

Reimbursement Update

JANUARY 2009

CMS Focuses on Quality of Care in FY 2009 Hospital Inpatient Prospective Payment System

The Centers for Medicare and Medicaid Services (CMS) published its fiscal year 2009 Hospital Inpatient Prospective Payment System (IPPS) Final Rule in the *Federal Register* on August 19, 2008. The rule completes the transition to cost-based weights started in FY 2007 and takes several actions that CMS believes will provide incentives for hospitals to improve the quality of care and reduce the number of preventable medical errors that result in serious consequences for the patient.

In last year's rule, CMS began taking steps to prevent Medicare from providing higher payments to hospitals for a list of conditions that have been determined to be reasonably preventable through proper care. The Deficit Reduction Act of 2005 (DRA) required CMS to begin selecting hospital-acquired conditions (HACs) that would not be paid at a higher rate unless they were present on admission. CMS added 3 new HACs for FY 2009:

- » Surgical site infections following certain elective procedures, including certain orthopedic surgeries, and bariatric surgery for obesity
- » Certain manifestations of poor control of blood sugar levels
- » Deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement procedures

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Physicians Eligible to Earn Pay Boost of Up to 5.1% for Calendar Year (CY) 2009

Physicians and other eligible professionals who adopt and use qualified electronic prescribing (e-prescribing) systems to transmit prescriptions to pharmacies may earn an incentive payment of 2% of their total Medicare allowed charges during 2009. This incentive is in addition to a 2% incentive payment for 2009 for physicians who successfully report measures under the Physician Quality Reporting Initiative (PQRI), and both incentives are in addition to the 1.1% fee schedule update required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Thus, a physician who successfully reports under both the e-prescribing and PQRI initiatives could receive up to a 5.1% pay boost for 2009.

On October 30, 2008, the CMS released its CY 2009 final rule for the Medicare Physician Fee Schedule (PFS) establishing payment rates and policy changes that will go into effect for services furnished on or after January 1, 2009. CMS expects total Medicare spending to the approximately 980,000 physicians and nonphysician practitioners billing under the 2009 PFS to be \$61.9 billion, up 4% over the \$59.5 billion projected for 2008.

Update for Physician Fees in CY 2009

CMS updates to the PFS are based on a statutory formula, including the Sustainable Growth Rate (SGR), that is intended to constrain the rapid growth in spending for physicians' services by setting a target rate of spending for a year, and then adjusting the update in

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- _____ Spine Service Line
- _____ Surgical Services

Physicians Eligible to Earn Pay Boost of Up to 5.1% for Calendar Year (CY) 2009 *continued*

subsequent years to keep actual spending over time in line with the target.

The final rule substitutes a positive 1.1% update, as required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) passed in July, for the 5.4% reduction that would have resulted from the application of the statutory formula. In addition, MIPPA required CMS to make a technical change in how a statutorily required budget-neutrality adjustment is applied. For CYs 2007 and 2008, CMS applied a separate budget-neutrality adjustment to the work RVUs, but MIPPA now requires that this adjustment be applied instead to the PFS conversion factor, resulting in the conversion factor being lowered from \$37.8975 in CY 2008 to \$36.0666 for CY 2009. Despite this lower conversion factor, the overall level of payments under the PFS remains the same because of the removal of the work RVU adjustment.

Results of Changes by Specialty (CY2009):

	Work & PE RVU Changes	CY 2009 Update	Combined Impact
Neurosurgery	-1%	1.1%	0%
Orthopedic Surgery	0%	1.1%	0%

Electronic Prescribing Incentive Program

CMS announced a new initiative for widespread physician adoption of electronic prescribing in an effort to eliminate medication errors from misread handwritten prescriptions and reduce Medicare beneficiary out-of-pocket costs as e-prescribing facilitates communication between prescribers and pharmacies on lower-cost generic alternatives.

To earn the 2% incentive payment for e-prescribing, physicians will need to have a qualified e-prescribing system and successfully report one of three codes for the e-prescribing measure when submitting claims for specified types of medical visits, indicating either that:

- » They did not prescribe any medications during the visit;
- » They used e-prescribing for any medications prescribed during the visit; or
- » They did not use e-prescribing for a prescription because the law prohibits electronic prescribing for the specific type of drug.

The e-prescribing incentive amount for reporting years 2009 and 2010 is 2%; for years 2011 and 2012 it is 1%; and for year 2013 the incentive amount is 0.5%. Starting in 2012, physicians will be subject to a payment differential if the physician is not a "successful electronic prescriber." Fee schedule amounts will be reduced by 1% in 2012, by 1.5% for 2013, and by 2% for 2014 and each subsequent year.

