

# 2017

## NuVasive® REIMBURSEMENT GUIDE

Assisting physicians and facilities in accurately billing for  
NuVasive implants and instrumentation systems.

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# 2017 Reimbursement Guide

## I. INTRODUCTION

This Reimbursement Guide has been prepared to assist physicians and facilities (“providers”) in accurately billing for NuVasive® implants and instrumentation systems. The NuVasive corporate headquarters houses a state-of-the-art education center and cadaver operating lab, designed to provide training and education to physicians on these technologies.

This information details our general understanding of the application of certain codes to NuVasive products. It is the provider’s responsibility to determine and submit appropriate codes, charges, and modifiers for the products and services rendered. Payors may have additional or different coding and reimbursement requirements. Therefore, before filing any claim, providers should verify these requirements in writing with local payors. For more information, visit **[www.nuvasive.com](http://www.nuvasive.com)**.

### Spine Reimbursement Support

**800-211-0713 or [reimbursement@nuvasive.com](mailto:reimbursement@nuvasive.com)**

Working with professional medical societies and legislators, NuVasive has taken an active role regarding reimbursement for spine products and procedures. To assist providers with coding and denial issues, NuVasive established Spine Reimbursement Support assistance, available at **800-211-0713** or **[reimbursement@nuvasive.com](mailto:reimbursement@nuvasive.com)**. Please use this resource for reimbursement questions regarding any of the NuVasive products and associated procedures.

## II. PHYSICIAN CODING AND PAYMENT

When physicians bill for services performed, payors require the physician to assign a Current Procedural Terminology (or CPT®) code to classify or identify the procedure performed. These CPT codes are created and maintained by the American Medical Association (AMA) and are reviewed and revised on an annual basis. The most commonly used CPT codes are referred to as Category I codes and are five-digit codes accompanied by narrative descriptions.

The AMA assigns a number of relative value units (or RVUs) to most CPT codes to represent the physician work, malpractice costs, and practice expenses associated with a given procedure or service. Medicare annually revises a dollar conversion factor that, when multiplied by the code's RVUs, results in the national Medicare reimbursement for that procedure. Most private payors also consider a code's RVUs when establishing physician fee schedules.

Industrial or work-related injury cases are usually paid according to state-established fee schedules or percentage of billed charges. A state-appointed agency or private third party payors handle administration of workers' compensation benefits and claims.

### 1. FUSION FACILITATING TECHNOLOGIES

The following CPT codes are generally used to report a decompression and/or arthrodesis procedures. The codes listed here are examples only, not an exhaustive listing. It is always the physician's responsibility to determine and submit appropriate codes, charges, and modifiers for the services that were rendered.

#### **CPT CODING FOR ARTHRODESIS USING THE NUVASIVE® MAXCESS® SYSTEM**

NASS provided coding guidance for physicians when performing a fusion through an anterolateral approach. During an XLIF® lateral approach procedure, the patient is typically positioned laterally in order to spread the abdominal muscles to approach the lumbar spine via a retroperitoneal exposure. The iliopsoas muscle is either split or mobilized to access the anterior spine from the lateral approach. The target of this approach is the vertebral body and anterior interspace. The physician is therefore performing an anterior fusion through an anterolateral approach. For this reason, NASS recommended the use of the anterior arthrodesis CPT code 22558, as well as the applicable instrumentation code(s) to describe the procedure.

When obtaining preauthorization for this procedure, please keep the following key points in mind:

- Medical necessity for the fusion must be established through relevant patient diagnosis codes.
- Preauthorization should be requested for all relevant procedure codes for the case (e.g., anterior arthrodesis, posterior arthrodesis, instrumentation, graft material, nerve monitoring, etc.).

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## Decompression Procedure Codes

CPT® CODE¹	MODIFIER (IF WARRANTED)	PROCEDURE DESCRIPTION
62380		Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
63001		Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; cervical
63003		Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; thoracic
63005		Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis
63015		Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; cervical
63016		Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; thoracic
63017		Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; lumbar
63020	-50	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
63030	-50	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
63035	-50	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (list separately in addition to code for primary procedure)
63040	-50	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; cervical
63042	-50	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; lumbar
63043	-50	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; each additional cervical interspace (list separately in addition to code for primary procedure)
63044	-50	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; each additional lumbar interspace (list separately in addition to code for primary procedure)
63045		Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [e.g., spinal or lateral recess stenosis]), single vertebral segment; cervical

QUESTIONS? CONTACT NUVASIVE® SPINE REIMBURSEMENT SUPPORT BY CALLING 800-211-0713 OR EMAILING [reimbursement@nuvasive.com](mailto:reimbursement@nuvasive.com). THE INFORMATION PROVIDED IS GENERAL CODING INFORMATION ONLY; IT IS NOT ADVICE ABOUT HOW TO CODE, COMPLETE, OR SUBMIT ANY PARTICULAR CLAIM FOR PAYMENT. IT IS ALWAYS THE PROVIDER'S RESPONSIBILITY TO DETERMINE AND SUBMIT APPROPRIATE CODES, CHARGES, MODIFIERS, AND BILLS FOR THE SERVICES THAT WERE RENDERED. PAYORS OR THEIR LOCAL BRANCHES MAY HAVE THEIR OWN CODING AND REIMBURSEMENT REQUIREMENTS. BEFORE RENDERING IOM SERVICES, PROVIDERS SHOULD OBTAIN PREAUTHORIZATION FROM THE PAYOR.

## Decompression Procedure Codes (cont.)

CPT® CODE <sup>1</sup>	MODIFIER (IF WARRANTED)	PROCEDURE DESCRIPTION
63046		Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; thoracic
63047		Laminectomy, facetectomy and foraminotomy, (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar
63048		Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (list separately in addition to code for primary procedure)
63055		Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; thoracic
63056		Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; lumbar (including transfacet or lateral extraforaminal approach) (e.g., far lateral herniated intervertebral disc)
63057		Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (list separately in addition to code for primary procedure)
63064		Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., herniated intervertebral disc), thoracic; single segment
63075		Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
63076		Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (list separately in addition to code for primary procedure)
63077		Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace
63078		Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, each additional interspace (list separately in addition to code for primary procedure)
63081		Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
63082		Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (list separately in addition to code for primary procedure)
63085		Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment

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## Decompression Procedure Codes (cont.)

CPT® CODE <sup>1</sup>	MODIFIER (IF WARRANTED)	PROCEDURE DESCRIPTION
63086		Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, each additional segment (list separately in addition to code for primary procedure)
63087		Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment
63088		Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; each additional segment (list separately in addition to code for primary procedure)
63090		Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment
63091		Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; each additional segment (list separately in addition to code for primary procedure)



## Spine Arthrodesis and Arthroplasty Procedure Codes

PROCEDURE	CPT® CODE¹	PROCEDURE DESCRIPTION
POSTERIOR FUSION	22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)
	22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment
	22610	Arthrodesis, posterior or posterolateral technique, single level; thoracic, with lateral transverse technique, <i>when performed</i>
	22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar, with lateral transverse technique, <i>when performed</i>
	22614	Each additional vertebral segment (list separately in addition to code for primary procedure)
	27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device
PLIF or TLIF	22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
	22632	Each additional interspace (list separately in addition to code for primary procedure)
ANTERIOR FUSION	22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy, and decompression of spinal cord and/or nerve root(s); cervical below C2
	22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (list separately in addition to code for separate procedure)
	22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
	22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic
	22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
	22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (list separately in addition to code for primary procedure)
	22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1



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## Spine Arthrodesis and Arthroplasty Procedure Codes (cont.)

