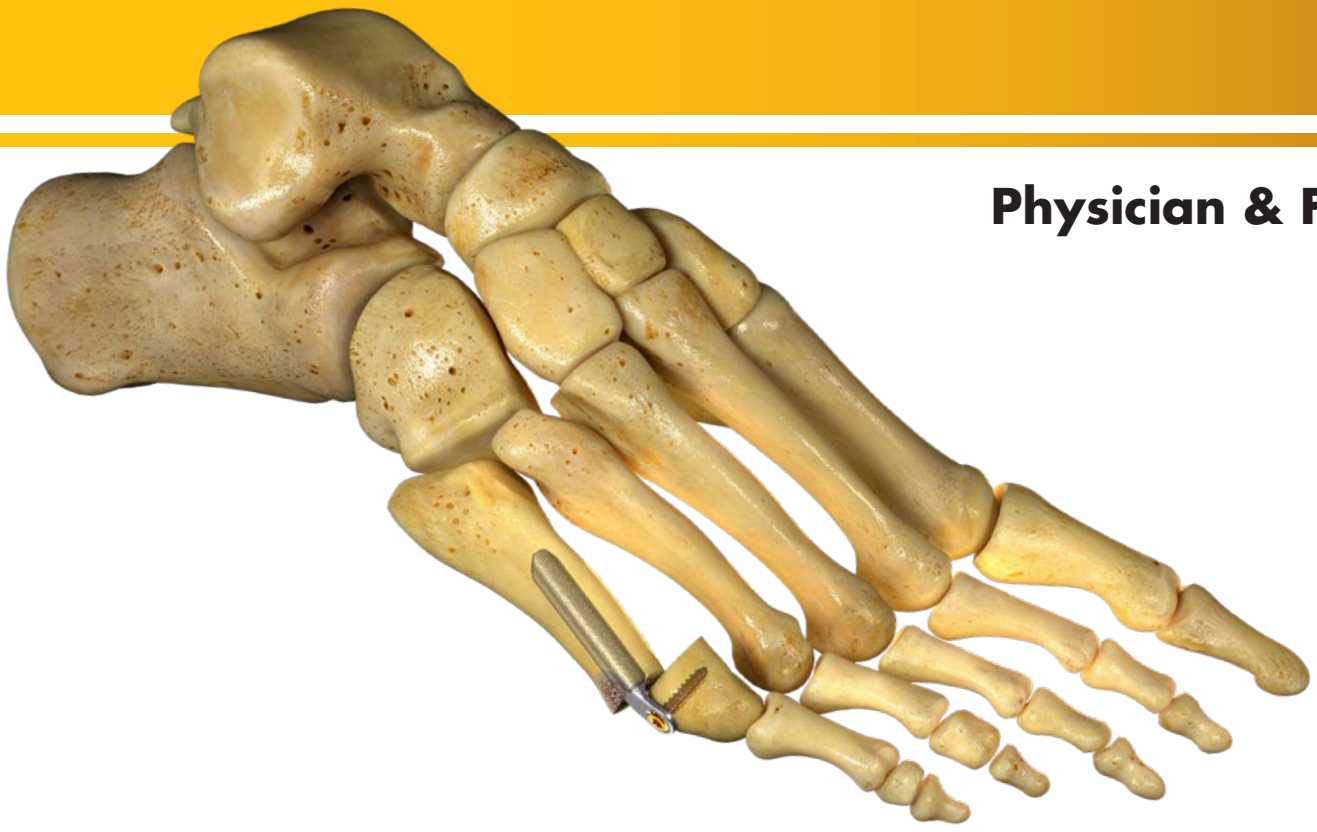
stryker

PROstep™ Bunionette

2022 Reimbursement Guide



Physician & Facility

Reimbursement helpline:
800-698-9985

Physician Reimbursement

Medicare reimburses physicians according to the Medicare Physician Fee Schedule (MPFS), which is based on Relative Value Units (RVUs), and payment varies by geographic region.

