2020 Coding and Reimbursement Guidelines for the Univers Revers™ Total Shoulder System

To help answer common coding and reimbursement questions about arthroplasty procedures completed with the Univers ReversTotal Shoulder System, the following information is shared for educational and strategic planning purposes only. While Arthrex believes this information to be correct, coding and reimbursement decisions by AMA, CMS, and leading payers are subject to change without notice. As a result, providers are encouraged to speak regularly with their payers.

FDA Regulatory Clearance:

The **Univers Revers™ Total Shoulder System** is indicated for use in a grossly rotator cuff deficient glenohumeral joint with severe arthropathy or a previously failed joint replacement with a gross rotator cuff deficiency. The Univers Revers is indicated for primary, fracture, or revision total shoulder replacement. (K130129, May 31, 2013)

Value Analysis Significance:

The **Univers Revers Total Shoulder System** provides the option to implant a traditional "Grammont-style" configuration which follows the principles of a constrained environment that medializes the center of rotation and lengthens the deltoid, resulting in increased torque with forward flexion. In addition, this unique implant design offers the option to create a more anatomic center of rotation by altering the neck-shaft angle from 155° to 135° and utilizing a lateralized glenosphere. This more lateralized center of rotation decreases the risk of scapular notching, while increasing the external rotator torque by lengthening the intact posterior cuff musculature. This adjustable neck-shaft angle, in combination with the wide range of offset options available in the humeral and glenoid components, allows the surgeon to tailor an implant specific to each patient's anatomy and disease process.

Coding Considerations:

Codes provide a uniform language for describing services performed by healthcare providers. The actual selection of codes depends upon the primary surgical procedure, supported by details in the patient's medical record about medical necessity. It is the sole responsibility of the healthcare provider to correctly prepare claims submitted to insurance carriers.

Physician's Professional Fee

The primary arthroplasty procedure determined by the surgeon may include:

2020 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician[2]		Hospital Outpatient[3]		ASC[4]
		Medicare National Average				
CPT[1] Code HCPCS Code	Code Description	Facility Setting (HOPD and ASC)	Non-Facility Setting (Office)	APC & APC Description	Medicare National Average	Medicare National Average
Arthroplasty						
Shoulder						
20902	Bone graft, any donor area; major or large	$294.49	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	$5,981.95	$2,803.36
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	$153.02	N/A	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
23334	Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component	$1,112.28	N/A	5073 - Level 3 Excision/ Biopsy/ Incision and Drainage	$2,318.89	$994.34
23335	Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid components (eg, total shoulder)	$1,326.29	N/A	Inpatient procedure only		

[1] CPT is the registered trademark of the American Medical Association. Healthcare providers and their professional coders must closely review this primary citation along with the patient's medical record before selecting the appropriate code.
[2] Source: AMA CPT 2020 and CMS PFS 2020 Final Rule
[3] Source: CMS 2020 OPPS Final Rule @ www.cms.gov
[4] Source: CMS 2020 ASC Final Rule @ www.cms.gov

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CPT[1] Code HCPCS Code	Code Description	Facility Setting (HOPD and ASC)	Non-Facility Setting (Office)	APC & APC Description	Medicare National Average	Medicare National Average
Arthroplasty						
Shoulder						
23395	Muscle transfer, any type, shoulder or upper arm; single	$1,338.20	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	$5,981.95	$2,803.36
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	$1,253.03	N/A	5115 - Level 5 MSK Procedures	$11,900.71	N/A
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	$1,515.04	N/A	Inpatient procedure only		
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	$1,690.08	N/A	5115 - Level 5 MSK Procedures	$11,900.71	N/A
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	$1,826.13	N/A	Inpatient procedure only		
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed;	$920.28	N/A	5115 - Level 5 MSK Procedures	$11,900.71	$8,289.65
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	$1,290.56	N/A	5116 - Level 5 MSK Procedures	$15,946.08	$11,670.74
24515	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage	$915.59	N/A	5115 - Level 5 MSK Procedures	$11,900.71	$7,815.83

Hospital and Facility Coding		
HCPCS Code	**Code Description**	**Notes**
C1776	**Joint device (implantable)** *An artificial joint that is implanted in a patient. Typically, a joint device functions as a substitute to its natural counterpart and is not used (as are anchors) to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone.* *(List of Pass Through Payment Device Category Codes – Updated January 2020 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Complet-list-DeviceCats-OPPS.pdf*	For Medicare, anchors/screws/joint devices are not separately reimbursed in any setting of care (e.g. hospital, ASC, office). These costs are absorbed by the facility via the appropriate reimbursement mechanism (e.g. MS-DRG, APC, etc.) For non-Medicare (e.g. Commercial) patients, depending on contractual terms and general stipulations of the payer, direct invoicing may be allowed. Contact the patient's insurance company or the facility's payer contract for further information.

For more information about the primary procedure, please speak with your admitting surgeon. You may also call Arthrex's Reimbursement Helpline at 1-877-734-6289 or e-mail us at arthrex@mcra.com.

This content is not intended to instruct medical providers on how to use or bill for healthcare procedures, including new technologies outside of Medicare national guidelines. A determination of medical necessity is a prerequisite that we assume will have been made prior to assigning codes or requesting payments. Medical providers should consult with appropriate payers, including Medicare fiscal intermediaries and carriers, for specific information on proper coding, billing, and payment levels for healthcare procedures.

The information provided in this handout represents no promise or guarantee concerning coverage, coding, billing, and payment levels. Arthrex specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on this information. It does not constitute legal advice and no warranty regarding completeness or accuracy is implied. The essential components which determine appropriate payment for a procedure or a product are site of service/coding/coverage/ payment system/geographical location/national and local medical review policies and/or payer edits.

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