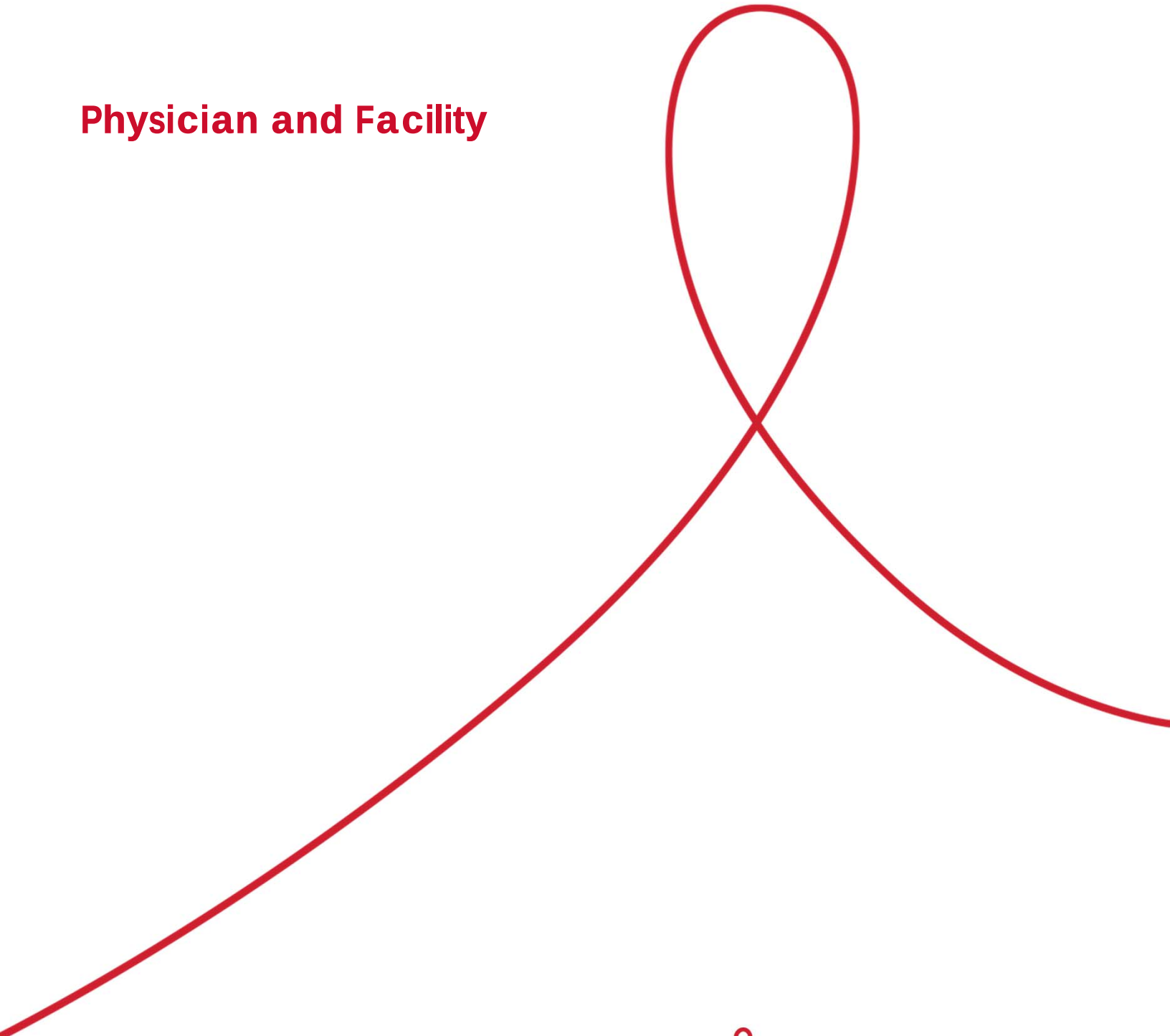
DePuy Synthes
2022 Spine Reimbursement Guide

Physician and Facility



DePuy Synthes
THE ORTHOPAEDICS COMPANY OF Johnson & Johnson

Contents

This guide has been developed to assist physicians and facilities in coding for the use of the DePuy Synthes Spine implants and devices.

These procedures may be a covered service if they meet all of the requirements established by Medicare and private payers. It is essential that each claim be coded properly and supported with appropriate documentation in the medical record.

Disclaimer

The information contained in this document is provided for informational purposes only and represents no statement, promise, or guarantee by DePuy Synthes concerning levels of reimbursement, payment, or charge. Similarly, all CPT, ICD-10 and HCPCS codes are supplied for informational purposes only and represent no statement, promise, or guarantee by DePuy Synthes that these codes will be appropriate or that reimbursement will be made. It is not intended to increase or maximize reimbursement by any payor. We strongly recommend that you consult your payor organization with regard to its reimbursement policies.

