Persona IQ® The Smart Knee™ Coding Reference Guide

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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 (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment
98977	Remote therapeutic monitoring (e.g., 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/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes
98981	Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes (listed 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) represent the review and monitoring of data related to signs, symptoms and functions of a therapeutic response. These data are reflective of therapeutic responses that provide a functionally integrative representation of patient status.[2]
- 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]
- 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]
- Code 98975 may be billed once per episode of care. An episode of care begins when the remote therapeutic monitoring service initiates and ends with the attainment of targeted treatment goals. Codes 98977 may be billed once per 30 days. Code 98980 may be billed once per calendar month regardless of the number of therapeutic monitoring modalities performed in a given calendar month. Code 98981 may be billed once per calendar month for each additional 20 minutes completed within such month.[2]
- CPT codes 98975 and 98977 require the RTM device to monitor at least 16 days of data per each 30-day period, in total.[2]
- The medical device supplied to a patient as part of CPT code 98977 must be a medical device as defined by Section 201(h) of the Federal Food, Drug and Cosmetic Act.[3]
- In the final rule, CMS stated 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.[2]

References:

[1] CPT® 2022. American Medical Association.

[2] CPT® 2022 Professional Edition. American Medical Association. p. 50.

[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.

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

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.

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				
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 (e.g., 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 (e.g., 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	N	5741	NA
98980	Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes	B	--	NA
98981	Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes (listed 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.

WARNING – The kinematic data from this device have not been demonstrated to have clinical benefit. It is not intended to be utilized for clinical decision-making, and no data have been evaluated by FDA regarding clinical benefits.

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3578.4-US-en-Issue Date 2022-01-28