



Shoulder Arthroplasty Surgical Procedures

2011 Reimbursement
and Coding Reference Guide
for Physicians and Hospitals



This coding reference guide is intended to illustrate the common CPT® codes, ICD-9 CM procedure codes, and common MS-DRG, APC and ASC assignment for shoulder arthroplasty surgical procedures performed in the inpatient hospital, outpatient hospital, and ambulatory surgical center settings. CPT® is a trademark of the American Medical Association (AMA).

Valid January 1, 2011 to December 31, 2011

Common PHYSICIAN Procedure Codes for Shoulder Arthroplasty Surgical Procedures

CPT* Code	Code Description	2011 Medicare National Average Payment ¹
23331	Removal of foreign body, shoulder; subcutaneous deep (eg, Neer hemiarthroplasty removal)	\$583
23332	Complicated (eg, total shoulder)	\$876
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	\$1,209
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)	\$1,498
23616	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; with proximal humeral prosthetic replacement	\$1,251
+20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure)	\$149

1 Per CMS-1503-FC determined by multiplying the physician fee schedule conversion factor (\$33.9764) by the total adjusted facility RVUs. Represents national average with no geographic adjustment, individual physician reimbursement will vary.

+ Add-on code

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Please Note: The table below includes the addition of a new ICD9-CM procedure code (81.88 Reverse Total Shoulder Replacement) which is effective October 1, 2010. Also note the description change for code 81.80 to "Other Total Shoulder Replacement."

Common INPATIENT HOSPITAL Procedure Codes and MS-DRG Assignment for Shoulder Arthroplasty Surgical Procedures

ICD-9-CM Procedure Codes		Code Description	Common Medicare MS-DRG Assignment	Medicare National Average Payment ^{1,2}
79.31		Open reduction of fracture of humerus with internal fixation	492 — Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with MCC	\$17,126
			493 — Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with CC	\$10,341
			494 — Lower Extremity and Humerus Procedures Except Hip, Foot, Femur without CC/MCC	\$7,337
80.01		Arthrotomy for removal of prosthesis of shoulder	495 — Local Excision and Removal Internal Fixation Devices Except Hip and Femur with MCC	\$16,017
			496 — Local Excision and Removal Internal Fixation Devices Except Hip and Femur with CC	\$9,050
			497 — Local Excision and Removal Internal Fixation Devices Except Hip and Femur without CC/MCC	\$6,014
81.80		Other total shoulder replacement	483 — Major Joint and Limb Reattachment Procedures of Upper Extremity with CC/MCC	\$13,413
81.81		Partial shoulder replacement		
**81.81		Reverse total shoulder replacement		
81.83		Other repair of shoulder	507 — Major Shoulder or Elbow Joint Procedures with CC/MCC	\$10,449
			508 — Major Shoulder or Elbow Joint Procedures without CC/MCC	\$7,793
81.97		Revision of joint replacement of upper extremity	515 — Other Musculoskeletal System and Connective Tissue O.R. Procedure with MCC	\$17,810
			516 — Other Musculoskeletal System and Connective Tissue O.R. Procedure with CC	\$10,476
			517 — Other Musculoskeletal System and Connective Tissue O.R. Procedure without CC/MCC	\$8,263
84.44		Implantation of prosthetic device of arm	507 — Major Shoulder or Elbow Joint Procedures with CC/MCC	\$10,449
			508 — Major Shoulder or Elbow Joint Procedures without CC/MCC	\$7,793
00.31		Computer assisted surgery with CT/CTA	Additional procedures that might be coded along with the above procedures, if applicable	
00.32		Computer assisted surgery with MR/MRA		
00.33		Computer assisted surgery with fluoroscopy		
00.34		Imageless computer assisted surgery		
00.35		Computer assisted surgery with multiple datasets		
00.39		Other computer assisted surgery		

1 FY 2011 Medicare Inpatient Prospective Payment System final rule (CMS-1498-F), Table 5.

2 Assumes payment for a large urban hospital with wage index >1 and full update. Medicare payment = MS-DRG relative weight x (labor standardized amount + non-labor standardized amount + national capital rate).

