Functional Anaesthetic Discography™ (F.A.D.™) Procedure

Reimbursement Guide

The Functional Anaesthetic Discography™ (F.A.D.™) Procedure is a novel way to aid in diagnosing the source of low back pain using a minimally invasive approach. The DISCYPHOR Direct™ Catheter System, used to perform the F.A.D.™ procedure, provides unique insight into the source of low back pain by combining a functional and anesthetic assessment of the intervertebral discs.

Physician Reimbursement

Physicians use Current Procedural Terminology (CPT®) codes to report all of their services. These codes are uniformly accepted by all payers. The following codes may be appropriate for the performance of a Functional Anaesthetic Discography™ procedure using the DISCYPHOR Direct™ Catheter System:

Code	Description	RVU*	Payment*
64999	Unlisted procedure, nervous system *(for the F.A.D.™ injection and evaluation)*	0.00	Payer Determination
77003-26	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction	0.79	$29

*Source: CY2010 Medicare Physician Fee Schedule. Federal Register, November 25, 2009. No geographic adjustment
Payment determined using the conversion factor cited in the Department of Defense Appropriations Act of 2010.

Coding Guidance:

As the F.A.D.™ procedure is not truly discography as defined by CPT (visualization and reporting of the disc morphology), the reporting of CPT codes 62290/62291 and 72285/72295 is not appropriate.

» CPT code 77003 is intended to be reported per spinal region, not per level. *(CPT Assistant, June 2008)*

» CPT code 64999 should be reported one time, regardless of the number of levels assessed. *(CPT Assistant, June 2008)*

Facility Reimbursement

Facilities use CPT and Healthcare Common Procedure Coding System (HCPCS) codes to report outpatient services. Under Medicare's methodology for outpatient payment, an Ambulatory Payment Classification (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 percent of charges mechanism, depending on their contract with the hospital.

Code	Description	APC*	Status/Payment Indicators*	Payment*	ASC Payment*
64999	Unlisted procedure, nervous system	204	T	$172	Not Covered
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction	N/A	N/N1	Packaged	Packaged

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

Status/Payment Indicators:

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

N Items and services packaged into APC rates

N1 Packaged service/item; no separate payment made

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.

Functional Anaesthetic Discography™ Performed in Sequence with Provocative Discography

Physician Reimbursement

Code	Description	RVU*	Payment*
62290	Injection procedure for discography, each level; lumbar	4.56	$308
or 62291	Injection procedure for discography, each level; cervical or thoracic	4.38	$289
72295-26	Discography, lumbar, radiological supervision and interpretation	1.14	$41
or 72285-26	Discography, cervical or thoracic, radiological supervision and interpretation	1.59	$57
64999	Unlisted procedure, nervous system *(for the F.A.D.™ injection and evaluation)*	0.00	Payer Determination
77003-26,59	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction	0.79	$29

*Source: CY 2010 Medicare Physician Fee Schedule. Federal Register, November 25, 2009. No geographic adjustment.
Payment determined using the conversion factor cited in the Department of Defense Appropriations Act of 2010.

Coding Guidance:

- As the F.A.D.™ procedure is not truly discography as defined by CPT (visualization and reporting of the disc morphology), the reporting of CPT codes 62290/62291 and 72285/72295 is not appropriate.
- CPT code 77003 is intended to be reported per spinal region, not per level. *(CPT Assistant, June 2008)*
- CPT code 64999 should be reported one time, regardless of the number of levels assessed. *(CPT Assistant, June 2008)*

Facility Reimbursement

Code	Description	APC*	Status/Payment Indicators*	Payment*	ASC Payment*
62290 *or* 62291	Injection procedure for discography, each level; lumbar Injection procedure for discography, each level; cervical or thoracic	N/A N/A	N/N1 N/N1	Packaged Packaged	Packaged Packaged
72295 *or* 72285	Discography, lumbar, radiological supervision and interpretation Discography, cervical or thoracic, radiological supervision and interpretation	388 388	Q2/N1 Q2/N1	Packaged Packaged	Packaged Packaged
64999	Unlisted procedure, nervous system	204	T	$172	Not Covered
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction	N/A	N/N1	Packaged	Packaged

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

Status/Payment Indicators:

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

N Items and services packaged into APC rates

N1 Packaged service/item; no separate payment made

Q2 T-Packaged Codes (Paid under OPPS. Packaged APC payment if billed on the same date of service as an HCPCS code assigned status indicator "T.")

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.

SPINELINE®

Coding and Reimbursement Support

Provides coding, billing, and reimbursement assistance for procedures performed using Medtronic Sofamor Danek USA, Inc. products.

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For more information visit www.myspinetools.com

For additional coding information contact the SpineLine® Coding Support Line at (877) 690-5353.

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As with most interventional procedures, the Functional Anaesthetic Discography™ (F.A.D.™) Procedure has associated risks, including serious complications. For complete information regarding indications for use, contraindications, warnings, precautions, adverse events, and methods of use, please reference the devices' Instructions for Use.

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