PROCEDURE	CPT® CODE¹	PROCEDURE DESCRIPTION
COMBINED FUSION	22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique, including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression); single interspace and segment, lumbar (Do not report with 22612 or 22630 at the same level)
	22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique, including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression); each additional interspace and segment, lumbar (Do not report with 22612 or 22630 at the same level) (list separately in addition to code for primary procedure) (Use 22634 in conjunction with 22633)
CERVICAL DISC ARTHROPLASTY	22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyctomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical (Do not report 22856 in conjunction with 69990) (For additional interspace cervical total disc arthroplasty, use 0092T)
	22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyctomy for nerve root or spinal cord decompression and microdissection), second level, cervical (list separately in addition to code for primary procedure)
	22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical (Do not report 22861 in conjunction with 69990)
	22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical 22864 in conjunction with 22861, 69990) (For additional interspace removal of cervical total disc arthroplasty, use 0095T)

## Grafting and Lumbar Instrumentation Procedure Codes

PROCEDURE	CPT® CODE¹	PROCEDURE DESCRIPTION
ALLOGRAFT & AUTOGRAFT	20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (list separately in addition to code for primary procedure)
	20931	Allograft, structural, for spine surgery only (list separately in addition to code for primary procedure)
	20936	Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from same incision (list separately in addition to code for primary procedure)
	20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (list separately in addition to code for primary procedure)
	20938	Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (list separately in addition to code for primary procedure)
POSTERIOR INSTRUMENTATION	0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar
	22840	Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (list separately in addition to code for primary procedure)
	22841	Internal spinal fixation by wiring of spinous processes (list separately in addition to code for primary procedure)
	22842	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (list separately in addition to code for primary procedure)
	22843	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (list separately in addition to code for primary procedure)
	22844	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (list separately in addition to code for primary procedure)
ANTERIOR INSTRUMENTATION	22845	Anterior instrumentation; 2 to 3 vertebral segments (list separately in addition to code for primary procedure)
	22846	Anterior instrumentation; 4 to 7 vertebral segments (list separately in addition to code for primary procedure)
	22847	Anterior instrumentation; 8 or more vertebral segments (list separately in addition to code for primary procedure)

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## Grafting and Lumbar Instrumentation Procedure Codes (cont.)

PROCEDURE	CPT® CODE¹	PROCEDURE DESCRIPTION
BIOMECHANICAL DEVICES	22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (list separately in addition to code for primary procedure)
	22854	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (list separately in addition to code for primary procedure)
	22859	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (list separately in addition to code for primary procedure)

## Surgical Modifiers in Spine Surgery

The following are surgical modifiers that may be used by spine surgeons to describe specific surgical circumstances, as described by AMA CPT. For complete information on modifiers, refer to AMA CPT 2017 edition.

## Surgical Session or Same Day Modifiers

These modifiers are appended to indicate a specific circumstance that occurred during a surgical procedure or the same day as a surgical procedure.

### Modifier 22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, the service may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

### Modifier 50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code.

### Modifier 51 Multiple Procedures

When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure(s) or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes.

### Modifier 52 Reduced Services

Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or canceled as a result of extenuating circumstances, or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74. (See modifiers approved for ambulatory surgical center (ASC)/outpatient hospital use.)

### Modifier 53 Discontinued Procedure

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For ASC/outpatient hospital reporting of a previously scheduled procedure/service that is partially reduced or canceled as a result of extenuating circumstances, or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74. (See modifiers approved for ASC/outpatient hospital use.)

### Modifier 59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, (other than E/M services), that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Medicare and some private payors have adopted new guidelines and alternative coding requirement for the use of modifier 59. Please consult each payor for its specific guidelines.

### Modifier 76 Repeat Procedure or Service by Same Physician or Other Qualified Healthcare Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified healthcare professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

### Modifier 77 Repeat Procedure by Another Physician or Other Qualified Healthcare Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified healthcare professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

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## Global Period Modifiers

These modifiers are appended to a subsequent procedure performed during the global period of an original procedure.

### Modifier 58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (e.g., unanticipated clinical condition), see modifier 78.

### Modifier 78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Healthcare Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

### Modifier 79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

## Surgeon Role Modifiers

These modifiers are used when more than one surgeon participates in a surgical procedure.

### Modifier 62 Two Surgeons

When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure, as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once, using the same procedure code. If additional procedure(s), (including add-on procedure(s)), are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

### Modifier 80 Assistant Surgeon

Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

### Modifier 81 Minimum Assistant Surgeon

Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

### Modifier 82 Assistant Surgeon (when qualified resident surgeon not available)

The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82, appended to the usual procedure code number(s).



## 2. NVM5® INTRAOPERATIVE MONITORING SYSTEM

For coding and billing information regarding physician-driven intraoperative monitoring during spinal surgery, please see the *2016 NVM5 Intraoperative Monitoring (IOM) Reimbursement Guide* (16-NUVA-0240).

### Medicare Note:

In April 2004, CMS (Centers for Medicare & Medicaid Services) issued Correct Coding Initiative (CCI) edits for the nerve monitoring codes listed in the *2016 NVM5 Intraoperative Monitoring (IOM) Reimbursement Guide* (16-NUVA-0240). The edits indicate that nerve monitoring codes are to be bundled into ALIF, PLIF, and TLIF procedure codes in Section III when the primary spine physician is performing both services. Medicare does not reimburse the operative physician for physician-driven intraoperative monitoring when performing the arthrodesis procedure.

Additionally, general coding guidelines do not allow the operating surgeon, assistant surgeon, or co-surgeon to separately report intraoperative neuromonitoring.

### IOM Coding Updates

- The American Medical Association (AMA) deleted CPT® code 95920 and replaced it with CPT codes 95940 and 95941. CPT codes 95940 and 95941 represent the IOM component of the study/studies and are add-on codes. CPT code 95940 or 95941 must always be billed together with the primary nerve monitoring procedure code.  
CPT code 95940: continuous IOM in the O.R., one-on-one monitoring requiring personal attendance, each 15 minutes.  
CPT code 95941: continuous IOM from outside the O.R. (remote or nearby) or for monitoring of more than one case while in the O.R., per hour.
- Additionally for Medicare cases, CMS invalidated CPT code 95941 and replaced it with HCPCS code G0453, which allows the remote physician to monitor one case at a time.  
HCPCS code G0453: continuous IOM from outside the O.R. (remote or nearby), per patient (attention directed exclusively to one patient), each 15 minutes.

### Navigation Coding Updates

- Below are key points to consider when reporting CPT code 61783.
  - Includes spinal applications, which allows for navigation using a stereotactic technique to identify anatomy for precise treatments and for avoidance of vital structures.
  - The application of the procedure is to help identify anatomy, and more specifically, to aid with instrument placement. Primary fusion procedure codes where pedicle screws are inserted to facilitate fusion are appropriate if covered by the payor.
  - Not applicable for spinal decompression for degenerative spine disease or disc replacement (codes 63030, 63042, 63047). Exceptions could include tumor-related surgeries.
  - Possible primary codes include: 22600, 22610, and 22612.

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## NVM5® Computer-Assisted Surgery Applications

- NVM5 Guidance aids physicians in the placement of pedicle screws through pre-planned angle measurements and integrated EMG information.

