MAGEC

Physician's coding and reimbursement guide for the MAGEC system

MAGEC (MAGnetic Expansion Control) is an adjustable growing rod that utilizes innovative magnet technology and an external remote controller (ERC) to non-invasively lengthen the device after implantation. This system is designed to eliminate the need for repeat surgeries for lengthening and allows for distraction to be done routinely in the physician's office.

The NuVasive MAGEC system has been cleared by the FDA for skeletally immature patients less than 10 years of age with severe progressive spinal deformities (e.g., Cobb angle of 30° or more; thoracic spine height less than 22 cm) associated with or at risk of thoracic insufficiency syndrome (TIS), defined as the inability of the thorax to support normal respiration or lung growth. The MAGEC system is an adjustable growing rod used to brace the spine during growth to minimize the progression of scoliosis. The rod includes a small internal magnet, which allows the rod to be lengthened by use of an ERC.

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Coding and payment

This guide has been developed to assist you in reporting of procedures associated with the MAGEC system. It is important to understand that coding is specific to the procedure being performed, not to the device being used. Ultimately, it is the physician's responsibility to choose codes that accurately describe the patient's condition and the services performed.

Physician coding and payment

Physicians and other providers use CPT codes to report procedures and services. Medicare reimburses CPT codes under a fee schedule, based on the relative value units (RVUs) assigned to each code. Private payors may base their reimbursement rates on the Medicare rates, RVUs or other physician contracted and/or negotiated amounts.

When billing for procedures, it is important to check the National Correct Coding Initiative edits to determine what, if any, payment edits may apply. For example, under Medicare payment policy, intraoperative monitoring (CPT code 95940) is bundled into spinal fusion procedures and not separately reimbursed.

Codes commonly reported for procedures associated with the MAGEC system are included in this guide. Spinal deformity procedures typically involve three parts: arthrodesis, instrumentation and insertion of a graft. Osteotomies may also be performed.

There is not currently a CPT code that describes the MAGEC distraction procedure. Often, new technologies do not have established coding and payment. However, physicians should expect to be reimbursed for procedures that are medically reasonable and necessary when treating a patient. The CPT code currently recommended for the MAGEC system is CPT 22899-unlisted procedure, spine.

Since unlisted procedure codes do not describe a specific procedure or service, claims must be submitted with supporting documentation and may be subject to manual review. Established codes similar to the unlisted code will be identified to determine reimbursement. Payors' lack of familiarity with MAGEC, together with the absence of established payment rates for the procedure, means that physician claims may require further information. In addition to justification of charges, payors may request technical information about the MAGEC system and clinical justification for its use, either generally or in a particular case.

Potential coding initial implant procedure (report the appropriate combination of codes) or final fusion procedure (post-explant) with Medicare 2020 physician facility national average payment

CPT[1] code	Description	2020 Medicare physician national average payment[2]	Physician facility RVUs[2]
22800*	Arthrodesis, posterior, for spinal deformity, with or without cast; up to six vertebral segments	$1,420.85	39.37
22802*	Arthrodesis, posterior, for spinal deformity, with or without cast; seven to twelve vertebral segments	$2,203.27	61.05
22804*	Arthrodesis, posterior, for spinal deformity, with or without cast; thirteen or more vertebral segments	$2,538.28	70.33
22899	Unlisted procedure, spine 2020 Medicare physician national average	Carrier priced	N/A
22212*	Osteotomy of spine, posterior or posterolateral approach; one vertebral segment; thoracic	$1,560.88	43.25
22214*	Osteotomy of spine, posterior or posterolateral approach; one vertebral segment; lumbar	$1,567.01	43.42

*When two or more eligible (starred) procedures are billed on the same date of service, multiple procedure reductions apply. The primary procedure, typically the most expensive, is reimbursed at 100% of the fee schedule; each additional eligible procedure is reimbursed at 50% of the fee schedule.

Potential coding initial implant procedure (report the appropriate combination of codes) or final fusion procedure (post-explant) with Medicare 2020 physician facility national average payment (cont.)