Physician Services

Current Procedural Terminology (CPT®) codes and Medicare Physician Fee Schedule values for common spine procedures are indicated below. CPT® coding has been provided for the following procedural groups:

- Spinal Decompression
- Thoracolumbar and Sacroiliac Joint Arthrodesis
- Cervical Arthrodesis
- Spinal Instrumentation
- Graft Placement
- Osteotomy and Corpectomy
- Disc Arthroplasty
- Laminoplasty
- Vertebroplasty and Vertebral Body Augmentation
- Halo Placement

Procedure Codes for Spinal Decompression

CPT® Code	Description	2022 Total RVUs	2022 Medicare National Average Payment
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	N/A	Carrier Priced
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; cervical	36.69	$1,270
63003	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; thoracic	36.68	$1,269
63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis	35.61	$1,232
63011	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; sacral	32.55	$1,126
63012	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)	35.53	$1,230
63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; cervical	43.97	$1,522
63016	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; thoracic	45.32	$1,568
63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; lumbar	37.55	$1,299

CPT® Code	Description	2022 Total RVUs	2022 Medicare National Average Payment
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	34.45	$1,192
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	29.00	$1,004
63035	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)	5.64	$195
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical	41.04	$1,420
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar	38.44	$1,330
63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)	N/A	Carrier Priced
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)	N/A	Carrier Priced
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical	38.28	$1,325
63046	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic	36.48	$1,262
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar	32.84	$1,136
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)	6.21	$215
63055	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic	48.26	$1,670
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)	44.32	$1,534
63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)	9.47	$328

CPT® Code	Description	2022 Total RVUs	2022 Medicare National Average Payment
63064	Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; single segment	52.82	$1,828
63066	Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; each additional segment (List separately in addition to code for primary procedure)	6.06	$210
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	40.37	$1,397
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)	7.18	$248
63077	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace	44.58	$1,543
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)	6.10	$211
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic	N/A	Carrier Priced
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar	N/A	Restricted Coverage

Procedure Codes for Thoracolumbar and Sacroiliac Joint Arthrodesis

Procedure codes for thoracolumbar arthrodesis through an anterior or lateral approach

CPT® Code	Description	2022 Total RVUs	2022 Medicare National Average Payment
22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	49.41	$1,710
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	45.34	$1,569
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)	9.60	$332
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace	60.36	$2,089
22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments	54.17	$1,875
22810	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments	59.44	$2,057
22812	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments	65.12	$2,254

Procedure codes for thoracolumbar arthrodesis through a posterior, posterolateral or lateral extracavitary approach and Sacroiliac joint arthrodesis

CPT® Code	Description	2022 Total RVUs	2022 Medicare National Average Payment
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	49.06	$1,698
22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)	10.59	$366
22610	Arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)	37.93	$1,313
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	47.06	$1,629
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)	11.53	$399
22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments	40.29	$1,394
22802	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments	62.72	$2,171
22804	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments	71.95	$2,490
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	46.96	$1,625
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)	9.46	$327
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	54.89	$1,900
22634	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, each additional interspace and segment (List separately in addition to code for primary procedure)	14.64	$507
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	24.86	$860
27280	Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed	40.43	$1,399

Procedure Codes for Cervical Arthrodesis

Procedure codes for cervical arthrodesis through an anterior or anterolateral approach

CPT® Code	Description	2022 Total RVUs	2022 Medicare National Average Payment
22548	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process	58.34	$2,019
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	50.50	$1,748
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)	11.69	$405
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	37.38	$1,294
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)	9.60	$332

Procedure codes for cervical arthrodesis through a posterior or posterolateral approach

CPT® Code	Description	2022 Total RVUs	2022 Medicare National Average Payment
22590	Arthrodesis, posterior technique, craniocervical (occiput-C2)	47.11	$1,630
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)	45.03	$1,558
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment	38.60	$1,336
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)	11.53	$399

Procedure Codes for Spinal Instrumentation

CPT® Code	Description	2022 Total RVUs	2022 Medicare National Average Payment
22840	Posterior non-segmental instrumentation (eg, 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)	22.38	$774
22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)	0.00	Bundled Code
22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)	22.50	$779

CPT® Code	Description	2022 Total RVUs	2022 Medicare National Average Payment
22843	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)	24.06	$833
22844	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure)	29.02	$1,004
22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)	21.46	$743
22846	Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)	22.31	$772
22847	Anterior instrumentation; 8 or more vertebral segments (List separately in addition to code for primary procedure)	23.61	$817
22849	Reinsertion of spinal fixation device	38.79	$1,342
22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)	7.61	$263
22854	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, 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)	9.88	$342
22859	Insertion of intervertebral biomechanical device(s) (eg, 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)	9.82	$340

Procedure Codes for Graft Placement

CPT® Code	Description	2022 Total RVUs	2022 Medicare National Average Payment
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)	0.00	Bundled Code
20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)	3.26	$113
20936	Autograft for spine surgery only (includes harvesting the graft; local (eg, ribs, spinous process, or laminar fragments) obtained from the same incision (List separately in addition to code for primary procedure)	0.00	Bundled Code
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)	4.92	$170
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)	5.43	$188

Procedure Codes for Osteotomy and Corpectomy

Osteotomy

CPT® Code	Description	2022 Total RVUs	2022 Medicare National Average Payment
22206	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); thoracic	72.57	$2,511
22207	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); lumbar	71.03	$2,458
22208	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)	17.40	$602
22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical	53.04	$1,836
22212	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic	44.83	$1,551
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar	44.84	$1,552
22216	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (List separately in addition to primary procedure)	10.70	$370
22220	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical	48.07	$1,664
22222	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic	52.25	$1,808
22224	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar	47.09	$1,630
22226	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)	10.62	$368

Corpectomy

CPT® Code	Description	2022 Total RVUs	2022 Medicare National Average Payment
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment	52.17	$1,805
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)	7.81	$270
63085	Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment	57.17	$1,978
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)	5.62	$194

CPT® Code	Description	2022 Total RVUs	2022 Medicare National Average Payment
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	71.29	$2,467
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)	7.56	$262
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	58.06	$2,009
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)	5.23	$181
63101	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment	68.99	$2,387
63102	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); lumbar, single segment	67.22	$2,326
63103	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic or lumbar; each additional segment (List separately in addition to code for primary procedure)	8.66	$300

