Pre-Operative Scans Associated with Zimmer Biomet Patient Specific Instruments and Signature System Coding Reference Guide

ZIMMER BIOMET
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Zimmer Biomet's Patient Specific Instruments (PSI) and Signature system streamline total knee and reverse shoulder replacement surgery by ensuring accurate and reproducible guide fixation. Our proprietary stabilizing feature enhances guide fixation while ensuring the end surgical result matches the preoperative plan. Based on the patient's MRI or CT, mechanical axis-based pin guides conform precisely to the patient's anatomy. Zimmer Biomet's PSI and Signature system simplify the total knee and reverse shoulder process from start to finish without compromising surgical decision making, surgical technique, or intraoperative flexibility.

Coverage will likely need to be evaluated for the pre-operative MRI or CT required to use the PSI or Signature system, along with that for total knee arthroplasty (TKA), unicompartmental knee replacement (UKR) or reverse shoulder arthroplasty (RSA). 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 the PSI or Signature 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.

Physician	
CPT® Code	**CPT Description**
73200	Computed tomography, upper extremity; without contrast material
73218	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)
73552	Radiologic examination, femur; minimum 2 views
73590	Radiologic examination; tibia and fibula, 2 views
73700	Computed tomography, lower extremity; without contrast material
73718	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s)
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation

Hospital Outpatient and Ambulatory Surgery Center (ASC)				
CPT® Code	**CPT Description**	**OPPS Status Indicator**	**Ambulatory Payment Classification**	**ASC Payment Indicator**
73200	Computed tomography, upper extremity; without contrast material	Q3	5522	Z2
73218	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)	Q3	5523	Z2
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)	Q3	5523	Z2
73552	Radiologic examination, femur; minimum 2 views	Q1	5521	N1
73590	Radiologic examination; tibia and fibula, 2 views	Q1	5521	N1
73700	Computed tomography, lower extremity; without contrast material	Q3	5522	Z2
73718	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)	Q3	5523	Z2
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s)	Q3	5523	Z2
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation	N	--	N1
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation	N	--	N1

OPPS - Medicare's Outpatient Prospective Payment System.
APC 5521 - Level 1 Imaging without Contrast. 5522 - Level 2 Imaging without contrast. 5523 - Level 3 Imaging without contrast.
Status Indicator N: Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment. Q1 - STV-Packaged Codes; Q3: Codes That May Be Paid Through a Composite APC.
Payment Indicator 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.

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

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