Physician Quality Reporting Initiative (PQRI)

The Tax Relief and Health Care Act (TRHCA) of 2006 authorized CMS, for the first time, to pay an incentive to eligible health care professionals who voluntarily report certain quality data to CMS as part of the PQRI program. Congress extended PQRI under the MIPPA, which continues the program indefinitely and increased the incentive that eligible professionals can receive for satisfactorily reporting data from 1.5% to 2% of their covered professional charges in 2009 and 2010.

CMS is adding 52 new quality measures, bringing the total number of measures to 153 from which eligible professionals can select from for 2009 PQRI. Six of these measures directly relate to spinal care services:

- » Back Pain: Initial Visit
- » Back Pain: Physical Exam
- » Back Pain: Advice for Normal Activities
- » Back Pain: Advice Against Bed Rest
- » Functional Outcome Assessment in Chiropractic Care
- » Radiology: Exposure Time Reported for Procedures Using Fluoroscopy

Four new measures groups were also created for 2009, bringing the total number of measures groups to seven. Measures groups aggregate several individual measures that address similar clinical conditions, allowing the professional to report on all the measures in a measures group for a specified number of patients in order to qualify for the incentive payment. The back pain measures listed above are only reportable as a measures group, not as individual measures.

To foster greater provider participation, CMS finalized multiple reporting periods and mechanisms for 2009. Providers can submit data through their normal claims billing process or through the registry-based quality data submission option during the periods of January 1 – December 31, 2009 or July 1 – December 31, 2009 (the 6-month reporting period only applies to providers submitting data for measures groups or those using a registry).

Changes in Enrollment and Billing Rules

The final rule establishes the effective date of billing for physicians and nonphysician practitioner as the later of: (1) the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2) the date an enrolled physician first started furnishing services at a new practice location. ■

FY 2009 Medicare Spine DRGs (using spinal instrumentation)

MS-DRG	Description	FY'05 (Relative Weight)	FY'06 (Relative Weight)	FY'07 (Relative Weight)	FY'08 (Relative Weight)	FY'09 (Relative Weight)	FY'05 - '09 Change
453	Combined Anterior/ Posterior Spinal Fusion w/ MCC	\$28,872 (5.8072)	\$31,393 (6.0932)	\$33,814 (6.3782)	\$45,670 (8.4313)	\$54,556 (9.8253)	\$25,684 (89%)
454	Combined Anterior/ Posterior Spinal Fusion w/ CC	\$28,872 (5.8072)	\$31,393 (6.0932)	\$33,814 (6.3782)	\$35,648 (6.581)	\$38,820 (6.9914)	\$9,948 (34%)
455	Combined Anterior/ Posterior Spinal Fusion w/o CC/MCC	\$28,872 (5.8072)	\$31,393 (6.0932)	\$33,814 (6.3782)	\$30,888 (5.7023)	\$28,582 (5.1476)	\$-290 (-1%)
456	Spinal Fusion except Cervical w/ Spinal Curvature, Malignancy or 9+ fusions w/ MCC	\$17,526 (3.5251)	\$26,141 (5.0739)	\$28,529 (5.3812)	\$36,655 (6.7669)	\$47,147 (8.4910)	\$29,621 (169%)
457	Spinal Fusion except Cervical w/ Spinal Curvature, Malignancy or 9+ fusions w/ CC	\$17,526 (3.5251)	\$26,141 (5.0739)	\$28,529 (5.3812)	\$29,602 (5.465)	\$31,349 (5.6459)	\$13,823 (79%)
458	Spinal Fusion except Cervical w/ Spinal Curvature, Malignancy or 9+ fusions w/o CC/MCC	\$13,189 (2.6527)	\$26,141 (5.0739)	\$28,529 (5.3812)	\$26,779 (4.9437)	\$25,965 (4.6762)	\$12,776 (97%)
459	Spinal Fusion except Cervical w/ MCC	\$17,526 (3.5251)	\$18,663 (3.6224)	\$20,248 (3.8192)	\$26,368 (4.8679)	\$33,086 (5.9587)	\$15,560 (89%)
460	Spinal Fusion except Cervical w/o MCC	\$13,189 (2.6527)	\$14,318 (2.7791)	\$15,849 (2.9896)	\$18,888 (3.4870)	\$19,771 (3.5607)	\$6,582 (50%)
471	Cervical Spinal Fusion w/ MCC	\$12,005 (2.4146)	\$12,723 (2.4695)	\$13,487 (2.5439)	\$18,809 (3.4723)	\$24,499 (4.4122)	\$12,494 (104%)
472	Cervical Spinal Fusion w/ CC	\$12,005 (2.4146)	\$12,723 (2.4695)	\$13,487 (2.5439)	\$13,444 (2.4819)	\$14,483 (2.6084)	\$2,478 (21%)
473	Cervical Spinal Fusion w/o CC/MCC	\$8,104 (1.6300)	\$8,649 (1.6788)	\$9,314 (1.7569)	\$10,533 (1.9446)	\$10,628 (1.9140)	\$2,524 (31%)
490	Back & Neck Procedures except Spinal Fusion w/ CC/MCC or disc device/neurostim	\$7,164 (1.4409)	\$7,126 (1.3831)	\$7,362 (1.3887)	\$8,077 (1.4912)	\$9,552 (1.7202)	\$2,388 (33%)
491	Back & Neck Procedures except Spinal Fusion w/o CC/MCC	\$4,691 (0.9436)	\$4,661 (0.9046)	\$4,890 (0.9223)	\$5,452 (1.0066)	\$5,210 (0.9383)	\$519 (11%)
Case-Mix Adjusted Annual Increase*		5.7%	6.7%	7.5 %	4.8%	5.8%	27.1%