Procedure Codes for Disc Arthroplasty

CPT® Code	Description	2022 Total RVUs	2022 Medicare National Average Payment
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	48.36	$1,674
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace; lumbar	52.27	$1,809
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)	14.93	$517

CPT® Code	Description	2022 Total RVUs	2022 Medicare National Average Payment
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	68.78	$2,380
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	68.75	$2,379
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	61.42	$2,126
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	67.12	$2,323
0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)	0.00	Carrier Priced
0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach; each additional interspace, cervical (List separately in addition to code for primary procedure)	0.00	Carrier Priced
0163T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)	0.00	Carrier Priced
0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)	0.00	Carrier Priced

Procedure Codes for Laminoplasty

CPT® Code	Description	2022 Total RVUs	2022 Medicare National Average Payment
63050	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments	43.99	$1,522
63051	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (eg, wire, suture, mini-plates), when performed)	50.35	$1,742

Procedure Codes for Vertebroplasty and Vertebral Body Augmentation

CPT® Code	Description	2022 Facility Total RVUs	2022 Facility Medicare National Average Payment	2022 Non-Facility Total RVUs	2022 Non-Facility Medicare National Average Payment
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	12.65	$438	56.14	$1,943
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	11.92	$413	56.05	$1,940

CPT® Code	Description	2022 Facility Total RVUs	2022 Facility Medicare National Average Payment	2022 Non-Facility Total RVUs	2022 Non-Facility Medicare National Average Payment
22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)	6.06	$210	22.54	$780
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	15.01	$519	179.55	$6,214
22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar	13.97	$483	178.67	$6,183
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	6.42	$222	92.45	$3,199

Procedure Codes for Halo Placement

CPT® Code	Description	2022 Facility Total RVUs	2022 Facility Medicare National Average Payment	2022 Non-Facility Total RVUs	2022 Non-Facility Medicare National Average Payment
20650	Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)	4.76	$165	6.63	$229
20660	Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)	7.12	$246	N/A	N/A
20661	Application of halo, including removal; cranial	15.18	$525	N/A	N/A
20664	Application of halo, including removal; cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta)	26.30	$910	N/A	N/A
20665	Removal of tongs or halo applied by another individual	2.82	$98	3.42	$118

Common Procedure Coding Scenarios

Outlined below are procedural coding scenarios for some of the most common spine procedures. Each table consists of a primary procedure code and various supplemental codes. Physicians should review the available codes from each section and report accordingly.

Anterior Cervical Discectomy with Fusion (ACDF)

CPT® Code	Description
	Fusion
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; 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 primary procedure)

CPT® Code	Description
	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)
	Bone Graft
+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 (eg, 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 Cervical Fusion

CPT® Code	Description
	Fusion
22590	Arthrodesis, posterior technique, craniocervical (occiput-C2)
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment
+22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)
	Posterior Instrumentation
+22840	Posterior non-segmental instrumentation (eg, 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)
+22842	Posterior segmental instrumentation (eg, 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 (eg, 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 (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure)

CPT® Code	Description
	Bone Graft
+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 (eg, 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)

Anterior Lumbar Interbody Fusion (ALIF) Extreme Lateral Interbody Fusion (XLIF) or Anterior to Psoas (ATP) fusion with Anterior/Posterior Instrumentation. (Based on recommendations from the AMA (American Medical Association) and NASS (North American Spine Society), the extreme lateral approach used during the XLIF Procedure may be reported utilizing CPT code 22558 for anterior arthrodesis.)

CPT® Code	Description
	Fusion
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)
	Cage
+22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (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)
	Posterior Instrumentation
+22840	Posterior non-segmental instrumentation (eg, 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)
+22842	Posterior segmental instrumentation (eg, 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 (eg, 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 (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure)

CPT® Code	Description
	Bone Graft
+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 (eg, 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 Lumbar Interbody Fusion (PLIF) or Transforaminal Lumbar Interbody Fusion (TLIF)

CPT® Code	Description
	Fusion
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)
	Cage
+22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)
	Posterior Instrumentation
+22840	Posterior non-segmental instrumentation (eg, 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)
+22842	Posterior segmental instrumentation (eg, 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 (eg, 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 (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure)
	Bone Graft
+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 (eg, 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)

Facility Services

Outpatient Services

Medicare reimburses outpatient hospital and Ambulatory Surgery Center (ASC) services under the Outpatient Prospective Payment System (OPPS), which bases payment on Ambulatory Payment Classifications (APCs) and ASC Payment Groups. Services are reported with CPT® codes. The Medicare national average payments for common spine procedures in the outpatient setting are listed below.

Procedure Codes for Spinal Decompression

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2022 Medicare National Average Payment	PI	2022 Medicare National Average Payment
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	J1	5114	$6,397	G2	$3,001
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; cervical	J1	5114	$6,397	G2	$3,001
63003	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; thoracic	J1	5114	$6,397	G2	$3,001
63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis	J1	5114	$6,397	G2	$3,001
63011	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; sacral	J1	5114	$6,397	N/A	N/A

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2022 Medicare National Average Payment	PI	2022 Medicare National Average Payment
63012	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)	J1	5114	$6,397	N/A	N/A
63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; cervical	J1	5114	$6,397	N/A	N/A
63016	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; thoracic	J1	5114	$6,397	N/A	N/A
63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; lumbar	J1	5114	$6,397	N/A	N/A
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	J1	5114	$6,397	G2	$3,001
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	J1	5114	$6,397	G2	$3,001
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)	N	N/A	N/A	N/A	N/A

