ROSA® Knee System for Robotic-Assisted Surgery Coding Reference Guide

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The ROSA Knee System is indicated as a stereotaxic instrumentation system for total knee replacement (TKA) surgery. It is to assist the surgeon in providing software-defined spatial boundaries for orientation and reference information to identifiable anatomical structures for the accurate placement of knee implant components.

Current Procedural Terminology (CPT) Code and Description	
CPT® Code	**Description**
NA	Robotic-assisted surgery is considered incidental to the primary procedure being performed and is not separately identified/reported via CPT coding mechanisms
S2900[1]	Surgical techniques requiring use of robotic surgical system
Pre-Operative Scans/Radiology	
73552	Radiologic examination, femur; minimum 2 views
73590	Radiologic examination; tibia and fibula, 2 views
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s)

[1] S codes are used by commercial and other health insurance plans to report drugs, services, and supplies for which there are no national codes but for which codes are needed by the private sector to implement policies, programs, or claims processing. These codes are also used by Medicaid programs, but they are not payable by Medicare.

Coverage will likely need to be evaluated for the pre-operative MRI or x-ray needed to use the ROSA Knee System, along with that for total knee arthroplasty (TKA). Providers should contact payers directly to clarify coverage policies and prior authorization requirements as these can vary by payer.

Pre-Operative Scans

The first scan may be acquired for a gross overview of the patient's anatomy; essentially a diagnostic scan that is ordinarily billable assuming formal interpretation is made with generation of an imaging report. If the patient has diagnostic findings on the first scan and is a surgical candidate, a scan with much greater detail may be needed.

If a second scan is taken for diagnostic purposes and a formal interpretation is made with generation of an imaging report, that substantiates separate coding and billing. However, if the second scan is taken only for the purpose of preoperative planning for the ROSA Knee System, it would be considered integral and should not be separately coded or billed.

Specialty Society Guidance

American College of Radiology (May/June 2009 ACR Radiology Coding Resource Q & A)

Question: An orthopedic surgeon ordered an MRI of the knee for use in prosthetic design and for the design of custom cutting jigs. An interpretation is not necessary. However, the hospital requires that the radiologist render an interpretation. Is it appropriate for the radiologist to report the professional component of the MRI study when an interpretation is rendered?

When magnetic resonance imaging (MRI) scans of the knee are performed and exported for prosthesis design and/or for the design of custom cutting jigs without a request for an interpretation, it would be appropriate for the entity that owns the equipment to report only the technical component of CPT code 73721, 73722, or 73723 (Magnetic Resonance Imaging, any joint of the lower extremity) based on whether or not contrast was administered. In this scenario, no professional component (PC) should be charged.

If, however, an interpretation of the study is requested, and the medical necessity of the procedure is substantiated with an order from the referring physician, then the professional component of the appropriate CPT code (73721-73723) should be reported by the radiologist that renders the interpretation.

Hospital Inpatient: ICD-10-PCS Code and Description			
8 Other Procedures **E** Physiological Systems and Anatomical Regions **Ø** Other Procedures: Methodologies which attempt to remediate or cure a disorder or disease			
Body Part	**Approach**	**Device**	**Qualifier**
Y Lower Extremity	**Ø** Open **3** Percutaneous **4** Percutaneous Endoscopic	**C** Robotic Assisted Procedure	**Z** No Qualifier

Hospital Inpatient: Medicare Severity-Diagnosis Related Group (MS-DRG)*	
MS-DRG	**Description**
The ICD-10-PCS code(s) listed does/do not determine MS-DRG assignment. Instead, the MS-DRG will be assigned based upon the patient's diagnosis(es) and any procedure(s) performed.	
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
488	Knee Procedures Without PDX Of Infection with CC/MCC
489	Knee Procedures Without PDX Of Infection without CC/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.

Hospital Outpatient and Ambulatory Surgical Center (ASC)				
CPT®Code	**Description**	**OPPS Status Indicator**	**Ambulatory Payment Classification**	**ASC Payment Indicator**
Robotic-assisted surgery is considered incidental to the primary procedure being performed and is not separately identified/reported via CPT/HCPCS coding mechanisms.				
Arthroplasty				
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	J1	5115	J8
Pre-Operative Scans/Radiology				
73552	Radiologic examination, femur; minimum 2 views	Q1	5521	N1
73590	Radiologic examination; tibia and fibula, 2 views	Q1	5521	N1
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s)	Q3	5523	Z2

OPPS - Medicare's Outpatient Prospective Payment System.
Status Indicator: J1 - Hospital Part B services paid through a comprehensive APC. Q1 – STV-Packaged Codes. Q3 – Codes That May Be Paid Through a Composite APC
APC: 5115 – Level 5 Musculoskeletal Procedures. 5521 – Level 1 Imaging without contrast. 5523 – Level 3 Imaging without contrast
Payment Indicator: J8 – Device-intensive procedure; paid at adjusted rate. N1 – Packaged service/item; no separate payment made. Z2 – Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.

HCPCS (Healthcare Common Procedure Coding System)	
Code	**Description**
Robotic-assisted surgery is considered incidental to the primary procedure being performed and is not separately identified/reported via CPT/HCPCS coding mechanisms.	

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 www.zimmerbiomet.com/reimbursement.

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