2022 NuVasive spine reimbursement and coding guide

Assisting physicians and facilities in accurate billing for NuVasive implants and instrumentation systems

NUVASIVE

Contents

Introduction

This reimbursement guide has been prepared to assist physicians and facilities ("providers") with accurate billing for NuVasive implants and instrumentation systems.

The information contained in this guide 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 payors.

Spine reimbursement support

To assist providers with coding questions or issues, **NuVasive provides spine reimbursement support assistance, available at reimbursement@nuvasive.com or 800.211.0713.**

Physician coding and payment

When physicians bill for services performed, payors require the physician to assign a current procedural terminology (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 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.

CPT coding for arthrodesis and decompression

A note about XLIF procedure coding: The North American Spine Society (NASS) provided coding guidance for physicians when performing a fusion through an anterolateral approach. During an eXtreme Lateral Interbody Fusion (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, and
- preauthorization should be requested for all relevant procedure codes for the case (e.g., anterior arthrodesis, instrumentation, graft material, nerve monitoring, etc.).

A note about two new decompression codes for 2022: The AMA issued two new decompression codes this year, 63052 and 63053, which are included in the table below. These new CPT codes are intended to enable billing for a complete decompression when performing a posterior or transforaminal lumber interbody fusion.

Decompression procedure codes

CPT code[1]	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; one 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), one or two 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), one or two 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), one or two 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 two 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 two 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 two vertebral segments; lumbar
63020	-50	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; one interspace, cervical
63030	-50	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; one interspace, lumbar

Decompression procedure codes (cont.)

CPT code[1]	Modifier (if warranted)	Procedure description
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		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		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
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)
63052		Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (list separately in addition to code for primary procedure)
63053		Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (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

Decompression procedure codes (cont.)

CPT code[1]	Modifier (if warranted)	Procedure description
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
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 code[1]	Procedure description
Posterior fusion	**22595**	Arthrodesis, posterior technique, atlas-axis (C1–C2)
	22600	Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment
	22610	Arthrodesis, posterior or posterolateral technique, single interspace; thoracic (with lateral transverse technique, when performed)
	22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)
	22614	Each additional interspace (list separately in addition to code for primary procedure)

Spine arthrodesis and arthroplasty procedure codes (cont.)

Procedure	CPT code[1]	Procedure description
PLIF or TLIF	**22630**	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
	22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (list separately in addition to code for primary procedure)
Anterior fusion	**22551**	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy, and decompression of spinal cord and/or nerve root(s); cervical below C2
	22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy 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
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)
Cervical disc arthroplasty	**22856**	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical
	22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy 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
	22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical

Grafting and lumbar instrumentation procedure codes

Procedure	CPT code[1]	Procedure description
Allograft and 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)
	20939	Bone marrow aspiration for bone grafting, spine surgery only, 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 one 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); three to six 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; two to three vertebral segments (list separately in addition to code for primary procedure)
	22846	Anterior instrumentation; four to seven vertebral segments (list separately in addition to code for primary procedure)
	22847	Anterior instrumentation; eight or more vertebral segments (list separately in addition to code for primary procedure)

Grafting and lumbar instrumentation procedure codes (cont.)

Procedure	CPT code[1]	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, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (list separately in addition to code for primary procedure)

NVM5 intraoperative neuromonitoring (IOM) system

For coding and billing information regarding physician-driven IOM during spinal surgery, please see the *2022 NVM5 IOM reimbursement guide*.

Medicare note: *According to National Correct Coding Initiative (NCCI) edits and the description of CPT codes 95940 and 95941, intraoperative monitoring may not be reported separately by the operating surgeon or anesthesiologist. Monitoring by the surgeon or anesthesiologist is considered a bundled component of the surgery.*

IOM codes

- 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 OR, one-on-one monitoring requiring personal attendance, each 15 minutes. CPT code 95941: continuous IOM from outside the OR (remote or nearby) or for monitoring of more than one case while in the OR,
  per hour.
- Medicare requires use of HCPCS code G0453 for IOM from outside the OR. Multiple cases can be monitored simultaneously, but the monitoring professional can only bill one case at a time. HCPCS code G0453: continuous IOM from outside the OR (remote or nearby), per patient (attention directed exclusively to one patient), each 15 minutes.

Computer-assisted (navigational) CPT code—NVM5 alignment assessment, NVM5 rod bending and NVM5 guidance

NuvaMap OR, an NVM5 software application, intraoperatively measures cervical, thoracolumbar, and pelvic parameters to assess patient alignment in real-time. This is done through the use of a lateral fluoroscopic image to support surgical decision making. The NVM5 Bendini rod bending system expedites manual rod manipulation via computer-assisted bend instructions.

Computer-assisted (navigational) code				
CPT code[1]	**Description**	**2022 conversion factor**	**RVUs[2]**	**2022 Medicare national average physician payment[2]**
+61783	Stereotactic computer-assisted (navigational) procedure; spinal (list separately in addition to code for primary procedure)	$34.6062	6.82	$237.05

+Add on code

Key descriptors of CPT code 61783

- Includes spinal applications, which allow for navigation using an image-guided 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.
- Not applicable for spinal decompression for degenerative spine disease or disc replacement. Exceptions could include tumor-related surgeries.
- Possible primary procedure codes for use with 61783 include 22600, 22610 and 22612. These are subject to payor-specific coverage guidelines.

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.

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

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. Please reach out to the NuVasive spine reimbursement support line regarding ICD-10 procedure codes.

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, please refer to our HCPCS Coding Guide.