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2022 Medicare National Average Payment	PI	2022 Medicare National Average Payment
63040	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)	J1	5114	$6,397	N/A	N/A
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar	J1	5114	$6,397	G2	$3,001
63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)	N	N/A	N/A	N/A	N/A
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)	N	N/A	N/A	N1	N/A
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	J1	5114	$6,397	G2	$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	J1	5114	$6,397	G2	$3,001

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2022 Medicare National Average Payment	PI	2022 Medicare National Average Payment
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	J1	5114	$6,397	G2	$3,001
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)	N	N/A	N/A	N/A	N/A
63055	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; thoracic	J1	5114	$6,397	G2	$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)	J1	5114	$6,397	G2	$3,001
63057	Transpedicular approach with decompression of spinal cord, equine 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)	N	N/A	N/A	N/A	N/A
63064	Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., herniated intervertebral disc), thoracic; single segment	J1	5114	$6,397	N/A	N/A
63066	Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., herniated intervertebral disc), thoracic; each additional segment (List separately in addition to code for primary procedure)	N	N/A	N/A	N/A	N/A

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2022 Medicare National Average Payment	PI	2022 Medicare National Average Payment
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	J1	5114	$6,397	N/A	N/A
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)	N	N/A	N/A	N/A	N/A
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic	J1	5114	$6,397	G2	$3,001
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method under indirect image guidance (e.g., fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar	J1	5114	$6,397	J8	$4,020

Procedure Codes for Thoracolumbar Arthrodesis

Procedure Codes for Thoracolumbar Arthrodesis through an Anterior or Lateral Approach

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2022 Medicare National Average Payment	PI	2022 Medicare National Average Payment
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)	N	N/A	N/A	N1	N/A

Procedure codes for thoracolumbar arthrodesis through a posterior or posterolateral approach and Sacroiliac joint arthrodesis

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2022 Medicare National Average Payment	PI	2022 Medicare National Average Payment
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	J1	5115	$12,593	J8	$8,817
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)	N	N/A	N/A	N1	N/A
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	J1	5115	$12,593	N/A	N/A
22634	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, each additional interspace and segment (List separately in addition to code for primary procedure)	N	N/A	N/A	N/A	N/A
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	J1	5116	$16,513	J8	$13,549

Procedure Codes for Cervical Arthrodesis

Procedure Codes for Cervical Arthrodesis through an Anterior or Anterolateral Approach

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2022 Medicare National Average Payment	PI	2022 Medicare National Average Payment
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	J1	5115	$12,593	J8	$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)	N	N/A	N/A	N1	N/A
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	J1	5115	$12,593	J8	$8,692
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)	N	N/A	N/A	N1	N/A

Procedure Codes for Cervical Arthrodesis through a Posterior or Posterolateral Approach

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2022 Medicare National Average Payment	PI	2022 Medicare National Average Payment
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)	N	N/A	N/A	N1	N/A

Procedure Codes for Spinal Instrumentation

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2022 Medicare National Average Payment	PI	2022 Medicare National Average Payment
22840	Posterior non-segmental instrumentation (eg, 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	N/A	N/A	N1	N/A
22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)	N	N/A	N/A	N1	N/A
22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)	N	N/A	N/A	N1	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 (List separately in addition to code for primary procedure)	N	N/A	N/A	N1	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	N/A	N/A	N1	N/A
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)	N	N/A	N/A	N1	N/A

Procedure Codes for Graft Placement

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2022 Medicare National Average Payment	PI	2022 Medicare National Average Payment
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)	N	N/A	N/A	N1	N/A
20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)	N	N/A	N/A	N1	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	N/A	N/A	N1	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	N/A	N/A	N1	N/A
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)	N	N/A	N/A	N1	N/A

Procedure Codes for Disc Arthroplasty

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2022 Medicare National Average Payment	PI	2022 Medicare National Average Payment
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	J1	5116	$16,513	J8	$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)	N	N/A	N/A	N1	N/A

Procedure Codes for Vertebroplasty and Vertebral Body Augmentation

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2022 Medicare National Average Payment	PI	2022 Medicare National Average Payment
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	J1	5113	$2,892	G2	$1,362
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	J1	5113	$2,892	G2	$1,362
22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)	N	N/A	N/A	N1	N/A
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	J1	5114	$6,397	G2	$3,001
22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar	J1	5114	$6,397	G2	$3,001
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	N	N/A	N/A	N1	N/A

Procedure Codes for Halo Placement

		Hospital Outpatient			Ambulatory Surgical Center	
CPT® Code	Description	SI	APC	2022 Medicare National Average Payment	PI	2022 Medicare National Average Payment
20650	Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)	J1	5113	$2,892	A2	$1,362
20660	Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)	Q2	5112	$1,423	N/A	N/A
20665	Removal of tongs or halo applied by another individual	Q1	5735	$277	G2	$141

Hospital Inpatient Services

Medicare reimburses inpatient hospital services under the Inpatient Prospective Payment System (IPPS), which bases payment on MS-DRGs (Medicare Severity Diagnosis Related Groups). The MS-DRGs and Medicare national average payments for the following procedures are provided below:

- Thoracolumbar Fusion
- Cervical Fusion
- Laminectomy/Discectomy/Disc Arthroplasty
- Laminoplasty
- Vertebroplasty/Vertebral Body Augmentation

