Persona IQ® The Smart Knee® Coding Reference Guide

Persona IQ® The Smart Knee® combines the Persona® The Personalized Knee® and the CANARY canturio™ Tibial Extension (CTE) with Canary Health Implanted Reporting Processor (CHIRP™). Persona IQ is the first-to-world smart knee implant that captures key kinematic data metrics.

Current Procedural Terminology (CPT®) Code and Description	
CPT Code	**Description**
Total Knee Arthroplasty with Implantation of CANARY canturio™ te Tibial Extension	
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
Remote Therapeutic Monitoring (RTM)	
98975	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment
98977	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes
98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)

Medicare Coverage Requirements for Reporting Remote Therapeutic Monitoring (RTM):

- RTM services (e.g., musculoskeletal system status, therapy adherence, therapy response, cognitive behavioral therapy, therapy adherence, therapy response) represent the review and monitoring of data related to signs, symptoms, and functions of a therapeutic response. These data may represent objective device-generated integrated data or subjective inputs reported by a patient. These data are reflective of therapeutic responses that provide a functionally integrative representation of patient status.[1]
- Physicians and eligible qualified health care professionals are permitted to bill RTM as general medicine services. A physician or other qualified health care professional is defined in the CPT Codebook as "an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service." Accordingly, RTM codes could be available for physical therapists (PT), occupational therapists (OT), speech-language pathologists, physician assistants, nurse practitioners, and clinical social workers.[3]
- Remote monitoring codes are designated as care management services and thus CMS' rules for general supervision apply to these services. [2]
- Billing for remote monitoring codes requires data collection for at least 16 days in a 30-day period and applies to the following RTM code: 98977. The 16-day data collection requirement does not apply to CPT codes 98980 and 98981 because these CPT codes are treatment management codes that account for time spent in a calendar month and do not require 16 days of data collection in a 30-day period. [2]
- To report 98975 and 98977 the device used must be a medical device as defined by the FDA.[1]
- Only one practitioner can bill for RPM or RTM (not both) during a 30-day period, and only when at least 16 days of data have been collected on at least one medical device. Even when multiple medical devices are provided to a patient, the remote monitoring services associated with all the medical devices can be billed by only one practitioner, only once per patient, per 30-day period, and only when at least 16 days of data have been collected; and that the services must be reasonable and necessary. [2]
- For an individual beneficiary who is currently receiving services during a global period, a practitioner may furnish RTM services (but not both RPM or RTM services) to the individual beneficiary, and the practitioner will receive separate payment, so long as the remote monitoring services are unrelated to the diagnosis for which the global procedure is performed, and as long as the purpose of the remote monitoring addresses an episode of care that is separate and distinct from the episode of care for the global procedure - meaning that the remote monitoring services address an underlying condition that is not linked to the global procedure or service.[2]
- RTM services being furnished during the global period only applies to billing practitioners who are receiving the global service payment. Practitioners, such as physical and occupational therapists, who are not receiving a global service payment because they did not furnish the global procedure, would be permitted to furnish RPM or RTM services during a global period. [2]

- CMS states that self-reported/entered data may be part of the non-physiologic data for purposes of RTM codes. RTM data can be self-reported by the patient, as well as digitally uploaded via the device. While RTM codes still require the device used to meet the FDA's definition of a medical device, self-reported RTM data via a smartphone app or online platform classified as Software as a Medical Device (SaMD) may qualify for reimbursement.[3]
- Practitioners must obtain consent either in advance or at the time RTM services are furnished and document that consent in the patient's record.[4]
- For new patients or patients not seen within the year by billing practitioner, RTM services must be initiated during an in-person visit.[4]
- RTM services may be provided to patients with either acute or chronic conditions.[4]

Hospital Inpatient: ICD-10-PCS Code and Description			
Replacement *(Putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a body part)*			
Ø Medical and Surgical **S** Lower Joints **R** Replacement			
Body Part	**Approach**	**Device**	**Qualifier**
C Knee Joint, Right **D** Knee Joint, Left	**Ø** Open	**J** Synthetic Substitute	**9** Cemented **Z** No Qualifier
Insertion *(Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part)*			
X New Technology **N** Bones **H** Insertion			
G Tibia, Right **H** Tibia, Left	**Ø** Open	**F** Tibial Extention with Motion Sensors	**9** New Technology Group 9

