



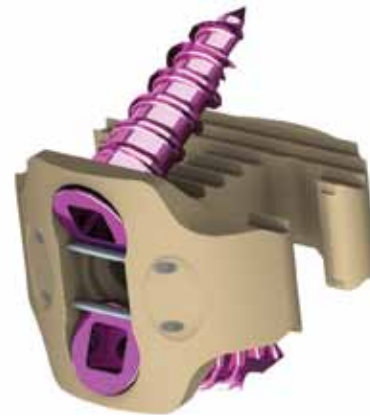
# PEEK PREVAIL<sup>®</sup>

Cervical Interbody Device

## Reimbursement Guide

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The PEEK PREVAIL<sup>®</sup> Cervical Interbody Device is indicated for anterior cervical interbody fusion procedures in skeletally mature patients with cervical disc disease at one level from the C2–C3 disc to the C7–T1 disc. Cervical disc disease is defined as intractable radiculopathy and/or myelopathy with herniated disc and/or osteophyte formation on posterior vertebral endplates producing symptomatic nerve root and/or spinal cord compression confirmed by radiographic studies. The PEEK PREVAIL<sup>®</sup> Cervical Interbody Device must be used with internal screw fixation provided by ZEPHIR<sup>®</sup> Anterior Cervical Screws. The PEEK PREVAIL<sup>®</sup> Cervical Interbody Device implants are to be used with autograft and implanted via an open, anterior approach. This cervical device is to be used in patients who have had six weeks of nonoperative treatment.



PEEK PREVAIL<sup>®</sup>  
Cervical Interbody Device

ZEPHIR<sup>®</sup> System incorporates technology developed by Gary K. Michelson, MD.



# Physician Coding/Reimbursement

Physicians use Current Procedural Terminology (CPT®) codes to report all of their services. These codes are uniformly accepted by all payers. Medicare and most indemnity insurers use a fee schedule to pay physicians for their professional services, assigning a payment amount to each CPT code. Under Medicare’s Resource-Based Relative Value Scale (RBRVS) methodology for physician payment, each CPT code is assigned a point value, known as the

relative value unit or RVU, which is then multiplied by a flat conversion factor to determine the physician payment. Many other payers use Medicare’s RBRVS fee schedule or a variation on it. Industrial or work-related injury cases are usually reimbursed according to the official fee schedule for each state.

Use of CPT codes is governed by various coding guidelines published by the American Medical Association (AMA) and other major sources such

as physician specialty societies. In addition, the National Correct Coding Initiative (NCCI), a set of CPT coding edits created and maintained by the Centers for Medicare and Medicaid Services (CMS), has become a national standard.

The following CPT codes may be appropriate for the performance of an anterior cervical discectomy and fusion (ACDF) using the PEEK PREVAIL® Cervical Interbody Device:

CPT Code	Description	RVUs	2010 Medicare Payment*
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, single interspace	36.04	\$1,300
22554-51	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	33.35	\$602**
22851	Application of intervertebral biomechanical device(s) (e.g., synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace	11.07	\$399
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision)	4.56	\$165

\*Calculated for 2010: RVU (no geographic adjustment) × Medicare Conversion Factor for 2010.

\*\*Multiple procedure reduction applies. Reimbursement is reduced by 50% when reported with a primary procedure.

Check bundling edits before applying and submitting codes for payment.

Source: FY 2010 Medicare Physician Fee Schedule, Final Rule. Federal Register, November 25, 2009.

Department of Defense Appropriations Act of 2010

## Coding of Anterior Instrumentation

There is some controversy over the coding for combination devices such as the PEEK PREVAIL® Cervical Interbody Device. The North American Spine Society (NASS) specifically addressed these types of devices in a November/December 2007 *SPINELINE* article, stating that “the term construct implies the use of an additional device placed on the spine to further enhance stability. An additional anterior instrumentation code (22845) is not included because there is not a separate construct placed across the vertebral segment.”

In addition, a September 1997 CPT Assistant article on coding for prosthetic devices states that, “if different (*emphasis added*) instrumentation is used in addition to the metal cages or methylmethacrylate through the same approach, then the appropriate instrumentation would be reported in addition to code 22851. However, 22851 and 22845 should not be reported if only the metal cage is inserted” (*emphasis added*).

# Facility Coding/Reimbursement

## Inpatient Reimbursement

Hospital payment for inpatient services/procedures is usually based on Diagnosis-Related Groups (DRGs), case rates, per diem rates or a line item payment methodology. Medicare uses the Medicare Severity-DRG (MS-DRG) payment methodology to reimburse hospitals for inpatient services. Each inpatient stay is assigned to one of 745 payment groups, based on the ICD-9-CM codes assigned to the major diagnoses and procedures. Each DRG group has a flat payment rate which bundles the reimbursement for all services the patient received during the inpatient

stay. Most insurers usually pay the hospital on a contractual basis (i.e., case rate or per diem rate) that has been negotiated between the hospital and insurance carrier.

