Comprehensive® Vault Reconstruction System (VRS) Coding Reference Guide

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The Comprehensive Vault Reconstruction System is indicated for primary, fracture, or revision total shoulder replacement for the relief of pain and significant disability due to gross rotator cuff deficiency.

The Comprehensive Vault Reconstruction System glenoid baseplate components are intended for cementless application with the addition of screw fixation in patients with unusual anatomy and/or extensive bone loss, which precludes the use of a standard glenoid baseplate component.

Physician	
CPT® Code	**CPT Description**
Arthroplasty	
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))
Revision	
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component
Anatomic 3-D Model	
0559T	Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure
0560T	Anatomic model 3D-printed from image data set(s); each additional individually prepared and processed component of an anatomic structure (List separately in addition to code for primary procedure)

Hospital Inpatient: ICD-10-PCS Code and Description			
Replacement			
Ø Medical and Surgical **R** Upper Joints **R** Replacement			
Body Part	**Approach**	**Device**	**Qualifier**
J Shoulder, Right **K** Shoulder, Left	**Ø** Open	**J** Synthetic Substitute	**6** Humeral Surface **7** Glenoid Surface **Z** No Qualifier
Revision *(Correcting a malfunctioning or displaced device by taking out or putting in components of the device, but not the entire device/all components of the device, such as a screw or pin)*			
Ø Medical and Surgical **R** Upper Joints **W** Revision			
J Shoulder, Right **K** Shoulder, Left	**Ø** Open	**J** Synthetic Substitute	**6** Humeral Surface **7** Glenoid Surface **Z** No Qualifier
Removal *(For revisions involving the removal and insertion of all components of a device, code the root operation REMOVAL in addition to the root operation REPLACEMENT from the list above)*			
Ø Medical and Surgical **R** Upper Joints **P** Removal			
J Shoulder, Right **K** Shoulder, Left	**Ø** Open	**J** Synthetic Substitute	**6** Humeral Surface **7** Glenoid Surface **Z** No Qualifier

Hospital Inpatient: Medicare Severity-Diagnosis Related Group (MS-DRG)*	
MS-DRG	**Description**
483	Major Joint & Limb Reattachment Procedure of Upper Extremity with CC/MCC
515	Other Musculoskeletal System and Connective Tissue Procedures with MCC
516	Other Musculoskeletal System and Connective Tissue Procedures with CC
517	Other Musculoskeletal System and Connective Tissue Procedures 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 Surgery Center (ASC)				
CPT® Code	**Description**	**OPPS Status Indicator**	**APC Assignment**	**ASC Payment Indicator**
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	J1	5116	J8
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	C	--	NA

OPPS – Medicare Outpatient Prospective Payment System; **APC** - Ambulatory Payment Classification; **ASC** - Ambulatory Surgery Center.
Status Indicator: C - Inpatient Procedure; J1 - Hospital Part B services paid through a comprehensive APC
APC: 5116 – Level 6 Musculoskeletal Procedures
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)

C-codes report devices used in conjunction with outpatient procedures billed and paid for under Medicare's Outpatient Prospective Payment System (OPPS).

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 VRS system, it would be considered integral and should not be separately coded or billed.

Hospital Outpatient and Ambulatory Surgery Center (ASC)				
CPT® Code	**Description**	**OPPS Status Indicator**	**APC Assignment**	**ASC Payment Indicator**
73200	Computed tomography, upper extremity; without contrast material	Q3	5522	Z2
73201	Computed tomography, upper extremity; with contrast material(s)	Q3	5572	Z3
73202	Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections	Q3	5571	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
0559T	Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure	Q1	5733	NA
0560T	each additional individually prepared and processed component of an anatomic structure (List separately in addition to code for primary procedure)	N	--	NA

OPPS - Medicare's Outpatient Prospective Payment System; **APC** - Ambulatory Payment Classification; **ASC** - Ambulatory Surgery Center.
APC 5522 - Level 2 Imaging without contrast. 5571 - Level 1 Imaging with contrast; 5572 -Level 2 Imaging with contrast; 5733 - Level 3 minor procedures
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: NA - This procedure is not on Medicare's ASC Covered Procedures List (CPL); 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; Z3 - Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.

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.

Zimmer Biomet Coding Reference Guide Disclaimer

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For product information, including indications, contraindications, warnings, precautions, potential adverse effects and patient counseling information, see the package insert and www.zimmerbiomet.com.

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