Assumes payment for a hospital with a wage index and geographic adjustment factor of 1.000 and receiving the full update.

MCC – Major Complication and/or Comorbidity CC– Complication and/or Comorbidity

* Constant volume year-to-year

Other DRGs:

Vertebroplasty/Percutaneous Vertebral Augmentation (e.g., Kyphoplasty)

MS-DRG	Description	FY'05 (Relative Weight)	FY'06 (Relative Weight)	FY'07 (Relative Weight)	FY'08 (Relative Weight)	FY'09 (Relative Weight)	FY'05 - 09 Change
477	Biopsies of Musculoskeletal & Connective Tissue w/ MCC	\$9,430 (1.8966)	\$9,857 (1.9131)	\$9,937 (1.8744)	\$14,384 (2.6555)	\$18,189 (3.2781)	\$8,759 (92.9%)
478	Biopsies of Musculoskeletal & Connective Tissue w/ CC	\$9,430 (1.8966)	\$9,857 (1.9131)	\$9,937 (1.8744)	\$10,745 (1.9836)	\$11,777 (2.1226)	\$2,347 (24.9%)
479	Biopsies of Musculoskeletal & Connective Tissue w/o CC/MCC	\$9,430 (1.8966)	\$9,857 (1.9131)	\$9,937 (1.8744)	\$9,091 (1.6784)	\$8,180 (1.4742)	-\$1,250 (-13.3%)
515	Other Musculoskeletal System & Connective Tissue O.R. Procedure w/ MCC	\$9,716 (1.9542)	\$9,884 (1.9184)	\$10,090 (1.9033)	\$13,465 (2.4858)	\$17,017 (3.0669)	\$7,301 (75.1%)
516	Other Musculoskeletal System & Connective Tissue O.R. Procedure w/ CC	\$9,716 (1.9542)	\$9,884 (1.9184)	\$10,090 (1.9033)	\$9,916 (1.8307)	\$10,033 (1.8083)	\$317 (3.3%)
517	Other Musculoskeletal System & Connective Tissue O.R. Procedure w/o CC/MCC	\$5,789 (1.1643)	\$6,295 (1.2219)	\$6,661 (1.2565)	\$7,687 (1.4192)	\$7,376 (1.3293)	\$1,587 (27.4%)

Spinal Procedures with a Neurologic Diagnosis (MDC 1)

MS-DRG	Description	FY'05 (Relative Weight)	FY'06 (Relative Weight)	FY'07 (Relative Weight)	FY'08 (Relative Weight)	FY'09 (Relative Weight)	FY'05 - 09 Change
28	Spinal Procedures with MCC	\$15,403 (3.098)	\$16,115 (3.1279)	\$16,524 (3.1169)	\$22,934 (4.2339)	\$28,828 (5.1919)	\$13,425 (87%)
29	Spinal Procedures with CC or Spinal Neurostimulators	\$15,403 (3.098)	\$16,115 (3.1279)	\$16,524 (3.1169)	\$15,360 (2.8356)	\$15,516 (2.7943)	\$113 (1%)
30	Spinal Procedures without CC/MCC	\$7,297 (1.4676)	\$7,313 (1.4195)	\$7,728 (1.4577)	\$9,543 (1.7617)	\$8,543 (1.5385)	\$1,246 (17%)