** New ICD-9 CM Procedure Code FY 2011

Common OUTPATIENT HOSPITAL APCs for Shoulder Arthroplasty Surgical Procedures

CPT*/ HCPCS Code	Code Description	Medicare APC Assignment	Status Indicator ¹	Final CY 2011 Payment Rate ²
23331	Removal of foreign body, shoulder; subcutaneous deep (eg, Neer hemiarthroplasty removal)	0022 – Level IV Excision/Biopsy	T	\$1,646.04
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	0425 – Level II Arthroplasty or Implantation with Prosthesis	T	\$8,596.24
23616	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; with proximal humeral prosthetic replacement	0064 – Level III Treatment Fracture/ Dislocation	T	\$4,608.20
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure)	N/A	N	N/A
C1776	Joint device (implantable)	N/A	N	N/A

Common AMBULATORY SURGERY CENTER (ASC) Payment Rates for Shoulder Arthroplasty Surgical Procedures

CPT* Code	Code Description	Final CY 2011 Payment Rate ³
23331	Removal of foreign body, shoulder; subcutaneous deep (eg, Neer hemiarthroplasty removal)	\$925.91
23616	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; with proximal humeral prosthetic replacement	\$2,592.14

Note: Surgical procedures for implantable prosthetic devices, performed in an inpatient or outpatient hospital setting, include the cost of the device in the Diagnosis Related Group (DRG) or Ambulatory Payment Classification (APC) rate.

1 Per addendum A, CMS-1504-FC; Status Indicator:

N = Items and services packaged into APC rates - no separate APC payment

T = Significant Procedure, multiple surgical reduction applies

2 Addendum A, CMS-1504-FC OPPS APC CY 2011 Payment Rate.

3 Addendum AA CMS-1504-FC Final ASC CY 2011 Final Payment.

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Common CPT* Code Modifiers

Below are common CPT code modifiers that may be applicable to shoulder arthroplasty surgical procedures. Reference should be made to the Current Procedural Terminology (CPT) 2011 Professional Edition (Appendix A) for complete modifier definitions, and for applicability with specific CPT procedure codes.

- 22 Increased Procedural Services:** When the service(s) provided is greater than that usually required for the listed procedure. A report may also be appropriate.
- 50 Bilateral Procedure:** Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative sessions should be identified by adding modifier 50 to the appropriate procedure code.
- 51 Multiple Procedures:** When multiple procedures, other than Evaluation and Management Services, physical medicine and rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same provider, 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). Modifier 51 should not be appended to designated CPT “add-on” codes.
- 52 Reduced Services:** Under certain circumstances a service or procedure is partially reduced or eliminated at the physician’s discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, indicating that the service is reduced.
- 53 Discontinued Procedure:** Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure due to extenuating circumstances that threaten the well being of the patient.
- 54 Surgical Care Only:** When one physician performs a surgical procedure and another provides pre-operative and/or post-operative management.
- 58 Staged or Related Procedure or Service by the Same Physician During a Post-operative Period:** The physician may need 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 diagnostic surgical procedure. This modifier is not used to report the treatment of a problem that requires a return to the operating room.
- 62 Two Surgeons:** When two 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 associate add-on code(s) for that procedure.
- 66 Surgical Team:** Highly complex procedures requiring concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, and various types of complex equipment.
- 73 Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia:** Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure due to extenuating circumstances that threaten the well being of the patient prior to the administration of anesthesia (Facility use only).
- 74 Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After the Administration of Anesthesia:** Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure due to extenuating circumstances that threaten the well being of the patient after the administration of anesthesia (Facility use only).
- 76 Repeat Procedure by Same Physician:** The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service.
- 77 Repeat Procedure by Another Physician:** The physician may need to indicate that a procedure or service performed by another physician had to be repeated.
- 80 Assistant Surgeon:** Surgical assistant services.
- 81 Minimum Assistant Surgeon:** Minimum surgical assistant services.
- 82 Assistant Surgeon (when qualified resident surgeon not available):** The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82.
- 99 Multiple Modifiers:** Under certain circumstances, two or more modifiers may be necessary to completely delineate a service.

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Data Sources

- ICD-9-CM Official Guidelines For Coding and Reporting, U.S. Department of Health and Human Services, Effective October 1, 2010.
- 42 CFR Parts 410, 411, 414 et al. Medicare Program [CMS-1503-FC]; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Final Rule; Medicare Program; Notice, November 2, 2010.
- 42 CFR Parts 410, 416, and 419 Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates [CMS-1504-FC]; Changes to the Ambulatory Surgical Center Payment System and CY 2011 Payment Rates; Final Rule, November 2, 2010.
- 42 CFR Parts 412, 413, 415, et al. Medicare Program [CMS-1498-F]; Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2011 Rates; and Changes to the Long Term Care Hospital Prospective Payment System and Rate Years 2010 and 2010 Rates; Final Rule, August 16, 2010.
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