Simplify Cervical Disc

2022 cervical total disc replacement reimbursement guide

NuVasive

Surgeon coding

Current Procedural Terminology (CPT®) codes describe procedures. While the fees assigned to these codes are determined by the surgeon's contracts with each health plan, most plans use relative value units (RVUs) to establish base payment rates for CPT codes. These RVUs are then multiplied by the plan's individual conversion factor. The only publicly available fee schedule is Medicare's, which is typically the baseline for commercial health plan fee schedules. The following CPT codes may be utilized to bill for the cervical total disc replacement (cTDR) procedure as appropriate:

CPT code[1]	No. of levels	Description
22856	One-level indication	Total disc arthroplasty (disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical
+22858	Two-level indication	Total disc arthroplasty (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)

Surgeon and outpatient/ambulatory surgery center (ASC) payment

The following table includes the 2022 Medicare national unadjusted payment rates associated with the CPT codes outlined above for the surgeon, as well as for the hospital outpatient and ASC sites of service when billing for a cTDR procedure:

CPT code	Surgeon RVUs/fee schedule	Hospital outpatient ambulatory payment classifications (APC)*/fee schedule	ASC fee schedule**
22856	48.36/$1,674	5116/$16,513	$12,395
22858	14.93/$517	No additional payment (packaged)	No additional payment (packaged)

*Status indicator J1, comprehensive APC

**Status indicator J8, device-intensive procedure

Sources: CY2022 Medicare Physician Fee Schedule, Final Rule, Federal Register, 2021; CY2022 Medicare Outpatient Prospective Payment System, Final Rule, Federal Register, 2021.

Implant billing

A healthcare common procedure coding system (HCPCS) code is required by Medicare for device-intensive procedures and may be needed by a commercial health plan to report devices used in conjunction with outpatient procedures. There is not a dedicated code for cTDR devices, so the following code may be reported when required and appropriate:

HCPCS code	Description
C1889	Implantable/insertable device for device-intensive procedure, not otherwise classified

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

The information contained in this document is for informational purposes only and is current as of January 2022. 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.

NuVasive, Inc.
7475 Lusk Blvd., San Diego, CA 92121 USA
+1 800.475.9131

nuvasive.com

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