Acute Tibia Fractures

MS-DRG	Description	FY'05 (Relative Weight)	FY'06 (Relative Weight)	FY'07 (Relative Weight)	FY'08 (Relative Weight)	FY'09 (Relative Weight)	FY'05 - 09 Change
492	Lower Extremity and Humerus Procedures except Hip, Foot, Femur w/ MCC	\$7,837 (1.5762)	\$8,577 (1.6648)	\$9,041 (1.7053)	\$12,141 (2.2413)	\$15,347 (2.7639)	\$7,510 (96%)
493	Lower Extremity and Humerus Procedures except Hip, Foot, Femur w/ CC	\$7,837 (1.5762)	\$8,577 (1.6648)	\$9,041 (1.7053)	\$9,309 (1.7186)	\$9,784 (1.7620)	\$1,947 (25%)
494	Lower Extremity and Humerus Procedures except Hip, Foot, Femur w/o CC/MCC	\$5,067 (1.0191)	\$5,380 (1.0443)	\$5,849 (1.1033)	\$6,907 (1.2752)	\$6,859 (1.2353)	\$1,792 (35%)

Assumes payment for a hospital with a wage index and geographic adjustment factor of 1.000 and receiving the full update.

MCC – Major Complication and/or Comorbidity CC- Complication and/or Comorbidity

CMS Publishes New ICD-9-CM Procedure Codes and Revisions for Spinal Procedures

CMS (Centers for Medicare and Medicaid Services) announced the creation of two new spinal procedure codes effective October 1, 2008. These new procedure codes were developed to report repair of the annulus fibrosus. These codes include:

- » Annular disc repair
- » Microsurgical suture repair with or without fascial autograft
- » Surgical mesh repair
- » Percutaneous repair of the annulus fibrosus
- » Closure(sealing) of the annulus fibrosus defect

The new codes for FY 2009 are as follows:

80.53	Repair of the annulus fibrosus with graft or prosthesis
80.54	Other and unspecified repair of the annulus fibrosus

The codes will most commonly group to MS-DRG 490 or 491.

CMS also revised the nomenclature for codes 81.65 and 81.66 which were vertebroplasty and kyphoplasty, respectively. The term "percutaneous" was added to the vertebroplasty code and the nomenclature for code 81.66 was changed to reflect the technical procedure. These revisions do not have an impact on the MS-DRG assignment.

81.65	Percutaneous vertebroplasty
81.66	Percutaneous vertebral augmentation

For more information, please contact Medtronic's coding and reimbursement support line, SpineLine®, at 1-877-690-5353. ■



Final Rule is Released for Medicare's Outpatient Prospective Payment System

Medicare outpatient payments include a 3.6% annual inflation update for calendar year (CY) 2009 based on the Outpatient Prospective Payment System (OPPS) Final Rule published in the *Federal Register* on November 18, 2008. This update will result in hospitals receiving a 3.9% payment increase to a total of \$30.1 billion in CY 2009 for outpatient services furnished to Medicare beneficiaries. The changes become effective for services furnished on or after January 1, 2009.

The Centers for Medicare and Medicaid Services (CMS) continues to reiterate its commitment to implementing Value Based Purchasing (VBP) initiatives across the continuum of beneficiary care, transforming Medicare from a passive payer to a prudent purchaser of health care. Pay is based on quality of care, not just quantity of services, and is intended to give hospitals greater flexibility in managing their resources and improving efficiency.

Specifically, the rule includes an expansion of CMS' efforts to measure and reward quality through the adoption of 4 new quality measures, increasing from 7 measures in CY 2008 to 11 measures in CY 2009. The four new measures focus on imaging efficiency:

- » MRI lumbar spine for low back pain
- » Mammography follow-up rates
- » Abdomen CT – use of contrast material
- » Thorax CT – use of contrast material

Starting in CY 2009, CMS will reduce the hospital's update factor by 2% for hospitals that fail to report their quality metric data as required by the Hospital Outpatient Quality Data Reporting Program (HOP QDRP).

CMS is also changing how it pays for imaging services when two or more imaging procedures from an imaging family are provided in one session to encourage greater imaging efficiency. To do this, CMS created 5 imaging composite Ambulatory Payment Classifications (APCs) that will be paid when the same imaging modality is used to complete the imaging procedures.