NVM5 COMPUTER-ASSISTED SURGERY PRIMARY CODE				
CPT®	DESCRIPTION	2017 CONVERSION FACTOR	RVU	2017 NATIONAL MEDICARE PAYMENT
61783	Stereotactic computer-assisted (navigational) procedure; spinal (list separately in addition to code for primary procedure)	\$35.8887 See CY 2017 PFS Final Rule: Relative Value File	6.83	\$245.12

## III. HOSPITAL INPATIENT CODING AND PAYMENT

Payment under Medicare for inpatient hospital services is based on a classification system determined by patient diagnosis known as Medicare Severity – Diagnosis Related Groups (MS-DRGs). Under MS-DRGs, a hospital is paid at a predetermined, specific rate for each Medicare discharge. Fixed prices are established for hospital services, based on the patient diagnosis(es) and procedure(s) performed and are paid regardless of the actual cost the hospital incurs when providing the services.

MS-DRGs take into consideration length of stay, the number of services provided, and the intensity of services. The system was designed to give hospitals incentives to provide care more efficiently and appropriately document patient diagnoses and procedures performed.

Only one MS-DRG is assigned to a patient for a particular hospital admission, and determined by ICD-10-CM diagnoses and procedure codes.

### 1. NUVASIVE® TECHNOLOGY

#### ICD-10-CM Procedure Codes

On October 1, 2015 the United States transitioned from ICD-9 to ICD-10 as the medical code set for medical diagnoses and inpatient hospital procedures. A chart outlining possible ICD-9 procedure codes for spine procedures associated with NuVasive technology and the corresponding ICD-10 procedure codes is available upon request through the NuVasive Spine Reimbursement Support line. This list is not designed to be a comprehensive list of procedure codes; the use of these codes do not ensure coverage and payment for the associated spine procedures.



## MS-DRGs

The MS-DRGs most likely applicable for reporting a spine procedure utilizing NuVasive® technology are:

MS-DRG <sup>2</sup>	DESCRIPTION	FY2017 SPINAL MS-DRG AND MEDICARE UNADJUSTED PAYMENT
	<b>LAMINECTOMY/DISCECTOMY/DISC ARTHROPLASTY</b>	
518	Back and Neck Procedures Except Spinal Fusion with MCC or Disc Device/Neurostimulator	\$17,253.42
519	Back and Neck Procedures Except Spinal Fusion with CC	\$10,236.24
520	Back and Neck Procedures Except Spinal Fusion without CC and MCC	\$7,349.34
	<b>ANTERIOR/POSTERIOR FUSION</b>	
453	Combined Anterior/Posterior Spinal Fusion with MCC (360)	\$64,678.87
454	Combined Anterior/Posterior Spinal Fusion with CC	\$48,429.10
455	Combined Anterior/Posterior Spinal Fusion without CC and MCC	\$37,848.16
	<b>COMPLEX FUSION</b>	
456	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, or 9+ Fusions with MCC	\$59,132.28
457	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, or 9+ Fusions with CC	\$42,055.97
458	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, or 9+ Fusions without CC and MCC	\$31,838.21
	<b>LUMBAR FUSION</b>	
459	Spinal Fusion Except Cervical with MCC	\$39,079.62
460	Spinal Fusion Except Cervical without MCC	\$23,790.55
	<b>CERVICAL FUSION</b>	
471	Cervical Spinal Fusion with MCC	\$28,717.54
472	Cervical Spinal Fusion with CC	\$17,168.15
473	Cervical Spinal Fusion without CC and MCC	\$13,711.14

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## 2. NON-MEDICARE REIMBURSEMENT

Many commercial payors reimburse hospitals using Medicare DRGs and associated payment rates as benchmarks for contracted rates while others reimburse on a per diem basis. Disposables, implants, or instrumentation associated with NuVasive® products generally are coded under Revenue Code 270: Medical/Surgical Supplies, 272: Sterile Medical/Surgical Supplies, or 278: Medical/Surgical Supplies and Devices, Other Implants. Payment will be according to the terms of the payor contract. For HCPCS codes (including C-codes) that may be relevant to NuVasive technology, see Section 4 on page 20.

## IV. OUTPATIENT FACILITY CODING AND PAYMENT

### 1. HOSPITAL OUTPATIENT

A procedure is considered to be performed in a hospital outpatient department when the procedure is performed in a facility that is administratively and financially linked to a hospital and the patient is registered at the hospital, but not admitted as an inpatient.

The Outpatient Prospective Payment System (OPPS) groups procedures into Ambulatory Payment Classifications (APCs).

Each APC encompasses services that are clinically similar and require similar resources.

APCs group together services, supplies, drugs, and devices that are used in particular procedures.

Each APC has a separate payment rate that is meant to account for all of the items used in the procedure.

Each APC is assigned a relative payment weight, based on the median costs of the services within the APC.

A hospital may receive multiple APC payments for a single visit if multiple services are delivered in that visit.

Transitional pass-through payments have been established for certain approved “new or innovative medical devices” and allow for additional payment outside the APC.

Many private payors use the APC payment rates established by Medicare to determine contracted rates with hospitals.

## Decompression and Arthrodesis Codes

Under the Medicare HOPPS, the following decompression CPT® codes map to the corresponding APC. For 2014, Medicare bundled procedure payment for add-on codes into payment for the primary procedure. In 2016, Medicare expanded creation of comprehensive APCs (C-APCs) and reassigned decompression and fusion procedure codes to these newly created C-APCs. For 2017, Medicare made additional C-APC changes impacting the following codes:

CPT CODE <sup>1</sup>	APC <sup>3</sup>	APC DESCRIPTION	2017 NATIONAL MEDICARE AVERAGE REIMBURSEMENT <sup>2</sup>
62380	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63001	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63003	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63005	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63015	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63017	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63020	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63030	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63035	N/A	N/A	
63040	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63042	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63045	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63046	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63047	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63048	N/A	N/A	
63055	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63056	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63057	N/A	N/A	
63064	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63066	N/A	N/A	
63075	5114	Level 4 Musculoskeletal Procedures	\$5,219.36
63076	N/A	N/A	
22551	5115	Level 5 Musculoskeletal Procedures	\$9,557.20
22554	5115	Level 5 Musculoskeletal Procedures	\$9,557.20
22612	5115	Level 5 Musculoskeletal Procedures	\$9,557.20
22614	N/A	N/A	
22853	N/A	N/A	
22854	5115	Level 5 Musculoskeletal Procedures	\$9,557.20
22859	5115	Level 5 Musculoskeletal Procedures	\$9,557.20

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## Decompression and Arthrodesis Codes (cont.)

Medicare has removed the following CPT® code from the inpatient only procedure list:

CPT Code 22585 (Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (list separately in addition to code for primary procedure)

CPT Code 22840 (Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (list separately in addition to code for primary procedure);

CPT Code 22842 (Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (list separately in addition to code for primary procedure);

CPT Code 22845 (Anterior instrumentation; 2 to 3 vertebral segments (list separately in addition to code for primary procedure);

CPT Code 22858 (Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (list separately in addition to code for primary procedure)

Payment for these added codes is considered packaged into the primary procedure payment.

## 2. NON-MEDICARE REIMBURSEMENT

Commercial and work-related injury payors may reimburse fusion procedures on an outpatient basis. Facilities may choose to preauthorize (relative to benefits) prior to the procedure. Payors may allow additional payment for disposables, fixation, or instrumentation associated with procedures billed under Revenue Code 270: Medical/Surgical Supplies, 272: Sterile Medical/Surgical Supplies, or 278: Medical/Surgical Supplies and Devices, Other Implants. Payment will be according to the terms of the contract or as line item supplies at cost plus markup.

