

Reimbursement Guidelines

Direct Lateral Interbody Fusion (DLIF)

The Direct Lateral Instrument Set delivers minimally invasive transpoas access to the lumbar spine for surgeons who want to address degenerative, deformity and adjacent level pathologies. This set offers vertebral body stabilization pins, sequential dilators for muscle retraction and incorporates neuromonitoring to aid retractor placement.

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 RBRVS methodology for physician payment, each CPT code is assigned a point

value, known as the relative value unit (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 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 CMS, has become a national standard.

The following CPT codes may be appropriate for the performance of a direct lateral interbody fusion (DLIF):

CPT Code	Description	RVUs	2010 Medicare Payment
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	40.62	\$1,466

Additional codes that may also be appropriate:

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	52.20	\$1,884
22845	Anterior instrumentation; two to three vertebral segments	19.90	\$718
22851	Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace	11.07	\$399

- Calculated for 2010: RVU (no geographic adjustment) × Medicare Conversion Factor for 2010

- Check bundling edits before applying and submitting codes for payment

Source: FY2010 Medicare Physician Fee Schedule, Final Rule. Federal Register, November 25, 2009. Department of Defense Appropriations Act of 2010.

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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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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 (e.g., 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 a DLIF:

Code	Description
81.08	Lumbar and lumbosacral fusion, posterior technique Posterior (interbody) technique Posterolateral technique
80.51	Excision of intervertebral disc
80.99	Other excision of joint of other specified site (corpectomy)
84.51	Insertion of interbody spinal fusion device

Source: AHA Coding Clinic, 2nd Quarter 2009, page 3–6.

Additional codes that may also be appropriate:

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
456	Spinal fusion except cervical with spinal curvature/malignancy/ infection or 9+ fusions with MCC	8	8.7412	\$49,409
457	Spinal fusion except cervical with spinal curvature/malignancy/ infection or 9+ fusions with CC	8	5.9617	\$33,698
458	Spinal fusion except cervical with spinal curvature/malignancy/ infection or 9+ fusions without CC/MCC	8	4.8966	\$27,678
459	Spinal fusion except cervical with MCC	8	5.1506	\$34,766
460	Spinal fusion except cervical without MCC	8	3.7097	\$20,969
907	Other OR procedures for injuries with MCC	21	3.0872	\$21,520
908	Other OR procedures for injuries with CC	21	1.8736	\$10,590
909	Other OR procedures for injuries without CC/MCC	21	1.1135	\$6,294
957	Other OR procedures for multiple significant trauma with MCC	24	6.2993	\$35,606
958	Other OR procedures for multiple significant trauma with CC	24	3.6544	\$20,656
959	Other OR 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.

Outpatient Reimbursement

Facility Coding/Reimbursement *continued*

Hospitals use the Healthcare Common Procedure Coding System (HCPCS) to report outpatient services. Under Medicare's (APC) 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 percent of charges mechanism, depending on their contract with the hospital.

Medicare does not cover instrumented spinal fusions in the outpatient setting. However, commercial payers may allow 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 the outpatient setting.

HCPCS Code	Description	APC	Status Indicator	Relative Weight	CY'10 Medicare Payment
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	--	C	--	--
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	--	C	--	--
22845	Anterior instrumentation; two to three vertebral segments	--	C	--	--
22851	Application of intervertebral biomechanical device(s) (e.g., 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 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 OPSS. 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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Reference: Coding Q&A, North American Spine Society, SpineLine, July/August 2006.

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