- » Ultrasound procedures
- » Computed tomography (CT) and computed tomography angiography (CTA) without contrast
- » CT and CTA with contrast
- » Magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) without contrast
- » MRI and MRA with contrast

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Final Rule is Released for Medicare's Outpatient Prospective Payment System *continued*

Interspinous Process Devices

CMS finalized its proposal to discontinue the pass-through payment status for C1821 (Interspinous process distraction device, implantable). In accordance with policy, the cost of the device is then packaged into the costs of the procedure in which the device was billed. Therefore, CMS is reassigning interspinous process device cases to an APC (0052) that pays \$3,746 more than the APC to which it was previously assigned (0050).

Many of the associated procedures that utilize Medtronic's Spinal and Biologics' products are on Medicare's "Inpatient List," meaning Medicare will reimburse for the procedure only if it is performed in the inpatient setting.

The codes for posterior and posterolateral fusions (22612 & 22614) were removed from the Inpatient List in CY 2003, allowing them to be performed in the outpatient setting. In addition, CMS removed code 22851 from the inpatient list for CY 2007. However, the interbody fusion codes, the instrumentation codes (2284X) and the bone graft codes (2093X) commonly reported with fusion procedures remain on the inpatient list, meaning that Medicare will only cover and pay for the procedures when performed in the inpatient setting.

The chart below details the procedures utilizing spinal technologies that are allowed in the outpatient setting by Medicare. ■

Code	Description	APC	2009 Payment	\$ Change	% Change
Interspinous Process Devices					
0171T	Insertion of posterior spinous process distraction device	0052	\$5,720	NA	NA
0172T	each additional level	0052	\$2,860	NA	NA
C1821	Interspinous implant	1821	Pass-through Expired	NA	NA
Percutaneous Vertebroplasty					
22520	thoracic	0050	\$1,974	\$115	6.2%
22521	lumbar	0050	\$1,974	\$115	6.2%
22522	each additional level	0050	\$987	\$57	6.2%
72291	Fluoroscopic guidance	NA	\$0 (bundled)	\$0	0%
72292	CT guidance	NA	\$0 (bundled)	\$0	0%
Percutaneous Vertebral Augmentation (e.g., Kyphoplasty)					
22523	thoracic	0052	\$5,720	\$662	13.1%
22524	lumbar	0052	\$5,720	\$662	13.1%
22525	each additional level	0052	\$2,860	\$331	13.1%
72291	Fluoroscopic guidance	NA	\$0 (bundled)	\$0	0%
72292	CT guidance	NA	\$0 (bundled)	\$0	0%
Posterior Lumbar Fusions					
22612	Fusion, posterior or posterolateral, lumbar	0208	\$3,211	\$232	7.8%
22614	Fusion, posterior or posterolateral, ea addtl segment	0208	\$1,605	\$116	7.8%
Intervertebral Biomechanical Device					
22851	Application of intervertebral biomechanical device	0049	\$1,439	\$84	6.2%
Unlisted Procedure, Spine					
22899	Unlisted procedure, spine	0049	\$1,439	\$84	6.2%

HCPCS Codes for Spinal Devices

The Healthcare Common Procedure Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS.

Level I of the HCPCS is comprised of Current Procedural Terminology (CPT) codes, a numeric coding system maintained by the American Medical Association (AMA). CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level I of the HCPCS, the CPT codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established for submitting claims for these items.

C Codes

C codes (a series of codes within level II of the HCPCS) report drugs, biologicals, and devices eligible for transitional pass-through payments for hospitals, and for items classified in new-technology Ambulatory Payment Classifications (APCs) under the Medicare Outpatient Prospective Payment System (OPPS). Hospitals are required to report applicable HCPCS codes, including C codes, for these items used in conjunction with outpatient procedures when billing APCs to Medicare.

The pass through payment for C-code C1821 Interspinous implant expires January 1, 2009. For more information, refer to the OPPS article in this publication.

Applicability to Spinal Devices

There are HCPCS level II codes that arguably describe some of Medtronic's spine technologies. However, the technologies' indication and application in instrumented spine fusions precludes the assignment of a level II HCPCS code to these products.

- » HCPCS level II codes report devices and other items used in conjunction with outpatient procedures billed and paid for under Medicare's OPPS (outpatient procedures only).
- » All spinal fusions and arthroplasty, with the exception of a posterior or posterolateral lumbar fusion (CPT codes 22612/22614), are on Medicare's "Inpatient List," meaning that Medicare will not cover and pay for these procedures in any other setting than the inpatient setting.