MS-DRGs for Thoracolumbar Fusion

MS-DRG	Description	2022 Relative Weight	2022 Medicare National Average Payment
453	Combined Anterior/Posterior Spinal Fusion with MCC*	9.1880	$60,589
454	Combined Anterior/Posterior Spinal Fusion with CC**	6.0931	$40,180
455	Combined Anterior/Posterior Spinal Fusion without CC/MCC	4.7813	$31,529
456	Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/Infection or Extensive Fusions with MCC	8.6000	$56,711
457	Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/Infection or Extensive Fusions with CC	6.4959	$42,836
458	Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/Infection or Extensive Fusions without CC/MCC	5.0076	$33,022
459	Spinal Fusion Except Cervical with MCC	6.7335	$44,403
460	Spinal Fusion Except Cervical without MCC	3.9307	$25,920

*MCC=Major Complications or Comorbidities

**CC=Complications or Comorbidities

MS-DRGs for Cervical Fusion

MS-DRG	Description	2022 Relative Weight	2022 Medicare National Average Payment
471	Cervical Spinal Fusion with MCC	5.0197	$33,101
472	Cervical Spinal Fusion with CC	3.0537	$20,137
473	Cervical Spinal Fusion without CC/MCC	2.5390	$16,743

MS-DRGs for Laminectomy/Discectomy/Disc Arthroplasty

MS-DRG	Description	2022 Relative Weight	2022 Medicare National Average Payment
518	Back and neck procedure except spinal fusion with MCC or disc device/neurostimulator	3.5869	$23,653
519	Back and neck procedure except spinal fusion with CC	1.9600	$12,925
520	Back and neck procedure except spinal fusion without CC/MCC	1.4183	$9,353

MS-DRGs for Laminoplasty

MS-DRG	Description	2022 Relative Weight	2022 Medicare National Average Payment
028	Spinal Procedures with MCC	5.8231	$38,399
029	Spinal Procedures with CC or Spinal Neurostimulator	3.2968	$21,740
030	Spinal Procedures without CC/MCC	2.3568	$15,541

MS-DRGs for Vertebroplasty and Vertebral Body Augmentation

MS-DRG	Description	2022 Relative Weight	2022 Medicare National Average Payment
515	Other Musculoskeletal System and Connective Tissue O.R. Procedure with MCC	3.1406	$20,710
516	Other Musculoskeletal System and Connective Tissue O.R. Procedure with CC	1.9628	$12,943
517	Other Musculoskeletal System and Connective Tissue O.R. Procedure without CC/MCC	1.3982	$9,220

Procedure Codes

Medicare uses The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and Procedure Coding System (PCS) codes to identify diagnoses and procedures in the hospital inpatient setting. Hospitals must report the principal diagnosis using the appropriate ICD-10-CM code, as well as any secondary diagnoses – some of which may be considered CCs or MCCs for MS-DRG assignment. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." The circumstances of inpatient admission always govern the selection of principal diagnosis.

For patient admissions involving procedures, hospitals must also report ICD-10-PCS procedure code(s) for the surgical and other procedures as well as ICD-10-CM diagnosis codes.

Listed below are the ICD-10-PCS procedure codes associated with common spine procedures. Please determine the appropriate ICD-10-PCS code section based on the general descriptions in the right-hand column. The first three characters outline the section, body system and operation. Once you have identified the section, the code can be coded to greater specificity by choosing the most appropriate body part, approach, device and qualifier within the brackets.

ICD-10-PCS	Description (See current ICD-10-PCS book for complete descriptions)
0RG0[0,3,4][7,A,J,K][0,1,J]	Fusion of occipital cervical joint
0RG1[0,3,4][7,A,J,K][0,1,J]	Fusion of cervical vertebral joint
0RG2[0,3,4][7,A,J,K][0,1,J]	Fusion of 2 or more cervical vertebral joints
0RG4[0,3,4][7,A,J,K][0,1,J]	Fusion of cervicothoracic vertebral joint
0RG6[0,3,4][7,A,J,K][0,1,J]	Fusion of thoracic vertebral joint
0RG7[0,3,4][7,A,J,K][0,1,J]	Fusion of 2-7 thoracic vertebral joints
0RG8[0,3,4][7,A,J,K][0,1,J]	Fusion of 8 or more thoracic vertebral joints
0RGA[0,3,4][7,A,J,K][0,1,J]	Fusion of throco-lumbar vertebral joint
0SG0[0,3,4][7,A,J,K][0,1,J]	Fusion of lumbar vertebral joint
0SG1[0,3,4][7,A,J,K][0,1,J]	Fusion of 2 or more lumbar vertebral joints
0SG3[0,3,4][7,A,J,K][0,1,J]	Fusion of lumbo-sacral joint
0SG7[0,3,4][4,7,J,K] Z	Fusion of sacro-iliac joint right
0SG8[0,3,4][4,7,J,K] Z	Fusion of sacro-iliac joint left
00Q[T,W,X,Y][0,3,4]ZZ	Spinal cord repair
0RT[3,4,5,9,B]0ZZ	Resection of vertebral disc