CPT[1] code	Description	2020 Medicare physician national average payment[2]	Physician facility RVUs[2]
22216**	Osteotomy of spine, posterior or posterolateral approach; one vertebral segment; each additional vertebral segment	$381.11	10.56
20930**	Allograft, morselized, or placement of osteopromotive material; for spine surgery only	$0	0
20931**	Allograft, structural; for spine surgery only	$116.21	3.22
20936**	Autograft; for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from the same incision	$0	0
20937**	Autograft; for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision)	$175.03	4.85
20938**	Autograft; for spine surgery only (includes harvesting the graft); structural, bicortical, or tricortical (through separate skin or fascial incision)	$192.72	5.34
22842**	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks, and sublaminar wires); three to six vertebral segments	$800.47	22.18
22843**	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks, and sublaminar wires); seven to twelve vertebral segments	$855.32	23.70
22844**	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks, and sublaminar wires); thirteen or more vertebral segments	$1,033.61	28.64
22848**	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum	$377.86	10.47

Replacement, revision or removal/explant procedure

CPT[1] code	Description	2020 Medicare physician national average payment	Physician facility RVUs
22849	Reinsertion of spinal fixation device ***Note:*** *When instrumentation is removed and reinserted at the same level during the same surgical session, 22849 is reported.*	$1,362.38	37.75
22852	Removal of posterior segmental instrumentation	$730.81	20.25

Distraction and distraction measurement

CPT[1] code	Description	2020 Medicare physician national average payment[2]	Physician facility RVUs[2]
22899	Unlisted procedure, spine	Carrier priced	N/A
76800	Ultrasound, spinal canal and contents	$59.91	1.66
72082	Radiologic examination; spine; entire thoracic and lumbar, including skull, and cervical and sacral spine, if performed (e.g., scoliosis evaluation); two or three views	$16.16	0.46

*When two or more eligible (starred) procedures are billed on the same date of service, multiple procedure reductions apply. The primary procedure, typically the most expensive, is reimbursed at 100% of the fee schedule; each additional eligible procedure is reimbursed at 50% of the fee schedule.

**List separately in addition to code for primary procedure

Benefits and coverage

Verifying a patient's insurance eligibility and benefits is an important step prior to scheduling a procedure. Providers should contact the insurer to ask whether the patient's coverage is currently active and what the patient's payment responsibilities are. Gather information about co-payments, deductibles, co-insurance and other out-of-pocket expenses prior to surgery and post-surgery, including any prior authorization requirements.

The prior authorization process

Commercial payors

Prior authorization, sometimes referred to as "pre-certification," is the process used to confirm if a proposed service or procedure is medically necessary. Prior authorization should be obtained before a procedure is performed. It is advised that you check with your patient's individual health plan for the policy on prior authorization for the CPT codes being performed.

Step 1 **Prior authorization request**	Step 2 **Appeal process**	Step 3 **Procedure**
Follow payor process to request prior authorization (or pre-determination) of CPT codes. This includes: • patient history and medical necessity for the procedure and • CPT and diagnosis codes.	If the payor does not approve the request for CPT codes, the surgeon and the provider or patient may write appeal letters to the payor. If the appeal is denied, the patient may request an external review with an Independent Review Organization.	Once authorization has been approved by the payor, you may proceed with the procedure and billing the payor.
Allow up to **30 days** for the payor to process the request.	Allow an additional **30 to 45 days** for each level of appeal.	Up to **four months** may lapse before final approval.

Reference

1. Current Procedural Terminology 2020. American Medical Association. 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 clauses apply.

2. Medicare Physician Fee Schedule Final Rule was published in the Federal Register/Vol. 84, No. 221/ Wednesday, November 15, 2019.

The information contained in this document is for informational purposes only and is current as of March 2020. It is always the responsibility of the provider to determine if the services actually provided are accurately described by any specific code(s) and to report services consistent with specific payor requirements. This information is subject to change at any time, and NuVasive strongly recommends that you consult your payor organization with regard to its reimbursement policies. In all cases, services billed must be medically necessary, actually performed as reported, and appropriately documented.

The NuVasive MAGEC system is comprised of a sterile single-use spinal rod that is surgically implanted using appropriate NuVasive Reline and Armada fixation components or Stryker Xia fixation components. The system includes a non-sterile hand-held ERC that is used at various times after implant to non-invasively lengthen or shorten the implanted spinal rod. The MAGEC system is indicated for skeletally immature patients less than 10 years of age with severe progressive spinal deformities (e.g., Cobb angle of 30° or more; thoracic spine height less than 22 cm) associated with or at risk of thoracic insufficiency syndrome. Please refer to the MAGEC system instructions for use for a complete list of the contraindications, warnings and precautions, as well as important directions for use. The bracing and distraction system and the ERC are to be used only by a trained licensed physician. ***Caution: U.S. Federal law restricts this device to sale by or on the order of a physician.***

For questions, please contact 1.800.211.0713
or **reimbursement@nuvasive.com**

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