- » While Medicare does allow posterior or posterolateral lumbar fusions in the outpatient setting, the add-on CPT codes that are billed with these procedures [posterior instrumentation (2284X) and bone grafts (2093X)] remain on Medicare's "Inpatient List" and thus will not be paid if performed in the outpatient setting.
- » Because instrumented spinal fusions are on Medicare's "Inpatient List" and HCPCS level II codes represent devices and other items used in conjunction with outpatient procedures, HCPCS level II codes do not exist for Medtronic's spinal devices (see OPPS article for information on the coding and payment for interspinous process devices).

INFUSE® Bone Graft

- » INFUSE® Bone Graft does not have a specific level II HCPCS code to describe its use. If an individually identifiable code is needed for billing by the facility, report HCPCS code L8699, Prosthetic implant, not otherwise specified. ■

Do You Have Coding and Reimbursement Questions Related to Spinal Products? SpineLine® Is Here to Help!

Medtronic's SpineLine® is not your typical support line – it is staffed with on-site certified coders that are experts in spinal coding and reimbursement. One simple phone call or email is all it takes to get the answers to your spinal coding and reimbursement questions. Medtronic's SpineLine® service provides hospital and physician coding, billing and reimbursement support for spinal procedures and services performed using Medtronic products. This service is complimentary and readily available.

SPINELINE®

Spine Coding and Reimbursement Support

1 (877) 690-5353

Spinalcodinghospital@medtronic.com
Spinalcodingmd@medtronic.com
www.medtronicspinal.com/spineline

Free Online Spinal Education + CEUs = The Spine Academy Learning SeriesSM

Medtronic recently changed the name of our popular web-based educational series to the Spine Academy Learning SeriesSM (formerly Live via WebEx). This new title better reflects the courses we provide. The name has changed but the convenience and quality has not. The Spine Academy offers complimentary spinal education sessions that are live and can be accessed online right from your computer. Our courses are as easy on your budget as they are your schedule. It is really easy to attend, all you need is:

- » An email address;
- » Access to the internet; and
- » A separate phone line.

The Spine Academy course offerings have been developed for a wide audience from hospital and practice administration to coding and billing staff. All courses are presented live with the opportunity to ask questions and interact with other participants.

Medtronic is also pleased to announce that our Spine Academy courses continue to allow you to receive free CEU credit while learning the details of complex spine coding. We have received prior approval from the American Academy of Professional Coders (AAPC) for Continuing Education Units (CEUs) for the following courses:

- » Basic Spine Coding for Physician Office Staff (1.5 CEUs)
- » Advanced Spine Coding for Physician Office Staff: Complex Case Analysis (1.5 CEUs)
- » Anatomy: Dissecting Spinal Procedures (2.0 CEUs)
- » Hospital Inpatient Coding: Spine Surgery Case Study Analysis (1.5 CEUs)

Official AAPC CEU certificates will be provided to those that register and attend the approved courses. To see our full course listing and to register (required for attendance and CEU credit) go to <http://www.medtronicspinal.com/spine/registration>.

Upcoming 2009 courses:

January 13	Spine Center Development
January 27	Basic Spine Coding for Physician Office Staff
February 10	Anatomy: Dissecting Spinal Procedures
February 17	Hospital Inpatient Coding: Spine Surgery Case Study Analysis
February 24	Reimbursement Strategies for the X-STOP® IPD® Procedure
March 10	Advanced Spine Coding for Physician Office Staff: Complex Case Analysis
March 17	Solving the Payer Puzzle: Evaluating and Negotiating Commercial Payer Reimbursement
March 24	(For Surgeons) Basic Spine Coding for Physicians Part 1: Coding Principals
March 26	(For Surgeons) Basic Spine Coding for Physicians Part 2: Case Examples
April 7	Inflate Your Kyphoplasty Reimbursement Knowledge: The Economics of Treating Vertebral Compression Fractures
April 14	Anatomy: Dissecting Spinal Procedures
April 21	Basic Spine Coding for Physician Office Staff
May 5	Spine Center Development
May 12	Solving the Payer Puzzle: Evaluating and Negotiating Commercial Payer Reimbursement
May 19	Hospital Inpatient Coding: Spine Surgery Case Study Analysis



Spinal Coding and Reimbursement Information is Right at Your Fingertips!

Do you want to find more information about spinal coding and reimbursement? Do you like to research questions before you ask for help? Well, Medtronic's coding and reimbursement Web site is the place for you! The SpineLine® Web site offers a variety of spinal coding and reimbursement resources for physicians, hospitals and payers right at your finger tips. The Web address is www.medtronicspinal.com/spineline.