## 3. AMBULATORY SURGICAL CENTER

To be eligible to receive facility fees, a center must be certified and/or accredited as an Ambulatory Surgical Center (ASC).

ASCs may use the following codes for billing any disposables, instrumentation, or fixation associated with NuVasive® technologies: Revenue Code 270: Medical/Surgical Supplies, 272: Sterile Medical/Surgical Supplies, or 278: Medical/Surgical Supplies and Devices, Other Implants. Payment will be according to the terms of the contract such as line item supplies at cost plus markup.

## FUSION CODES

PROCEDURE CODE	DESCRIPTION	2017 ASC CMS PAYMENT RATES
22551	Neck spine fusion & removal below c2	\$7,008.82
22554	Neck spine fusion	\$6,940.69
22612	Lumbar spine fusion	\$4,981.42

## DECOMPRESSION CODES

PROCEDURE CODE	DESCRIPTION	2017 ASC CMS PAYMENT RATES
62380	Endoscopic decompression 1 interspace lumbar	\$3,574.44
63001	Remove spine lamina 1/2 crvl	\$2,651.09
63003	Remove spine lamina 1/2 thr	\$2,651.09
63005	Remove spine lamina 1/2 lmb	\$2,651.09
63020	Neck spine disk surgery	\$2,651.09
63030	Low back disk surgery	\$2,651.09
63042	Laminotomy single lumbar	\$2,651.09
63045	Remove spine lamina 1 crvl	\$2,651.09
63046	Remove spine lamina 1 thr	\$2,651.09
63047	Remove spine lamina 1 lmb	\$2,651.09
63055	Decompress spinal cord thr	\$2,651.09
63056	Decompress spinal cord lumbar	\$2,651.09

For 2017, Medicare added the following spine codes to the list of ASC Covered Surgical Procedures:

**20936** Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from the same incision (list separately in addition to code for primary procedure)

**20937** Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (list separately in addition to code for primary procedure)

**20938** Autograft for spine surgery only (includes harvesting the graft); structural, biocortical or tricortical (through separate skin fascial incision)

**22552** Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical C2, each additional interspace (list separately in addition to code for separate procedure)

**22585** (Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy, and decompression of spinal cord and/or nerve roots; each additional interspace (list separately in addition to code for primary procedure)

**22840** Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)

**22842** Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)

**22845** Anterior instrumentation; 2 to 3 vertebral segments

**22853** Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (list separately in addition to code for primary procedure)

**22854** Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (list separately in addition to code for primary procedure)

**22859** Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (list separately in addition to code for primary procedure)

Payment for these added codes is considered packaged into the primary procedure payment.

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## 4. FACILITY DEVICE AND IMPLANT CODES

C-codes report drugs, biologicals, and devices eligible for transitional pass-through payments and for items classified in new technology Ambulatory Payment Classifications (APCs) under the Outpatient Prospective Payment System (OPPS).

The following information highlights certain product codes that may or may not be relevant to surgical cases performed using NuVasive® products:

### MASTER HCPCS SUPPLY LISTING<sup>4</sup>

Surgical tray	A4550
Electrodes, per pair	A4556
Lead wires, per pair	A4557
Surgical supply, miscellaneous	A4649
Noncovered item or service	A9270
Anchor/Screw for opposing bone-to-bone or soft tissue-to-bone (implantable)	C1713
Connective tissue, non-human (includes synthetic)	C1763
Connective tissue, human	C1762
Prosthetic implant, not otherwise specified	L8699

### REVENUE CODES<sup>5</sup>

Medical/Surgical supplies	0270
Medical/Surgical supplies: Nonsterile supplies	0271
Medical/Surgical supplies: Sterile supplies	0272
Medical/Surgical supplies: Other implants	0278

<sup>1</sup> Current Procedural Terminology 2016, American Medical Association. Chicago, IL. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®) is copyright American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

<sup>2</sup> CMS FY2017 IPPS Final Rule; rates are not geographically adjusted.

<sup>3</sup> CMS CY2017 OPPS Final Rule.

<sup>4</sup> HCPCS codes are used for outpatient claims only and may or may not be reimbursed separately from the procedure payment.

<sup>5</sup> Revenue codes are used on inpatient and outpatient claims for cost reporting. MS-DRG payments include the cost of all equipment and supplies associated with spine procedures.



## V. CODING AND PAYMENT SCENARIOS

The following scenarios provide examples of possible coding options when using NuVasive® technology. While each manufacturer has their own trademark or marketing names for various technology, it is important to use the appropriate clinical terminology when reporting procedures.

### 1. Cervical Anterior Scenarios

a) ACDF, C5-C6, with NuVasive Helix ACP™ or Archon® ACP System, Triad® CR, and Osteocel® Cellular Allograft – anterior cervical decompression and fusion with anterior plate instrumentation, structural allograft, morselized allograft.

CPT® CODE¹	DESCRIPTION	POSSIBLE MS-DRG
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2	471, 472, or 473
22845	Anterior instrumentation; 2 to 3 vertebral segments (list separately in addition to code for primary procedure)	N/A
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (list separately in addition to code for primary procedure)	N/A
20931	Allograft, structural, for spine surgery only (list separately in addition to code for primary procedure)	N/A

b) ACDF, C5-C6, with Helix ACP or Archon ACP System, CoRoent® Small, and Osteocel Cellular Allograft – anterior cervical decompression and fusion with anterior plate instrumentation, synthetic intervertebral device, morselized allograft.

CPT CODE	DESCRIPTION	POSSIBLE MS-DRG
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2	471, 472, or 473
22845	Anterior instrumentation; 2 to 3 vertebral segments (list separately in addition to code for primary procedure)	N/A
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges) when performed to intervertebral disc space in conjunction with interbody arthrodesis, each interspace	N/A
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (list separately in addition to code for primary procedure)	N/A
20931	Allograft, structural, for spine surgery only (list separately in addition to code for primary procedure)	N/A



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## 1. CERVICAL ANTERIOR SCENARIOS (CONT.)

c) ACDF, C5-C6, with NuVasive® Helix ACP™ or Archon® ACP System, CoRoent® Small, and morselized autograft – anterior cervical decompression and fusion with anterior plate instrumentation, synthetic intervertebral device, morselized autograft from the iliac crest through a separate incision.

CPT® CODE¹	DESCRIPTION	POSSIBLE MS-DRG
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2	471, 472, or 473
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges) when performed to intervertebral disc space in conjunction with interbody arthrodesis, each interspace	N/A
22845	Anterior instrumentation; 2 to 3 vertebral segments (list separately in addition to code for primary procedure)	N/A
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (list separately in addition to code for primary procedure)	N/A

d) ACDF, C5-C6, with CoRoent Small Interlock™, and Osteocel® Cellular Allograft – anterior cervical decompression and fusion with synthetic intervertebral device and morselized allograft.

CPT CODE	DESCRIPTION	POSSIBLE MS-DRG
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2	471, 472, or 473
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges) when performed to intervertebral disc space in conjunction with interbody arthrodesis, each interspace	N/A
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (list separately in addition to code for primary procedure)	N/A

e) Cervical Disc Arthroplasty (CDA) with PCM® Cervical Disc

CPT CODE	DESCRIPTION	POSSIBLE MS-DRG
22856	Total disc arthroplasty (artificial disc) anterior approach, including discectomy to prepare interspace (other than for decompression) single interspace: cervical	518

## 2. CERVICAL POSTERIOR SCENARIOS

a) Posterior fusion with VuePoint® OCT and Osteocel Cellular Allograft – Posterior cervical arthrodesis, C5-C6, using posterior non-segmental fixation and bone graft substitute.