MS-DRGs

MS-DRG[3]	Description	2022 Medicare national average payment[4]
518	Back and neck procedures except spinal fusion with MCC or disc device/neurostimulator	$23,717
519	Back and neck procedures except spinal fusion with CC	$12,958
520	Back and neck procedures except spinal fusion without CC/MCC	$9,380
453	Combined anterior and posterior spinal fusion with MCC	$60,753
454	Combined anterior and posterior spinal fusion with CC	$40,289
455	Combined anterior and posterior spinal fusion without CC/MCC	$31,615
456	Spinal fusion except cervical with spinal curvature, malignancy, infection or extensive fusions with MCC	$56,813
457	Spinal fusion except cervical with spinal curvature, malignancy, infection or extensive fusions with CC	$42,963
458	Spinal fusion except cervical with spinal curvature, malignancy, infection or extensive fusions without CC/MCC	$33,117
459	Spinal fusion except cervical with MCC	$44,528
460	Spinal fusion except cervical without MCC	$25,990
471	Cervical spinal fusion with MCC	$33,191
472	Cervical spinal fusion with CC	$20,192
473	Cervical spinal fusion without CC/MCC	$16,788

Outpatient facility coding and payment

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.
- 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

CPT code[1]	APC[5]	APC description	2022 Medicare national average payment[5]
62380	5114	Level four musculoskeletal procedures	$6,397
63001	5114	Level four musculoskeletal procedures	$6,397
63003	5114	Level four musculoskeletal procedures	$6,397
63005	5114	Level four musculoskeletal procedures	$6,397
63015	5114	Level four musculoskeletal procedures	$6,397
63017	5114	Level four musculoskeletal procedures	$6,397
63020	5114	Level four musculoskeletal procedures	$6,397
63030	5114	Level four musculoskeletal procedures	$6,397
63035	N/A	N/A	Packaged
63040	5114	Level four musculoskeletal procedures	$6,397
63042	5114	Level four musculoskeletal procedures	$6,397
63045	5114	Level four musculoskeletal procedures	$6,397
63046	5114	Level four musculoskeletal procedures	$6,397
63047	5114	Level four musculoskeletal procedures	$6,397
63048	N/A	N/A	Packaged
63055	5114	Level four musculoskeletal procedures	$6,397
63056	5114	Level four musculoskeletal procedures	$6,397
63057	N/A	N/A	Packaged
63064	5114	Level four musculoskeletal procedures	$6,397
63066	N/A	N/A	Packaged

Decompression and arthrodesis codes (cont.)

CPT code[1]	APC[5]	APC description	2022 Medicare national average payment[5]
63075	5114	Level four musculoskeletal procedures	$6,397
63076	N/A	N/A	Packaged
22551	5115	Level five musculoskeletal procedures	$12,593
22554	5115	Level five musculoskeletal procedures	$12,593
22585	N/A	N/A	Packaged
22612	5115	Level five musculoskeletal procedures	$12,593
22614	N/A	N/A	Packaged
22840	N/A	N/A	Packaged
22842	N/A	N/A	Packaged
22845	N/A	N/A	Packaged
22853	N/A	N/A	Packaged
22854	N/A	N/A	Packaged
22856	5116	Level six musculoskeletal procedures	$16,513
22858	N/A	N/A	Packaged
22859	N/A	N/A	Packaged

Ambulatory surgery center coding and payment

Ambulatory surgical center (ASC)

To be eligible to receive ambulatory surgery center facility fees, a center must be certified and/or accredited as an ASC.

Non-Medicare reimbursement

In the ASC, payors may allow additional payment for disposables, fixation or instrumentation associated with procedures. Payment will be according to the terms of the contract or as line item supplies at cost or cost plus markup.

ASC

CPT code[1]	Description	2022 Medicare national average ASC payment[6]
Decompression and fusion codes		
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	$8,746
+22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (list separately in addition to code for primary procedure)	Packaged
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	$8,692

ASC (cont.)

CPT code[1]	Description	2022 Medicare national average ASC payment[6]
Decompression and fusion codes (cont.)		
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)	Packaged
22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)	$8,817
+22614	Arthrodesis, posterior or posterolateral technique, single interspace; each additional vertebral segment (list separately in addition to code for primary procedure)	Packaged
+22840	Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (list separately in addition to code for primary procedure)	Packaged
+22842	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); three to six vertebral segments (list separately in addition to code for primary procedure)	Packaged
+22845	Anterior instrumentation; two to three vertebral segments (list separately in addition to code for primary procedure)	Packaged
+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)	Packaged
+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)	Packaged
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical	$12,395
+22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (list separately in addition to code for primary procedure)	Packaged
+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)	Packaged
Decompression codes		
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, one interspace, lumbar	$3,001
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), one or two vertebral segments; cervical	$3,001

ASC (cont.)

CPT code[1]	Description	2022 Medicare national average ASC payment[6]
Decompression codes (cont.)		
63003	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), one or two vertebral segments; thoracic	$3,001
63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), one or two vertebral segments; lumbar, except for spondylolisthesis	$3,001
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; one interspace, cervical	$3,001
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; one interspace, lumbar	$3,001
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar	$3,001
+63044	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (list separately in addition to code for primary procedure)	Packaged
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	$3,001
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	$3,001
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	$3,001
63055	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; thoracic	$3,001
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)	$3,001

+Add on code

References:

1. 2022 Current Procedural Terminology (CPT) Professional Edition. CPT is a registered trademark of the American Medical Association. All rights reserved.
2. Medicare Physician Fee Schedule Final Rule CY2022. Conversion factor $34.6062
3. 2022 DRG Expert. AAPC.
4. Medicare Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2022 Rates.
5. Medicare Outpatient Payment System Final Rule CY2022.
6. Ambulatory Surgical Center Payment System Final Rule CY2022.

**Final Medicare payment will vary based on physician locality adjustments. Commercial payment will be determined by individually negotiated contracts.*

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