In general, the site offers:

- » Reimbursement guides for technologies
- » Explanations of spinal procedures
- » Definitions of common spinal terms
- » An overview of spinal anatomy
- » Spine Academy Learning SeriesSM registration
- » Frequently asked questions

If you are a physician or work in a physician practice you can expect to find:

- » CPT code data sheets
- » Physician coding examples
- » Medicare CPT fee calculator
- » Documentation pocket guide for surgeons

If you are a hospital, you can expect to find information regarding:

- » Spinal DRGs and related procedures
- » Hospital coding examples
- » HCPCS codes
- » Complications and comorbidities



Patient Access: Medtronic's Therapy Access Solutions Group Continues Advocacy Efforts for Cervical Disc Reimbursement

What is TAS?

The FDA approval of the PRESTIGE® Cervical Disc on July 16, 2007, gave surgeons a new treatment option for patients suffering from single-level radiculopathy and/or myelopathy. Even with FDA approval and solid clinical data, it takes time for a new technology to be accepted and become standard of care. As part of Medtronic's focus on improving patient access to Medtronic therapies and technologies, Therapy Access Solutions (TAS) was formed to assist in navigating the prior authorization and denial processes with payers. Although prior authorization does not guarantee payment, it is an essential prerequisite.

How does TAS work?

Since the authorization process starts in the doctors' office, either the surgeon or the surgeon's office staff can contact Therapy Access Solutions at 1-866-446-3873 for information on authorization, or one of our case managers can actually conduct the prior authorization for cases involving on-label usage. They can assist in dealing with denials even if they were not involved with the prior authorization and can assist the hospital with the denial as well. TAS offers the following services:

- » **Coverage:** Determine patient benefits, assist with letters of medical necessity and documentation requirements
- » **Coding:** Educate physician or hospital staff on relevant codes
- » **Payment:** Assist with strategies to negotiate payment
- » **Appeals:** Provide assistance with denials

What about insurance coverage?

As of November 15, 2008, over 40 commercial insurance plans have published positive coverage policies for cervical arthroplasty and the PRESTIGE® Cervical Disc. Most recently, BCBS Highmark, BCBS of Florida and Premera have noted positive medical policies. Additionally, other plans have agreed to cover this procedure on a case-by-case basis. In total there are more than 65 plans representing approximately 110 million covered lives, which account for over half of the commercially covered lives. Call TAS to check on the coverage policy for a particular payer. ■

Therapy Access Solutions

Support for New Technology

1 (866) 446-3873 • FAX: (901) 399-3020

ASCs Enter 2nd Year of Transition to the ASC Prospective Payment System

Calendar year (CY) 2009 marks the second year of a 4-year transition to the Ambulatory Surgery Center (ASC) Prospective Payment System (PPS) that aligns ASC payment rates with the APC groups used to pay for services in hospital outpatient departments. The system expands beneficiary access to surgical procedures in ASCs and implements steps to make ASC payments more accurate, while aligning payments across Medicare's payment systems to encourage efficient and appropriate choices of outpatient settings for ambulatory surgical procedures.

The ASC PPS rule allows ASCs to be paid for any surgical procedure that CMS determines does not pose a significant safety risk to Medicare beneficiaries when performed in an ASC and that is not expected to require services exceeding 24 hours following admission. Because procedures performed in ASCs are generally less costly than those performed in the hospital outpatient department, the ASC payment rates are projected to be set at 65% of the OPPS rates for the corresponding procedures, phased in over a 4-year transition period.

Medicare will also make payment adjustments for those ASC procedures with high device costs which ensure that the ASC receives the same payment for an implantable device as when the procedure is performed in a hospital outpatient department. In other words, the device portion of the ASC payment will not be subject to the 65% payment rate, instead being paid at 100% of the corresponding OPPS payment for the device cost.

The final rule setting ASC payment rates, effective for services on or after January 1, 2009, is expected to result in payments of almost \$3.9 billion in CY 2009 to more than 5,100 ASCs that participate in Medicare. It also establishes new conditions of coverage for ASCs. CMS finalized a new definition of "ASC" and modified the conditions of coverage related to the governing body and management, quality assessment and performance improvement, laboratory and radiologic services, patients' rights, infection control, and patient admission, assessment, and discharge.