### ICD-9-CM Procedure Codes

Hospitals use ICD-9-CM procedure codes to report inpatient services. The following ICD-9-CM codes may be appropriate for the performance of an anterior cervical discectomy and fusion (ACDF) using the PEEK PREVAIL® Cervical Interbody Device:

Code	Description
81.02	Other cervical fusion, anterior technique
80.51	Excision of intervertebral disc
81.62	Fusion or refusion of 2–3 vertebrae
84.51	Insertion of interbody spinal fusion device
77.79	Excision of other bone for graft, except facial bones

## Diagnosis-Related Groups (DRGs)

### Medicare Severity—Diagnosis Related Group (MS-DRG) Assignment

MS-DRG	Description*	MDC	Relative Weight	FY'10 Medicare Payment
028	Spinal Procedures with MCC	1	5.1090	\$28,878
029	Spinal Procedures with CC or Spinal Neurostimulator	1	2.7768	\$15,696
030	Spinal Procedures without CC/MCC	1	1.6019	\$9,055
453	Combined Anterior/Posterior Spinal Fusion with MCC	8	10.0108	\$56,585
454	Combined Anterior/Posterior Spinal Fusion with CC	8	6.9533	\$39,303
455	Combined Anterior/Posterior Spinal Fusion without CC/MCC	8	5.0197	\$28,373
471	Cervical Spinal Fusion with MCC	8	4.6182	\$26,104
472	Cervical Spinal Fusion with CC	8	2.7547	\$15,571
473	Cervical Spinal Fusion without CC/MCC	8	2.0033	\$11,323
907	Other O.R. Procedures for Injuries with MCC	21	3.0872	\$21,520
908	Other O.R. Procedures for Injuries with CC	21	1.8736	\$10,590
909	Other O.R. Procedures for Injuries without CC/MCC	21	1.1135	\$6,294
957	Other O.R. Procedures for Multiple Significant Trauma with MCC	24	6.2993	\$35,606
958	Other O.R. Procedures for Multiple Significant Trauma with CC	24	3.6544	\$20,656
959	Other O.R. Procedures for Multiple Significant Trauma without CC/MCC	24	2.2000	\$12,435

\* MCC – Major Complication and/or Comorbidity. CC – Complication and/or Comorbidity.

Assumes payment for a hospital with wage index and geographic adjustment factor of 1.000.

Source: FY 2010 Medicare Hospital Inpatient Prospective Payment System, Final Rule. Federal Register, August 27, 2009.

FY 2010 Updated Medicare Hospital Inpatient Prospective Payment System, Final Rule. Federal Register, October 5, 2009.

# Facility Coding/Reimbursement *continued*

## Outpatient Reimbursement

Hospitals use the Healthcare Common Procedure Coding System (HCPCS) to report outpatient services. Under Medicare's Ambulatory Payment Classifications (APCs) methodology for hospital outpatient payment, each HCPCS code is assigned to one of 879 payment classes. Each APC class has a relative weight which is multiplied by a flat conversion factor to determine the hospital payment. An APC and payment amount are assigned to each significant service.

Although some services are bundled and not separately payable, total payment to the hospital is the sum of the APC amounts for the services provided during the outpatient encounter.

Many payers use Medicare's APC methodology or a similar type of fee schedule to reimburse hospitals for outpatient services. Other payers use a percentage of charges mechanism, depending on their contract with the hospital.

Medicare does not cover instrumented spinal fusions in an outpatient setting. However, commercial payers may allow for the procedure to be performed in this setting. In these cases, hospitals will want to contact the payer and review their payer contracts to ensure that they provide adequate payment for this procedure in an outpatient setting.

HCPCS Code	Description	APC	Status Indicator	Relative Weight	CY'10 Medicare Payment
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace	0208	T	49.2256	\$3,318
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical	—	C	—	—
22851	Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace	0049	T	22.0149	\$1,484

Source: CY 2010 Medicare Hospital Outpatient Prospective Payment System, Final Rule. Federal Register, November 20, 2009.

### Status Indicators:

Each HCPCS code in the Hospital Outpatient Prospective Payment System (HOPPS) is assigned a status indicator to signify whether a discount (payment reduction) applies to the respective APC payment. The following two status indicators are represented in these procedures:

C Inpatient Procedure (Not paid under OPPS. Admit patient.)

T Significant Procedure, Multiple Procedure Reduction Applies

If a claim includes more than one HCPCS code with a status indicator of "T," full payment will be made for the highest paying procedure. All other services/procedures with a "T" status indicator will be discounted and paid at 50% of the amount allowed by Medicare.

# Coding and Reimbursement Assistance

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## SPINELINE®

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### Coding and Reimbursement Support

Provides coding, billing and reimbursement assistance for procedures performed using Medtronic products.

Phone: 877-690-5353

E-mail: (Physician) [spinalcodingmd@medtronic.com](mailto:spinalcodingmd@medtronic.com)  
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References: Coding Q&A, North American Spine Society, SpineLine, November/December 2007.  
How to Code Prosthetic Devices, American Medical Association, CPT Assistant, September 1997.

*The materials and information cited here are for informational purposes only and are provided to assist in obtaining coverage and reimbursement for health care services. However, there can be no guarantee or assurances that it will not become outdated, without the notice of Medtronic, Inc., or that government or other payers may not differ with the guidance contained herein. The responsibility for coding correctly lies with the health care provider ultimately, and we urge you to consult with your coding advisors and payers to resolve any billing questions that you may have. All products should be used according to their labeling.*

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Notes

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