.74	$856
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee	25.03	$902
27443	Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy	23.40	$843
27445	Arthroplasty, knee, hinge prosthesis (eg, Walldius type)	36.12	$1,302
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	33.42	$1,204
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	39.07	$1,408
	Revision		
27486	Revision of total knee arthroplasty, with or without allograft; 1 component	40.54	$1,461
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	50.73	$1,828
	Removal		
27488	Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee	34.64	$1,248

CPT/HCPCS Modifier Options	
Modifier[B]	**Description**
-22	Increased Procedural Service
-50	Bilateral Procedure
-51	Multiple Procedures
-58	Staged or Related Procedure or Service by Same Physician
-59	Distinct Procedural Service
-XE	Separate Encounter
-XS	Separate Structure
-XP	Separate Practitioner
-XU	Unusual Non-Overlapping Service

[A] Total RVU (Relative Value Unit) – Total includes work RVU, Practice Expense RVU and Malpractice RVU.

[B] The CPT codes in this Guide are unilateral procedures. If performed bilaterally, some payors require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payors.

Hospital Outpatient & Ambulatory Surgical Center (ASC) Facility Reimbursement

CPT Code	C-APC Description[C]	C-APC	SI	HOPD[2] 2019 Payment	PI	ASC[3] 2019 Payment
		Arthroplasty Coding Options				
27440	Level 5 Musculoskeletal Procedures	5115	J1	$10,714	J8	$7,393
27441	Level 5 Musculoskeletal Procedures	5115	J1	$10,714	G2	$5,282
27442	Level 5 Musculoskeletal Procedures	5115	J1	$10,714	J8	$7,695
27443	Level 5 Musculoskeletal Procedures	5115	J1	$10,714	A2	$5,282
27445	Inpatient Procedure Only	-	C	-	C5	-
27446	Level 5 Musculoskeletal Procedures	5115	J1	$10,714	J8	$7,695
27447	Level 5 Musculoskeletal Procedures	5115	J1	$10,714		-
		Revision Coding Options				
27486	Inpatient Procedure Only	-	C	-	C5	$2,175
27847	Inpatient Procedure Only	-	C	-	C5	$2,175
		Removal Coding Options				
27488	Inpatient Procedure Only	-	C	-	C5	-

C-APC – Comprehensive Ambulatory Payment Classification
OPPS – Outpatient Prospective Payment System
Status Indicator: C- Inpatient procedure. Not paid under OPPS; J1 – Hospital Part B services paid though a comprehensive APC; C5 – Surgical procedures that are excluded from payment in the ASC
Payment Indicator: A2 –Surgical procedure on ASC list; G2- Non office-based surgical procedure. J8 – Device-intensive procedure; paid at adjusted rate.

HCPCS Level II Coding Options	
HCPCS Code[4]	**HCPCS Code Description**
C1776	Joint device (implantable)
C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)
A4649	Surgical supply; miscellaneous

Note: HCPCS codes report devices used in conjunction with outpatient procedures billed under Medicare OPPS

Inpatient Reimbursement

ICD-10-PCS Hospital Procedure Code			
Replacement (putting in or on biological or synthetic material that physically takes the place and/or function of all or part of a body part)			
0 Medical and Surgical **S** Lower Joints **R** Replacement			
Body Part	Approach	Device	Qualifier
C Knee Joint, Right **D** Knee Joint, Left	**0** Open	**6** Synthetic Substitute, Oxidized Zirconium on Polyethylene E Articulating Spacer J Synthetic Substitute L Synthetic Substitute, Unicondylar Medial M Synthetic Substitute, Unicondylar Lateral N Synthetic Substitute, Patellofemoral	**9** Cemented **A** Uncemented **Z** No Qualifier
T Knee Joint, Femoral Surface, Right **U** Knee Joint, Femoral Surface, Left **V** Knee Joint, Tibial Surface, Right **W** Knee Joint, Tibial Surface, Left	**0** Open	**J** Synthetic Substitute,	**9** Cemented **A** Uncemented **Z** No Qualifier
Revision *(Correcting a malfunctioning or displaced device by taking out or putting in components of the device, but not the entire device/all components of the device, such as a screw or pin)*			
0 Medical and Surgical **S** Lower Joints **W** Revision			
C Knee Joint, Right **D** Knee Joint, Left	**0** Open **3** Percutaneous **4** Percutaneous, Endoscopic	**8** Spacer **9** Liner **J** Synthetic Substitute	**C** Patellar Surface **Z** No Qualifier

[C] A comprehensive APC (C-APC) results in one bundled payment for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. Status Indicator J1 = all services are packaged.

ICD-10-PCS Hospital Procedure Code			
T Knee Joint, Femoral Surface, Right **U** Knee Joint, Femoral Surface, Left **V** Knee Joint, Tibial Surface, Right **W** Knee Joint, Tibial Surface, Left	**0** Open **3** Percutaneous **4** Percutaneous, Endoscopic	**J** Synthetic Substitute	**Z** No Qualifier
Removal *(Taking out or off a device from a body part. If a device is taken out and a similar device put in without cutting or puncturing the skin or mucous membrane, the procedure is coded to the root operation CHANGE. Otherwise, the procedure for taking out the device is coded to the root operation REMOVAL.)*			
0 Medical and Surgical S Lower Joints P Removal			
Body Part	Approach	Device	Qualifier
C Knee Joint, Right **D** Knee Joint, Left	0 Open 3 Percutaneous 4 Percutaneous, Endoscopic	**8** Spacer **9** Liner **E** Articulating Spacer **J** Synthetic Substitute **L** Synthetic Substitute, Unicondylar Medial **M** Synthetic Substitute, Unicondylar Lateral **N** Synthetic Substitute, Patellofemoral	C Patellar Surface Z No Qualifier
A Hip Joint, Acetabular Surface, Right **E** Hip Joint, Acetabular Surface, Left **R** Hip Joint, Femoral Surface, Right S Hip Joint, Femoral Surface, Left	0 Open 3 Percutaneous 4 Percutaneous, Endoscopic	J Synthetic Substitute	Z No Qualifier

MS-DRG	MS-DRG Description	2019[5] Payment
461	Bilateral Or Multiple Major Joint Procedures Of Lower Extremity with MCC	$27,368
462	Bilateral Or Multiple Major Joint Procedures Of Lower Extremity without MCC	$19,502
466	Revision Of Hip Or Knee Replacement with MCC	$31,219
467	Revision Of Hip Or Knee Replacement with CC	$21,188
468	Revision Of Hip Or Knee Replacement without CC/MCC	$17.043
469	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity with MCC Or Total Ankle Re-placement	$19,380
470	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity without MCC	$12,149
486	Knee Procedures with Principal Diagnosis of Infection with CC	$12,591
487	Knee Procedures with Principal Diagnosis of Infection without CC/MCC	$10,075
488	Knee Procedures without Principal Diagnosis of Infection with CC/MCC	$12,898
489	Knee Procedures without Principal Diagnosis of Infection without CC/MCC	$7,921

CC – Complication and/or Comorbidity. MCC – Major Complication and/or Comorbidity.

References

[1] CPT 2019 Professional Edition, 2018 American Medical Association (AMA); CPT is a trademark of the AMA

[2] 2019 Medicare Outpatient Prospective Payment System, www.cms.gov

[3] 2019 Medicare ASC Payment Rates, www.cms.gov

[4] 2019 HCPCS, www.cms.gov

[5] 2019 MS-DRG relative weight multiplied by 2019 rate per IPPS Final Rule, as calculated by MCRA, payment rates will vary by facility. Calculation includes labor related, non-labor related and capital payment rates.