CY 2022 Final Physician Payment

CPT® code[1]	Description	Facility (POS 21, 22 or 24)		Non-Facility (POS 11)	
		RVUs	Medicare National Average Payment[2]	RVUs	Medicare National Average Payment[2]
Bunionectomy/Ostectomy/Osteotomy					
28110	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)	8.54	$296	13.59	$470
28296	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method	15.04	$520	26.38	$913
28299	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method	17.30	$599	29.88	$1,034
Unlisted					
28899	Unlisted procedure, foot or toes	N/A	Carrier Priced	N/A	Carrier Priced

POS=Place of Service

Outpatient Facility Reimbursement

Hospital outpatient services are reimbursed under Medicare's Outpatient Prospective Payment System (OPPS) based on the associated Ambulatory Payment Classification (APC). Procedures requiring similar resources are grouped into APCs and facilities are paid a lump sum payment for the services provided.

CY 2022 Final Hospital Outpatient and Ambulatory Surgical Center Payment

CPT® code[1]	Description	Hospital Outpatient (POS 22)		Ambulatory Surgical Center (POS 24)		
		APC	Medicare National Average Payment[3]	SI	Medicare National Average Payment[3]	PI
Bunionectomy/Ostectomy/Osteotomy						
28110	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)	5113	$2,892	J1	$1,362	A2
28296	"Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method"	5113	$2,892	J1	$1,362	A2
28299	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method	5114	$6,397	J1	$3,918	J8
Unlisted						
28899	Unlisted procedure, foot or toes	5111	$211	T	Not on ASC allowable list	N/A

HCPCS Codes

Relevant HCPCS Level II codes are reported for materials, products and devices utilized in procedures for tracking and/or reimbursement purposes. Please review each payer's guidelines for reporting and payment.

HCPCS Code	Description
C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)
C1889	Implantable/insertable device for device intensive procedure, not otherwise classified
L8642	Hallux implant
L8699	Prosthetic implant, not otherwise specified

Modifiers

Modifiers indicate that a reported service has been altered by a specific circumstance but that the code description has not changed. Some of the modifiers will impact reimbursement while others are informational only.

Modifier	Description
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant surgery.
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.
26	**Professional Component:** Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.
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.
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.
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.
Effective January 1, 2015 CMS established four new modifiers to define specific subsets of the 59 modifier. Modifier 59 is still recognized but should not be used when a more descriptive modifier is available. The X{EPSU} modifiers are below[4]	
XE	**Separate Encounter:** A service that is distinct because it occurred during a separate encounter.
XS	**Separate Structure:** A service that is distinct because it was performed on a separate organ/structure
XP	**Separate Practitioner:** A service that is distinct because it was performed by a different practitioner
XU	**Unusual Non-Overlapping Service:** The use of a service that is distinct because it does not overlap usual components of the main service
80	**Assistant Surgeon:** Surgical assistant services may be identified by adding the modifier 80 to the usual procedure numbers. This modifier should be reported to identify surgical assistant services performed in a non-teaching setting or in a teaching setting when a resident was available, but the surgeon opted not to use the resident. In the latter case, the service is generally not covered by Medicare.

The Stryker Reimbursement Helpline staff can assist with the following:

- General coding and reimbursement questions
- Prior authorization and pre-determination questions
- Medicare unadjusted national average payment rates

For assistance with coding and reimbursement, please contact:

Reimbursement helpline: 800-698-9985

Fax: 949-449-8699
Email: orthoreimbursement@stryker.com

9 a.m. - 5 p.m. CT,
Monday through Friday

(except holidays and unexpected closures)

Visit us at www.stryker.com.

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Status Indicator (SI) Definitions: C - Not paid under OPPS. inpatient only procedure; **J1** - Hospital Part B services paid through a Comprehensive APC; **N** - Items and Services Packaged into APC Rates. Paid under OPPS; payment is packaged into payment for other services; **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, multiple procedure reduction applies,

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; **P3** - Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on based on MPFS non-facility PE RVUs.

References:

1. Current Procedural Terminology 2022. CPT® copyright 2021 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS apply.
2. Calendar Year 2022 Medicare Physician Fee Schedule, Final Rule [CMS-1751-F].Federal Register, November 19, 2021.PPRRVU January 2022 update December 15, 2021.Medicare national average physician payment rates listed in this document are based on the conversion factor of $34.6062. No geographic adjustments have been made to the reported payment rates.
3. Calendar Year 2022 Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, Final Rule [CMS-1753-FC], Federal Register, November 16, 2021 and its associated addenda posted on theCenters for Medicare and Medicaid Services web site on November 1, 2021.

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