ICD-10-PCS	Description (See current ICD-10-PCS book for complete descriptions)
0ST[2,4]0ZZ	Resection of vertebral disc
0RB[0,1,3,4,5,6,9,A,B][0,3,4]ZZ	Excision of spine joint cervical/cervico-thoracic/thoracic (links to other operations of spinal canal)
0SB[0,2,3,4,5,6,7,8][0,3,4]ZZ	Excision of spine joint lumbar (links to other operations of spinal canal)
00J[U,V][0,3,4]ZZ	Other exploration of spinal canal
00N[W,X,Y][0,3,4,]ZZ	Other decompression of spinal cord
0PU[0,3,4][0,3,4][7,J,K]Z	Bone grafting options
00N[W,X,Y][0,3,4]ZZ	Release of spinal cord
0RP[3,5,9,B][0,3,4]JZ	Removal of synthetic substitute cervical/cervico-thoracic/thoracic
0SP[2,4][0,3,4]JZ	Removal of synthetic substitute lumbar
0PU[3,4]3[7,J,K]Z OR 0QU03[7JK]Z	Percutaneous vertebral augmentation
0PS43ZZ	Reposition thoracic vertebra, percutaneous approach
0QS03ZZ	Reposition lumbar vertebra, percutaneous approach
0QS13ZZ	Repostition sacrum, percutaneous approach
BR0[0,1,2,3,4,5,6,7,8,9,B,D,F,G][0,1,Y,Z]ZZ	Radiography of the spine
BR1[0,1,2,3,4,5,6,7,8,9,B,D,F,G][0,1,Y,Z]ZZ	Fluoroscopy of the spine
0RR[3,5,9,B]0JZ	Replacement of artificial disc cervical/cervico-thoracic/thoracic
0RW[3,5,9,B][0,3,4]JZ	Revision of artificial disc cervical/cervico-thoracic/thoracic
0SR[2,4]0JZ	Replacement of artificial disc lumbar
0SW[2,4][0,3,4]JZ	Revision of artificial disc lumbar

Diagnosis Codes

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes entered on hospital and physician claims are important in conveying information about the patient's condition to payers. All healthcare providers must report the principal diagnosis using the appropriate ICD-10-CM code, as well as any secondary diagnoses. Payers use this information to evaluate the medical necessity for the episode of care and the appropriateness of the treatment the patient received.

Diagnosis codes should be reported to the highest level of specificity available – a code is invalid if it has not been coded to the full number of digits required for that code.

The table below includes examples only of ICD-10-CM diagnosis codes associated with spine conditions:

ICD-10-CM	Description (See current ICD-10-CM Diagnosis book for complete descriptions)
M40.0-M40.299	Kyphosis
M41.00-M41.27	Idiopathic Scoliosis
M43.00-M43.09	Spondylolysis
M43.10-M43.19	Spondylolisthesis
M46.40-M46.49	Discitis
M47.011-M47.029	Spinal Artery Compression Syndromes
M47.10-M47.899	Spondylosis
M48.00-M48.08	Spinal Stenosis
M48.50XA-M48.58XS	Collapsed Vertebra
M50.00-M50.92	Cervical Disc Disorders
M51.04-M51.87	Intervertebral Disc Disorders
M54.10-M54.18	Radiculopathy
M54.30-M54.32	Sciatica
M54.40-M54.9	Low Back Pain
M80.08XA-M80.08XS	Age-Related Osteoporosis of the Vertebrae
M84.58XA-M84.58XS	Pathological Fractures
M96.1	Post Laminectomy Syndrome
M99.20-M99.79	Spinal Stenosis
Q76.411-Q76.419	Congenital Kyphosis
S12.000A-S12.9XXS	Other Fractures of the Spine
S32.000A-S32.059S	Fractures of the Lumbar Vertebra
S34.101A-S34.109S	Unspecified Injury to Lumbar Spinal Cord
S34.111A-S34.132S	Spinal Cord Lesion

HCPCS Codes and Revenue Codes

Medicare uses HCPCS (C-codes) to track device cost information for future APC rate-setting purposes. No additional payment will be provided to the facility. All appropriate C-codes should be added to the hospital's chargemaster to report device costs used in the outpatient setting. CMS will return a hospital claim if the appropriate tracking code is not identified on the claim when a device-dependent procedure is performed. The tables below may be referenced when reporting various DePuy Synthes Spine products.

HCPCS Code	Description
A4649	Surgical Supply, Miscellaneous
C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable). Implantable pins and/or screws that are used to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone. Screws oppose tissues via drilling as follows: soft tissue-to-bone, tendon-to-bone, or bone-to-bone fixation. Pins are inserted or drilled into bone, principally with the intent to facilitate stabilization or oppose bone-to-bone. This may include orthopedic plates with accompanying washers and nuts. This category also applies to synthetic bone substitutes that may be used to fill bony void or gaps (i.e., bone substitute implanted into a bony defect created from trauma or surgery).
C1889	Implantable/insertable device, not otherwise classified
L8699	Prosthetic Implant, Not otherwise specified

Revenue codes allow hospitals to categorize services provided by revenue center for cost reporting. For Medicare, revenue codes must be included for each service on a CMS 1450 (UB-04) claim form. Sample revenue codes that hospital facilities may use to track costs for services associated with spine procedures are listed in the following table.

Revenue Code	Description
0270	Medical/Surgical Supplies
0271	Medical/Surgical Supplies: Non-sterile
0272	Medical/Surgical Supplies: Sterile
0278	Medical/Surgical Supplies: Other Implants

Modifiers

The modifiers outlined below may be used to report special circumstance during spine surgery. These include some of the most common modifiers used in conjunction with spine surgery and do not represent a full listing. Please refer to the most up to date version of the AMA CPT® Code book for a complete listing.

Modifiers	Description
22	**Increased Procedural Services:** When the work required to provide a service is substantially greater than typically required, it 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 (ie, 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.
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.
51	**Multiple Procedures:** When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, 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 or service code(s). Note: This modifier should not be appended to designated "add-on" codes (see Appendix D).
52	**Reduced Services:** Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. 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 cancelled 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 hospital outpatient use).
53	**Discontinued Procedure:** Under certain circumstances, the physician or other qualified health care professional 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 individual 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 outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled 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 hospital outpatient use).
58	**Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional 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 (eg, unanticipated clinical condition), see modifier 78.

Modifiers	Description
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: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.
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), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.
76	**Repeat Procedure or Service by the Same Physician or Other Healthcare Professional:** It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care 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.
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 health care 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.
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.)
79	**Unrelated Procedure or Service by the Same Physician During the Postoperative Period:** The individual 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.)
80	**Assistant Surgeon:** Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).
81	**Minimum Assistant Surgeon:** Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.
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).