CPT CODE	DESCRIPTION	POSSIBLE MS-DRG
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment	471, 472, or 473
22840	Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (list separately in addition to code for primary procedure)	N/A
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (list separately in addition to code for primary procedure)	N/A

QUESTIONS? CONTACT NUVASIVE SPINE REIMBURSEMENT SUPPORT BY CALLING 800-211-0713 OR EMAILING [reimbursement@nuvasive.com](mailto:reimbursement@nuvasive.com). THE INFORMATION PROVIDED IS GENERAL CODING INFORMATION ONLY; IT IS NOT ADVICE ABOUT HOW TO CODE, COMPLETE, OR SUBMIT ANY PARTICULAR CLAIM FOR PAYMENT. IT IS ALWAYS THE PROVIDER'S RESPONSIBILITY TO DETERMINE AND SUBMIT APPROPRIATE CODES, CHARGES, MODIFIERS, AND BILLS FOR THE SERVICES THAT WERE RENDERED. PAYORS OR THEIR LOCAL BRANCHES MAY HAVE THEIR OWN CODING AND REIMBURSEMENT REQUIREMENTS. BEFORE RENDERING IOM SERVICES, PROVIDERS SHOULD OBTAIN PREAUTHORIZATION FROM THE PAYOR.

- b) Cervical laminectomy and decompression, C5-C6, with Leverage® LFS fixation – Posterior cervical laminectomy, decompression, and fixation using posterior non-segmental instrumentation and bone marrow aspirated from the iliac crest through a separate fascial incision.

CPT® CODE¹	DESCRIPTION	POSSIBLE MS-DRG
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; cervical	518, 519, or 520
22840	Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (list separately in addition to code for primary procedure)	N/A
38220-59	Bone marrow, aspiration only	N/A

### 3. THORACOLUMBAR ANTERIOR SCENARIOS

- a) Thoracic interbody fusion, T11-T12, through an anterolateral incision with grafting material – Anterior thoracic interbody arthrodesis with placement of a synthetic intervertebral device and an autograft from the same incision.

CPT CODE	DESCRIPTION	POSSIBLE MS-DRG
22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	456, 457, 458, 459, or 460
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges) when performed to intervertebral disc space in conjunction with interbody arthrodesis, each interspace	N/A
20936	Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from same incision (list separately in addition to code for primary procedure)	N/A

- b) Lumbar fusion, L4-L5, through an anterior or anterolateral incision with CoRoent® XL, Triad®, and autograft – Anterior lumbar interbody fusion with placement of a synthetic intervertebral device and autograft obtained from the iliac crest through a separate incision.

CPT CODE	DESCRIPTION	POSSIBLE MS-DRG
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	456, 457, 458, 459, or 460
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges) when performed to intervertebral disc space in conjunction with interbody arthrodesis, each interspace	N/A
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (list separately in addition to code for primary procedure)	N/A

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## 3. THORACOLUMBAR ANTERIOR SCENARIOS (CONT.)

- c) Lumbar fusion, L4-L5, through an anterior or anterolateral incision with CoRoent® XL, Triad®, and XLIF Decade™ Plate, or CoRoent XLR, Triad, and Brigade® ALIF plate – Anterior lumbar interbody arthrodesis with placement of a synthetic intervertebral device, autograft obtained from the iliac crest through a separate incision, and an anterior plate.

CPT® CODE¹	DESCRIPTION	POSSIBLE MS-DRG
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	456, 457, 458, 459, or 460
22845	Anterior instrumentation; 2 to 3 vertebral segments (list separately in addition to code for primary procedure)	N/A
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges) when performed to intervertebral disc space in conjunction with interbody arthrodesis, each interspace	N/A
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (list separately in addition to code for primary procedure)	N/A

- d) Complete corpectomy, L2, and fusion through an anterior or anterolateral incision with X-CORE® 2 and autograft (local) with Traverse® anterior plate – Corpectomy, anterior lumbar interbody fusion, L1-L2, L2-L3, placement of synthetic intervertebral devices, corpectomy defect, L1-L3, autograft from the same incision, and anterior plate.

CPT CODE	DESCRIPTION	POSSIBLE MS-DRG
63090	Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment	518, 519, or 520
22558-51	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	456, 457, 458, 459, or 460
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace	N/A
22845	Anterior instrumentation; 2 to 3 vertebral segments (list separately in addition to code for primary procedure)	N/A
22854	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (list separately in addition to code for primary procedure)	N/A
20936	Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from same incision (list separately in addition to code for primary procedure)	N/A

e) Costovertebral approach thoracic discectomy with X-CORE® Mini, autograft, and Osteocel® Cellular Allograft – Costovertebral thoracic discectomy, autograft, and morselized allograft.

CPT® CODE¹	DESCRIPTION	POSSIBLE MS-DRG
63064	Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., herniated intervertebral disc), thoracic; single segment	518, 519, or 520
20936	Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from same incision (list separately in addition to code for primary procedure)	N/A
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (list separately in addition to code for primary procedure)	N/A

f) Anterior fusion, L4-L5 through an anterior approach Brigade®-H and autograft, and PLF with Precept® or SpheRx® DBR® III and Osteocel Cellular Allograft, with Anterior Longitudinal Ligament Release and Osteotomy (Osteotomy only with the determination of a rigid/ankylosed spine). Anterior lumbar interbody arthrodesis with placement of a synthetic intervertebral device and autograft from the iliac crest through a separate incision and posterolateral lumbar arthrodesis, L4-L5, with non-segmental instrumentation and morselized allograft.

CPT CODE¹	DESCRIPTION	POSSIBLE MS-DRG
22558-51	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	456, 457, 458, 459, or 460
22224-51	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar	N/A
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges) when performed to intervertebral disc space in conjunction with interbody arthrodesis, each interspace	N/A
20936	Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from same incision (list separately in addition to code for primary procedure)	N/A

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## 3. THORACOLUMBAR ANTERIOR SCENARIOS (CONT.)

g) Anterolateral fusion, L4-L5 through an anterior or anterolateral approach with CoRoent® XL-H, or Brigade®-H and autograft, and PLF with Precept® or SpheRx® DBR® III and Osteocel® Cellular Allograft, with Anterior Longitudinal Ligament Release and Osteotomy (Osteotomy only with the determination of a rigid/ankylosed spine). Anterior lumbar interbody arthrodesis with placement of a synthetic intervertebral device and autograft from the iliac crest through a separate incision and posterolateral lumbar arthrodesis, L4-L5, with non-segmental instrumentation and morselized allograft with osteotomy.

CPT® CODE¹	DESCRIPTION	POSSIBLE MS-DRG
22224	Lumbar	N/A
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	453, 454, or 455
22612-51	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	N/A
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges) when performed to intervertebral disc space in conjunction with interbody arthrodesis, each interspace	N/A
22840	Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (list separately in addition to code for primary procedure)	N/A
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (list separately in addition to code for primary procedure)	N/A
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (list separately in addition to code for primary procedure)	N/A

## 4. LUMBAR COMBINED ANTERIOR-POSTERIOR SCENARIOS

Anterolateral fusion, L4-L5, through an anterior or anterolateral approach with CoRoent XL or XLR and autograft, and PLF with Precept, Reline®, or SpheRx DBR III, Triad®, and Osteocel Cellular Allograft – Anterior lumbar interbody arthrodesis with placement of a synthetic intervertebral device and autograft from the iliac crest through a separate incision and posterolateral lumbar arthrodesis, L4-L5, with non-segmental instrumentation and morselized allograft.