Hospital Inpatient: Medicare Severity-Diagnosis Related Group (MS-DRG)*	
MS-DRG	**Description**
461	Bilateral Or Multiple Major Joint Procedures Of Lower Extremity with MCC
462	Bilateral Or Multiple Major Joint Procedures Of Lower Extremity without MCC
469	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity with MCC Or Total Ankle Replacement
470	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity without MCC

CC – Complication and/or Comorbidity. MCC – Major Complication and/or Comorbidity.
*Other MS-DRGs may be applicable. MS-DRG will be determined by the patient's diagnosis and any procedure(s) performed.

New Technology Add-on Payments for Persona IQ

For the period October 1, 2023 – September 30, 2024, Medicare beneficiary discharges from the hospital inpatient setting will be eligible to receive New Technology Add-on Payments (NTAP) of up to $850.85 for one knee, or $1,701.70 for two knees, for the implantation of the canturio Tibial Extension (CTE) with Canary Health Implanted Reporting Processor (CHIRP) System.[5] A NTAP is a special payment made by Medicare for services and technologies provided in the hospital inpatient setting to recognize the additional costs of innovative new technologies and to encourage the diffusion of such technologies.

The NTAP provides supplemental payment to the hospital in addition to the reimbursement it receives for the Medicare Severity-Diagnosis Related Group (MS-DRG) assigned to the case. Cases involving the use of the CTE with CHIRP System that are eligible for NTAP will be identified by reporting ICD-10-PCS code XNHG0F9 (Insertion of tibial extension with motion sensors into right tibia, open approach, new technology group 9) and/or XNHH0F9 (Insertion of tibial extension with motion sensors into left tibia, open approach, new technology group 9).

Hospital Outpatient and Ambulatory Surgical Center (ASC)				
CPT Code	**Description**	**OPPS Status Indicator**	**APC Assignment**	**ASC Payment Indicator**
Total Knee Arthroplasty with Implantation of CANARY canturio™ te Tibial Extention				
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	J1	5115	J8
Remote Therapeutic Monitoring (RTM)				
98975	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment	V	5012	NA
98977	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days	Q1	5741	NA
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes	B	--	NA
98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)	B	--	NA

OPPS -Outpatient Prospective Payment System; APC - Ambulatory Payment Classification; ASC - Ambulatory Surgical Center.
Status Indicator: B - Codes That are Not Recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x). Not paid under OPPS.; J1 - Hospital Part B services paid through a comprehensive APC; N - Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.; V - Clinic or Emergency Department Visit Paid under OPPS; separate APC payment.
APC: 5012 – Clinic Visits and Related Services; 5115 – Level 5 Musculoskeletal Procedures; 5741 – Level 1 Electronic Analysis of Devices
Payment Indicator: J8 – Device-intensive procedure; paid at adjusted rate; NA - This procedure is not on Medicare's ASC Covered Procedures List (CPL).

HCPCS (Healthcare Common Procedure Coding System)	
Code	**Description**
C1776	Joint device (implantable)

Note: HCPCS codes report devices used in conjunction with outpatient procedures billed and paid for under Medicare's Outpatient Prospective Payment System.

For further assistance with reimbursement questions, contact the Zimmer Biomet Reimbursement Hotline at 866-946-0444 or reimbursement@zimmerbiomet.com, or visit our reimbursement web site at zimmerbiomet.com/reimbursement.

References:
[1] CPT® 2024 Professional Edition. American Medical Association. p. 875
[2] Calendar Year 2024 Medicare Physician Fee Schedule, Final Rule. Federal Register, November 2, 2023.
[3] Calendar Year 2022 Medicare Physician Fee Schedule, Final Rule. Federal Register, November 19, 2021.
[4] Calendar Year 2021 Medicare Physician Fee Schedule, Final Rule. Federal Register, December 28, 2020.
[5] Fiscal Year 2024 Medicare Inpatient Prospective Payment System, Final Rule. Federal Register, August 28, 2023

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For Persona IQ: The objective kinematic data generated by the CTE with CHIRP System are not intended to support clinical decision-making and have not been shown to provide any clinical benefit.

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