Frequently Asked Questions for Stand-Alone Devices

What is a stand-alone device?

A stand-alone device is an interbody device/synthetic cage with integral anterior instrumentation for device anchoring. This device anchoring may consist of integrated screws or flanges that are used to anchor the device in place. DePuy Synthes Spine's stand-alone products include SYNFIX™ LR Spacer, ZERO-P™ VATM and the ZERO-P™ Spacer.

What CPT® code is used to report the implantation of stand-alone devices?

AMA CPT® released a series of CPT® codes, January 1, 2017 that are used to report the various surgical methods associated with interbody biomechanical devices 22853-22854. CPT® code 22853 is used to report the insertion of a stand-alone device following discectomy and CPT® code 22854 is used to report the insertion of a stand-alone device following corpectomy.

The full descriptions for both CPT® Codes are outlined below:

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) is the most appropriate CPT® code to report when a stand-alone device is implanted as it includes the integrated screws and flanges for device anchoring.

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)

Can CPT® anterior instrumentation be separately reported when a stand-alone device with integral anterior instrumentation is implanted?

No, the integral anterior instrumentation for device anchoring outlined in CPT® Code 22853 does not constitute anterior instrumentation as reported under CPT® code 22845-22847.

What constitutes the use of CPT® Code 22845 for "anterior instrumentation"?

An AMA CPT® Changes 2017 publication notes, "Anterior instrumentation of the spine is denoted by the ability of the instrumentation to stabilize the spinal segment(s) as a standalone device without the cage present, such as with anterior cervical plating or anterior rod system fixation. If the plate is "integrated", and only used with the cage to keep it in the disc space and not able to be used as a standalone device for biomechanical support such as in a fracture or deformity, then you would not report 22845 and just 22853 or 22854 only."

Are CPT® codes 22853 and 22854 for use when reporting the use of interbody fusion devices that do not have integral anterior instrumentation?

Yes, CPT® codes 22853 and 22854 can be used to report the use of biomechanical interbody fusion devices without integral instrumentation. The descriptors for CPT® codes 22853 and 22854 both include the term "when performed". Therefore, when integral anterior instrumentation is not performed CPT® code 22853 and 22854 may still be reported for the application of biomechanical interbody fusion devices without integral instrumentation. These types of biomechanical interbody fusion devices are used in conjunction with anterior or posterior instrumentation which may be reported separately.

What is appropriate coding when decompression (when medically necessary) is performed during TLIF?

AMA CPT has made some revisions to their language in 2022 for CPT codes 22633 and 22634. The language changes were made to provide consistency in the use of the term "interspace" instead of "level" or "segment".* These codes are only applicable when a combined interbody and posterolateral technique are used.

In addition, AMA CPT approved two new decompression codes (63052 and 63053) for use when performed with interbody arthrodesis. These CPT codes are add-on codes and the associated RVUs are 7.62 and 5.72 respectively. AMA CPT includes a parenthetical instruction that notes, "(use 63052, 63053 in conjunction with 22630, 22632, 22633, 22634)".

Frequently Asked Questions for ViviGen® Cellular Bone Matrix

Background Information: The first two questions are included in an effort to provide information regarding the product make up and processing. This information is needed to address payor coverage issues regarding the use of cell-based products.

What is ViviGen®?

ViviGen® Cellular Bone Matrix is a morselized allograft comprised of cryopreserved viable cortical cancellous bone matrix and demineralized bone. ViviGen® is processed from donated human tissue and is a Human Cells, Tissues, and Cellular and Tissue-based Product (HCT/P) as defined by the U.S. Food and Drug Administration in 21 CFR 1271.3(d).[i]

Does ViviGen® include stem cells?

No. During the processing of ViviGen, bone marrow and mesenchymal stem cells are removed and only the bone cells (osteoblasts, osteocytes and bone lining cells) remain.[ii]

What CPT® Code is used to report the use of ViviGen® in spine procedures?

AMA CPT® code 20930 is used to report the placement of ViviGen® in spine procedures only. Please see the full CPT® description below:

20930 – Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)

What is the HCPCS code to report the use of ViviGen®?

There is not an applicable HCPCS code available to report ViviGen®. ViviGen® is considered an implant and may be reported by the facility under Revenue code 278; other implants.

Do insurance companies cover ViviGen® in spine procedures?

Commercial: Coverage policies will differ between insurance companies. Whether or not an insurance covers the procedure is often listed under medical policies titled, "Bone Graft Substitutes," found via the "provider" resources section of their website. For additional coverage details, contact the patient's insurance plan directly.

Medicare: At this time, Medicare does not have a National Coverage Determination for ViviGen® when used in spine procedures. Medicare allows coverage and payment for services considered medically necessary and reasonable. Coverage is subject to standard medical necessity guidelines, which should be supported in the patient medical record. Please refer to your individual Medicare Administrative Contractors Local Coverage Determinations for additional information.

Do I need to obtain a prior authorization for ViviGen®?

Most insurance companies will require prior-authorization for spine procedures. Submission of a written prior authorization request is strongly recommended. This request should outline the primary surgical procedure as well as the products to be used, including the use of ViviGen®. Supporting clinical documentation should also be included. Please consult the commercial plan directly for additional prior authorization submission information.

What can I do if ViviGen® is not approved by the patient's insurance company?

If ViviGen® is denied by insurance a peer-to-peer review may be scheduled between the surgeon and an insurance medical reviewer to provide further explanation as to the benefits of ViviGen® in addition to responding to any questions or concerns regarding medical necessity. If the peer-to-peer review is unsuccessful, a written provider appeal may be submitted to the insurance company for review.