CPT® CODE <sup>1</sup>	DESCRIPTION	POSSIBLE MS-DRG
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	453, 454, or 455
22612-51	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	N/A
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges) when performed to intervertebral disc space in conjunction with interbody arthrodesis, each interspace	N/A
22840	Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (list separately in addition to code for primary procedure)	N/A
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (list separately in addition to code for primary procedure)	N/A
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (list separately in addition to code for primary procedure)	N/A
20931	Allograft, structural, for spine surgery only	N/A

## 5. LUMBAR POSTERIOR-POSTEROLATERAL SCENARIOS

PLIF/TLIF, L4-L5, with CoRoent®, Precept®, Reline®, SpheRx®, or Armada®, and FormaGraft® collagen bone graft matrix – Combined posterior lumbar interbody arthrodesis and posterolateral lumbar arthrodesis with placement of a synthetic intervertebral device, non-segmental instrumentation, bone marrow aspirated from the iliac crest through a separate incision, and morselized allograft.

CPT CODE	DESCRIPTION	POSSIBLE MS-DRG
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar (do not report with 22612 or 22630 at the same level)	456, 457, 458, 459, or 460
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges) when performed to intervertebral disc space in conjunction with interbody arthrodesis, each interspace	N/A
22840	Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (list separately in addition to code for primary procedure)	N/A
38220-59	Bone marrow, aspiration only	N/A
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (list separately in addition to code for primary procedure)	N/A

<sup>1</sup> Current Procedural Terminology 2016, American Medical Association. Chicago, IL. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®) is copyright American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.



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## VI. TECHNOLOGY OVERVIEW

### 1. CERVICAL

#### A. Anterior/Interbody Procedures

- i. The *Archon® Anterior Cervical Plate system* is designed to stabilize the anterior column of the cervical spine after an ACDF (anterior cervical discectomy and fusion).
- ii. The *NuVasive® Helix ACP™ (Anterior Cervical Plate) family of systems* (NuVasive Helix ACP, NuVasive Helix Mini ACP, NuVasive Helix-T ACP, and NuVasive Helix-Revolution ACP) are designed to stabilize the anterior column of the cervical spine after an ACDF.
- iii. The *CoRoent® Small Interlock™ system* is a standalone anterior cervical interbody fusion system indicated for use in a single level from C2-T1.
- iv. The *CoRoent Small family of implant systems* is designed to be placed in the interbody space in the cervical spine to help restore interbody height and stabilize the anterior column of the spine, and is indicated for use in a single level from C2-T1. (**Note:** Requires supplemental fixation.)
- v. The *PCM® Cervical Disc* is designed to replace the degenerated cervical disc at a single level from C3-C7, providing support for the vertebrae while allowing for movement of the joint.

#### B. Posterior Procedures

- i. The *VuePoint® OCT Fixation system* is designed to stabilize the posterior column of the cervical spine (via sub-laminar hooks) and upper thoracic spine (via pedicle screws or sub-laminar hooks).
- ii. The *Leverage® LFS system* (allograft and plate) is designed to stabilize the posterior column of the cervical and upper thoracic spine via laminoplasty allograft and plates.

### 2. THORACOLUMBAR

#### A. Anterior/Lateral Procedures

- i. The *XLIF Decade™ Plate system* is designed to stabilize the anterior column of the spine during a fusion via an anterolateral approach.
- ii. The *StruXure™ Lateral Deformity Fixation system* is designed for multi-level segmental stabilization of the anterior column of the spine via an anterolateral approach.
- iii. The *BASE™ Interfixated Titanium system*, *Brigade® ALIF plate system*, and *Brigade Hyperlordotic ALIF system* are designed to stabilize the anterior column of the spine from an anterior approach.
- iv. The *CoRoent XL/XLR Interbody Implant systems* are designed to be placed in the interbody space in the lumbar spine, along with supplemental fixation, to help restore interbody height and stabilize the anterior column of the spine. It is indicated for one or two contiguous levels from L2-S1. The CoRoent Thoracolumbar Implants are indicated for interbody fusions at one or two contiguous levels in the thoracic and lumbar spine from T1-T2 to L5-S1. The devices are cleared for use with autogenous bone graft and supplemental spinal fixation.
- v. The *Brigade Standalone ALIF* is an interfixated thoracolumbar interbody fusion system.
- vi. The *X-CORE® 2 Expandable VBR system* is designed for restoring interbody height, restoring alignment, and stabilizing the spine.
- vii. The *Traverse® Anterior Plating system* is designed to stabilize the anterior column of the spine during corpectomy procedures.

#### B. Posterior Procedures



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- i. The *Reline*®, *SpheRx*®, and *Armada*® systems are universal instrumentation sets consisting of pedicle screws, hooks, rods, and various other connectors.
- ii. The *CoRoent*® Large family (Narrow, Wide, Tapered, Contoured, Impacted, Large Oblique, MP, TLIF Anterior and Oblique) of interbody products is designed for interbody stabilization during posterior interbody approaches, such as PLIF and TLIF. (**Note:** Requires supplemental fixation.) It is indicated for one or two contiguous levels from L2-S1.
- iii. The *Affix*® II Spinous Process Plating system is used as posterior instrumentation to achieve posterior stabilization and fusion following either a posterior decompression (e.g., laminectomy) or interbody fusion (ALIF, PLIF, and TLIF).
- iv. The *Reline MAS*® system is a universal instrumentation set consisting of pedicle screws, rods, and various other connectors.
- v. NuVasive® Power is a comprehensive surgical power platform designed to work with quarter square systems for tapping and screw delivery.
- vi. The *Magec*® system is a noninvasive solution for growth modulation in pediatric deformity, featuring proprietary magnetic technology, allowing surgeons to externally adjust a growing rod construct in a clinical setting.

## C. Instruments

- i. The *MaXcess*® systems are universally applicable, full-featured, retractor systems which can be used to access the cervical, thoracic, and lumbar spine during a variety of spine procedures. The MaXcess systems give the physician direct, open visualization, including illumination, for the surgery while minimizing disruption to the patient's anatomy.

## 3. BIOLOGICS

- A. *Osteocel*® Cellular Allograft is an allograft cellular bone matrix. Osteocel Plus and Osteocel Pro are product categories that utilize Osteocel technology.
- B. *FormaGraft*® Collagen Bone Graft Matrix is a collagen- and mineral-based bone graft substitute for use in filling bony voids.
- C. The *Triad*® Allograft system is comprised of machined, saline-packaged allograft, designed to be implanted in the intervertebral space in cervical or lumbar spinal fusion procedures.
- D. The *ExtenSure*® H2™ Allograft system is implanted via a posterior approach during posterior decompression and fusion procedures.
- E. *Propel*™ DBM Putty is a demineralized bone matrix for use as a bone graft extender as filler for gaps and voids that are not intrinsic to the stability of the bony structure.

## 4. NVM5® INTRAOPERATIVE MONITORING SYSTEM

- A. The NVM5 system is a versatile tool, incorporating proprietary methods of providing intraoperative monitoring and innovative computer-assisted surgical technologies such as Bendini® and NuvaMap™ O.R.

When used for intraoperative monitoring, NVM5 combines intraoperative electrically stimulated EMG and spontaneous EMG activity to assess possible nerve root irritation or injury during spine surgery. Patented software algorithms\* help provide the physician with real-time data to help assess a patient's neurophysiologic status. Spinal cord integrity is assessed using MEPs or SSEPs, whereby a controlled stimulation elicits a response that is transmitted through the spinal cord and measured at recording sites. Electrodes record activity during the procedure, providing information about the health and function of the spinal cord and/or specific spinal nerves.

\*U.S. Patent No. 7,522,953

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## ADDENDUM A

### HEALTHCARE ACRONYMS

#### A

<b>AARP</b>	American Association of Retired Persons
<b>AHA</b>	American Hospital Association
<b>AHIP</b>	America's Health Insurance Plans
<b>AHRQ</b>	Agency for Healthcare Research and Quality
<b>ALOS</b>	Average Length of Stay
<b>AMA</b>	American Medical Association
<b>APC</b>	Ambulatory Payment Classification
<b>ASC</b>	Ambulatory Surgery Center

#### B

<b>BCBS</b>	BlueCross BlueShield
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#### C

<b>CC</b>	Complications and Comorbidities
<b>CMS</b>	Centers for Medicare & Medicaid Services (formerly known as HCFA)
<b>CMS-1500</b>	Universal claim form for physician services (formerly known as HCFA-1500)
<b>COB</b>	Coordination of Benefits
<b>COBRA</b>	Consolidated Omnibus Budget Reconciliation Act
<b>CPT®</b>	Current Procedural Terminology

#### D

<b>DME</b>	Durable Medical Equipment
<b>DOS</b>	Date of Service
<b>DRG</b>	Diagnosis Related Group (now MS-DRG)

#### E

<b>EDI</b>	Electronic Data Interchange
<b>EOB</b>	Explanation of Benefits
<b>ERISA</b>	Employee Retirement Income Security Act

#### F

<b>FDA</b>	Food and Drug Administration
<b>FEHBP</b>	Federal Employees Health Benefits Program
<b>FFS</b>	Fee-for-Service

#### H

<b>HCPCS</b>	Healthcare Common Procedure Coding System
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#### HHS

<b>HMO</b>	Department of Health & Human Services Health Maintenance Organization
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#### I

<b>ICD</b>	International Classification of Diseases
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#### M

<b>MAC</b>	Medicare Administrative Contractor
<b>MCC</b>	Major Complications and Comorbidities
<b>MCO</b>	Managed Care Organization
<b>MFS</b>	Medicare Fee Schedule
<b>MS-DRG</b>	Medicare Severity – Diagnosis Related Group

#### N

<b>Non-PAR</b>	Non-Participating Physician
<b>NOS</b>	Not Otherwise Specified

#### O

<b>OPPS</b>	Outpatient Prospective Payment System
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#### P

<b>PAR</b>	Participating Physician
<b>PCP</b>	Primary Care Physician
<b>PHO</b>	Physician Hospital Organization
<b>POS</b>	Point-of-Service
<b>PPO</b>	Preferred Provider Organization
<b>PPS</b>	Prospective Payment System
<b>PRO</b>	Peer Review Organization

#### R

<b>RBRVS</b>	Resource-Based Relative Value Scale
<b>RVU</b>	Relative Value Unit

#### T

<b>TPA</b>	Third-Party Administrator
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#### U

<b>UB-92</b>	Uniform Billing 1992
<b>UCR</b>	Usual, Customary, and Reasonable
<b>UPIN</b>	Unique Physician Identification Number
<b>UR</b>	Utilization Review
<b>URO</b>	Utilization Review Organization

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## ADDENDUM B

### GLOSSARY OF REIMBURSEMENT TERMS

#### A

**Allowed Charges:** Charges for services furnished by a healthcare provider, which qualify as covered expenses, paid in whole or in part by an insurer. Charges are subject to deductibles and/or coinsurance.

**Ambulatory Payment Classification (APC):** The basic unit of payment in the Medicare Prospective Payment System for outpatient visits or procedures (similar to DRGs).

**Ambulatory Surgery Center (ASC):** An organization that provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient, acute care hospital bed. May be a component of a hospital or a freestanding, privately owned center.

**Ancillary Services:** Services other than hospital room and board, nursing and physician services.

**Appeal:** A process whereby the provider and/or beneficiary (or representative) exercises the right to request a review of a contractor determination to deny commercial insurance, Medicare coverage, or payment for a service in full or in part.

**Assignment:** A decision by a healthcare provider made in advance of submitting a claim to an insurer to accept the allowed charge and subsequent payment as payment in full.

**Automated Claim Review:** Claim review and determination made using system logic (edits). Automated claim reviews never require human intervention to make a claim determination.

#### B

**Balance Billing:** Billing the beneficiary for any fee in excess of that allowed by the insurance carrier. Providers should check with the patient's insurance carrier for any limitations on balance billing.

**Beneficiary:** A person eligible to receive benefits under a healthcare plan.

**Benefit:** The amount payable by the third-party payor to a claimant, assignee, or beneficiary.

**Bundling:** The use of a single payment for a group of related services or surgeries and principal procedures when performed together.

#### C

**Capitation:** A reimbursement system whereby a monthly payment is made to providers, based on membership rather than services provided. The payment covers contracted services and is paid in advance of care provided. Capitation is expressed as a "per member per month" amount. Under most capitation-based contracts, providers do not receive additional payment even if the costs of care exceed the fixed rate of payment.

**Carrier:** A commercial insurance company that writes and administers health insurance policies and pays claims.

**Centers for Medicare & Medicaid Services (CMS):** The U.S. Government agency with responsibility for the administration of the Medicare and Medicaid programs (previously known as HCFA). [www.cms.hhs.gov](http://www.cms.hhs.gov).

**CHAMPUS (TRICARE):** The former Civilian Health and Medical Program of the Uniformed Services, now known as TRICARE. A federally funded comprehensive health benefits program administered by the Department of Defense and designed to provide healthcare benefits to eligible veterans and their dependents.

**Claim:** A demand to an insurer, by the insured person or provider acting on behalf of the insured, for payment of benefits under a policy.

**CMS-1500 (HCFA-1500):** A universal insurance claim form mandated for Medicare billing and generally accepted by all insurance carriers for outpatient-based healthcare providers. Physicians and medical suppliers use the CMS-1500 claim form (previously known as the HCFA-1500).

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**Coinsurance:** Beneficiary is responsible for a percentage of the overall cost of care after the care has been provided; e.g., Medicare beneficiaries are responsible for a 20% coinsurance amount on all outpatient Part B services.

**Complications and Comorbidities (CC):** There are three levels of severity in MS-DRGs, based upon assignment of secondary diagnosis codes. CCs reflect the second highest severity assignment and are included on the list if they could demonstrate that their presence leads to substantially increased hospital resource use.

**Consolidated Omnibus Budget Reconciliation Act (COBRA):** A federal law that allows and requires past employees to be covered under company health insurance plans for a set premium. This program gives individuals the opportunity to retain insurance when their current plan or position has been terminated.

**Coordination of Benefits (COB):** A provision in an insurance plan wherein a person covered under more than one group plan has benefits coordinated such that all payments are limited to 100% of the actual charge or allowance. Most plans also specify rules whereby one insurer is considered primary and the other is considered secondary.

**Copayment:** Like coinsurance, copayment is a cost-sharing arrangement for the beneficiary, although typically paid at the time that a service is provided; e.g., a \$10 copayment for an office visit or an outpatient drug prescription.