Please see the DePuy Synthes Spine Physician Prior-Authorization and Appeals Process Flow Chart provided separately. For additional questions or information contact DePuy Synthes Spine Reimbursement Support Services.

[i] ViviGen® MIS Cellular Bone Matrix and Delivery System Instructions for Use (63-0146-09)

[ii] ViviGen® Cellular Bone Matrix; DePuy Synthes Brochure (page 4) Data on File LifeNet Health 65-0347

Frequently Asked Questions for FIBERGRAFT™ Bioactive Bone Graft Substitutes

Background Information: The first two questions are included in an effort to provide information regarding the product make up and processing. This information is needed to address payor coverage issues.

What are FIBERGRAFT Bioactive Bone Graft Substitutes?

FIBERGRAFT products are ultraporous synthetic bone graft substitutes made from crystalline 45S5 bioactive glass. These products provide a bone void filler that resorbs and is replaced with bone during the healing process. FIBERGRAFT Bone Graft products are indicated to be gently packed into bony voids or gaps of the skeletal system from either surgically-created osseous defects or osseous defects created from traumatic injury to the bone (i.e posterolateral spine, extremities, and pelvis). **Please refer to instructions for use for full Indications and Contraindications.

What CPT® Code is used to report the use of FIBERGRAFT products in spine procedures?

AMA CPT® code 20930 is used to report the placement of FIBERGRAFT products in spine procedures only. Please see the full CPT® description below:

20930 – Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)

What is the HCPCS code to report the use of FIBERGRAFT products?

C1763: Connective tissue, non-human (includes synthetic). FIBERGRFT products are considered implants and may be reported by the facility under Revenue code 278; other implants.

Do insurance companies cover FIBERGRAFT products in spine procedures?

Commercial: Coverage policies will differ between insurance companies. Whether or not an insurance covers the procedure is often listed under medical policies titled, “Bone Graft Substitutes,” found via the “provider” resources section of their website. For additional coverage details, contact the patient’s insurance plan directly.

Medicare: At this time, Medicare does not have a National Coverage Determination for FIBERGRAFT products when used in spine procedures. Medicare allows coverage and payment for services considered medically necessary and reasonable. Coverage is subject to standard medical necessity guidelines, which should be supported in the patient medical record. Please refer to your individual Medicare Administrative Contractors Local Coverage Determinations for additional information.

Do I need to obtain a prior authorization for FIBERGRAFT products?

Most insurance companies will require prior-authorization for spine procedures. Submission of a written prior authorization request is strongly recommended. This request should outline the primary surgical procedure as well as the products to be used, including the use of FIBERGRAFT products. Supporting clinical documentation should also be included. Please consult the commercial plan directly for additional prior authorization submission information.

What can I do if FIBERGRAFT products are not approved by the patient's insurance company?

If FIBERGRAFT products are denied by insurance a peer to peer review may be scheduled between the surgeon and an insurance medical reviewer to provide further explanation as to the benefits of the product in addition to responding to any questions or concerns regarding medical necessity. If the peer to peer review is unsuccessful, a written provider appeal may be submitted to the insurance company for review.

Please see the DePuy Synthes Spine Physician Prior-Authorization and Appeals Process Flow Chart provided separately. For additional questions or information contact DePuy Synthes Spine Reimbursement Support Services.

Notes

Not all codes provided are applicable for the recommended uses of DePuy Synthes products. The most appropriate code for the patient's clinical presentation must be selected. All Current Procedural Terminology (CPT) five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines and other material are copyright 2021 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT®, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Sources

Calendar Year 2022 Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1753-F, Vol. 86, No. 218; November 16, 2021); Addendum B and Final ASC Addenda AA. Calendar Year CY 2022 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B (CMS-1751-F, Vol 86, No. 221; November 19, 2021); Addendum B. All MPFS Fee Schedules calculated using CF of $34.6062 effective January 2022. Medicare Inpatient Prospective Payment System Final Rule [CMS-1752-F], Federal Register (Vol. 86, Issue 154), Friday, August 13, 2021; Final: National Average DRG Payment. ICD-10 Procedural Coding System (ICD-10-PCS) is developed and maintained by the Centers for Medicare and Medicaid Services (CMS). No geographic adjustments have been made to the reported payment rates.

Status Indicator (SI) Definitions

J1 - Hospital Part B services paid through a Comprehensive APC. **N** - Items and Services Packaged into APC Rates. Paid under OPPS; payment is packaged into payment for other services. **Q1**- Packaged APC payment if billed on same date of service as a HCPCS assigned status indicator S, T, V or X; otherwise payment is made through a separate APC payment. **Q2** - Payment is packaged if billed on the same date of service as a HCPCS code assigned a status indicator "T"; otherwise payment is made through a separate APC payment.

Carriers priced code. Carriers/MACS will establish RVUs and payment amounts for these services, generally on an individual case-by-case basis following review of documentation such as an operative report.

Restricted coverage. Special coverage instructions apply.

Payment Indicator (PI) Definitions

A2 - Surgical procedure on ASC list in CY 2007, payment based on OPPS relative payment weight; **G2** - Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight; **J8** - Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate. **N1**- Packaged service/item; no separate payment made.

For additional questions or information contact

DePuy Synthes Reimbursement Support Services

800-410-8177 dpsreimbursementsupport@its.jnj.com

Please refer to the instructions for use for a complete list of indications, contraindications, warnings and precautions.

DePuy Synthes
THE ORTHOPAEDICS COMPANY OF Johnson & Johnson

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