**CPT® (Current Procedural Terminology):** The coding system for physicians' services, developed by the American Medical Association and the basis of the HCPCS coding system for physicians' services. Each procedure or service rendered by a physician is identified with a five-digit code. CPT codes are revised annually by the American Medical Association. [www.ama-assn.org](http://www.ama-assn.org)

**Customary Charge:** The provider's standard charge for a given service.

## D

**Date of Service (DOS):** The specific date a service was provided to an individual under a particular health plan.

**Deductible:** A stipulated amount that the insured is required to pay toward the cost of medical treatment before the benefits of the insurance policy or program take effect.

**Denial:** The refusal of an insurer to cover an item or service under a healthcare plan or program.

**Dependents:** The spouse and/or children of the insured, as defined in the insurance contract.

**Diagnosis Related Group (DRG):** A system of classifying medical cases for payment on the basis of diagnostic codes. Used under Medicare's inpatient prospective payment system (IPPS) for inpatient hospital services. (DRG is now referred to as MS-DRG.)

**Durable Medical Equipment (DME):** Any equipment that undergoes repeated use, is usable at home, and is not beneficial to a person without an illness or injury. Splinting, orthopaedic bracing, and wheelchairs are examples of DME.

## E

**Electronic Claim:** A claim form that is processed and delivered from one computer to another via some form of magnetic media (e.g., magnetic tape, diskette) or via telecommunications.

**Encounter Data:** Claims that are not paid fee-for-service because they are the responsibility of the provider under the capitation agreement.

**EOB (Explanation of Benefits):** A form included with a check from the insurer explaining the benefits that were paid and/or charges that were rejected.

**Evaluation & Management (E/M) Service:** A professional service provided by physicians for the purpose of diagnosing and treating diseases and counseling and evaluating patients.

**Exclusion:** Specific services or conditions that a health insurance policy or program will not cover or will only do so at a limited rate.

**Experimental Procedures:** Medical procedures for which basic safety or effectiveness has not been established.



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## F

**Fee-for-Service:** Refers to paying medical providers a specified amount for individual services rendered.

**Fee Schedule:** A list of predetermined payments for medical services. For example, Medicare Part B reimburses physicians based on a fee schedule.

## G

**Global Surgery:** The payment policy in the Medicare fee schedule stating that in addition to the procedure itself, the global surgical fee includes all related services and visits that occur within a designated time period (typically 90 days).

## H

### **HPCPS (Healthcare Common Procedure Coding System):**

A two-level coding system, consisting of Level I CPT® codes and Level II codes for medical supplies, equipment, and drugs, etc.

**Health Maintenance Organization (HMO):** Prepaid health plans that provide a range of services in return for fixed monthly premiums or other payment method. Virtually any organization can sponsor an HMO, including the government, hospitals, employers, labor unions, and insurance companies.

## I

**ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modifications):** A standardized system of describing diagnoses and identifying codes for reporting treatment and diagnosis of health plan enrollees. The coding and terminology provide a uniform language that accurately designates primary and secondary diagnosis and ensures consistent communication on claim forms. Maintained jointly by the American Hospital Association and CMS.

### **Individual Practice Association (IPA) Model HMO:**

A healthcare model that contracts with an Individual Practice Association (IPA) entity to provide healthcare services in return for a negotiated fee. The IPA, in turn, contracts with physicians who continue in their existing individual or group practices.

**Initial (Claim) Determination:** The first adjudication made by a MAC (i.e., the Medicare affiliated contractor) following a request for Medicare (or insurance) payment.

## M

**Major Complications and Comorbidities (MCC):** There are 3 levels of severity in MS-DRGs, based upon assignment of secondary diagnosis codes. MCCs reflect the highest severity assignment and are included on the list if they could demonstrate that their presence leads to substantially increased hospital resource use.

**Medicaid:** A state/federal government sponsored medical assistance program to enable eligible recipients to obtain essential medical care and services.

**Medical Necessity:** Medical information justifying that a service rendered was reasonable and appropriate for the diagnosis or treatment of a medical condition.

**Medicare:** A federal health insurance program for people age 65 or older, for disabled persons, and for those with end-stage renal disease.

**Medicare Advantage:** Under the Balanced Budget Act of 1997 (BBA97), Congress created a new Medicare Part C, known as Medicare Advantage, which allows CMS to contract with a number of managed care organizations including, but not limited to, health maintenance organizations, preferred provider organizations, provider service organizations, and medical savings accounts.

**Medicare Contractor:** An organization that enters into a legal agreement with the Department of Health & Human Services to handle specified administrative, payment, and review functions. These organizations are charged with the responsibility of ensuring payments are made only for services covered under Medicare Part A or Part B. They determine whether a particular service is covered under Medicare in the course of adjudicating a Medicare claim or conducting utilization and quality review.

**Medi-Gap:** Health insurance policies that provide benefits for services and costs, such as deductibles and coinsurance, not covered under the Medicare program.

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## N

**Non-Participating Physician:** A physician who does not sign a health plan participation agreement and therefore is not obligated to accept assignment on all claims.

## P

**Part A (Medicare):** The Medicare hospital insurance program which covers hospital and related institutional care.

**Part B (Medicare):** The Medicare supplementary medical insurance program, which covers the costs of physician services, outpatient lab, x-ray, DME, and certain other healthcare services.

**Participating Provider:** A hospital, pharmacy, physician, or ancillary services provider who has contracted with a health plan to provide medical services for a determined fee or payment.

**Point-of-Service Plan (POS):** The newest type of managed care organization in which beneficiaries who decide to go outside the plan for healthcare services receive reduced benefits.

**Preferred Provider Organization (PPO):** An arrangement whereby an insurer or managing entity contracts with a group of healthcare providers who provide services at lower than usual fees in return for prompt payment and a guaranteed volume of patients.

**Prior Authorization:** An assessment of healthcare services by the insurer in advance of provision of services by the provider. This may be required under the healthcare plan or program, or may be performed routinely by the provider to ensure coverage and payment.

## R

### **RBRVS (Resource-Based Relative Value Scale):**

A government mandated relative value system (implemented in 1992) that is used for calculating national fee schedules for services provided to Medicare patients. Physicians are paid on relative value units (RVUs) for procedures and services. The three components of each established value include: work expense, practice expense, and malpractice expense.

## S

**Secondary Insurer:** The insurer that is second in responsibility under Coordination of Benefits.

**Self-insured/Self-funded:** Employers fund benefit plans from their own resources without purchasing insurance. Self-funded plans may be self-administered, or the employer may contract with a third-party administrator.

**Staff Model HMO:** This healthcare model employs physicians to provide healthcare to its members. The HMO compensates the physicians by salary and incentive programs (e.g., Kaiser Permanente).

## T

**Third-Party Administrator (TPA):** An organization that processes healthcare claims without bearing any insurance risk.

**TRICARE (formerly known as CHAMPUS):** Formerly named the Civilian Health and Medical Program of the Uniformed Services, TRICARE is a federally funded comprehensive health benefits program administered by the Department of Defense and designed to provide healthcare benefits to eligible veterans and their dependents.

## U

**UB-92 and UB-04:** A uniform billing form required for submitting and processing claims for institutional providers.

**Usual, Customary, and Reasonable (UCR):** A term indicating fees charged for medical services that are considered normal, common, and in line with the prevailing fees in the provider's area.

**Utilization Management:** Activities that include admission/pre-admission review, second surgical opinion, concurrent review, discharge planning, individual case management, focused review, and provider profiling.

**Utilization Review:** The process of reviewing services to determine if those services are or were medically necessary and appropriate. Utilization review may be performed in advance of services or retrospectively.





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