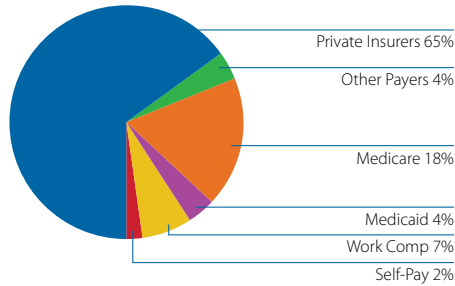
The list of procedures associated with Medtronic's Spinal and Biologics products, along with their respective ASC payment rates, is included in the next column.

Code	Description	APC	CY'08 ASC Payment	CY'09 ASC Payment
Percutaneous vertebroplasty				
22520	thoracic	0050	\$1,306	\$1,256
22521	lumbar	0050	\$1,306	\$1,256
22522	each additional level	0050	\$653	\$628
72291	Percutaneous vertebroplasty or kyphoplasty, fluoro guidance	NA	\$0 (bundled)	\$0 (bundled)
72292	Percutaneous vertebroplasty or kyphoplasty, CT guidance	NA	\$0 (bundled)	\$0 (bundled)
Percutaneous vertebral augmentation (e.g., kyphoplasty)				
22523	thoracic	0052	\$3,288	\$3,495
22524	lumbar	0052	\$3,288	\$3,495
22525	each additional level	0052	\$1,644	\$1,748
72291	Percutaneous vertebroplasty or kyphoplasty, fluoro guidance	NA	\$0 (bundled)	\$0 (bundled)
72292	Percutaneous vertebroplasty or kyphoplasty, CT guidance	NA	\$0 (bundled)	\$0 (bundled)

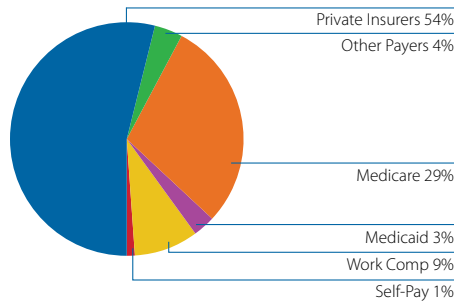
Payer Mix Information

You know the overall payer mix for your hospital, but many times the payer mix for specific services can be vastly different. Here are a few of the national payer mixes for procedures commonly performed using Medtronic's Spinal and Biologics technologies.

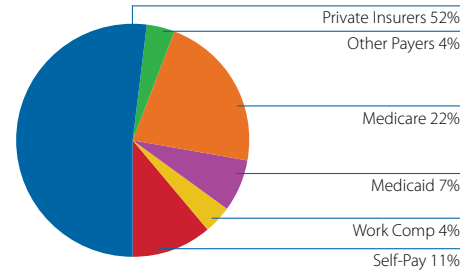
Cervical Fusions



Lumbar Fusions

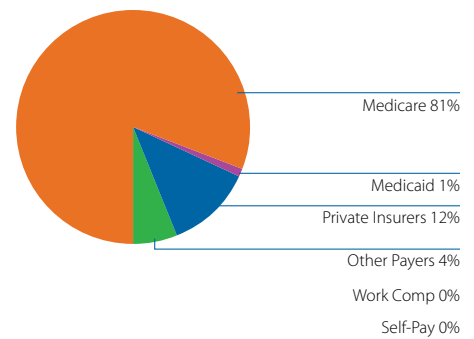


Open Reduction with Internal Fixation of Tibia/Fibula Fractures



Source: SDI. National Patient Profile 2002-2006.

Percutaneous Vertebral Augmentation (e.g., Kyphoplasty)



Source: SDI. National Patient Profile 2005-2006.

CMS Focuses on Quality of Care *continued*

Hospitals are also required to report quality measures on their claims for Medicare inpatient services to qualify for a full update to their payment rates under the Reporting Hospital Quality Data for Annual Payment Update Program (RHQDAPU). If a hospital fails to successfully report the quality measures adopted under the program, Medicare law requires CMS to reduce the hospital's payments by 2%. For FY 2009, CMS has adopted 13 new measures and deleted one to bring the total number of measures for reporting to 42.

In addition, CMS took steps to address charge compression within the inpatient system. Charge compression occurs when hospitals apply different mark-up rates to supplies and devices, many times causing high cost items to be undervalued in the payment system and thus leads to inaccurate payment rates for these technologies. To help correct this, CMS finalized the creation of a new cost center for implanted medical devices on the hospital cost report. This will allow hospitals to improve the reporting of their cost data and

provide CMS will more accurate information on which to base their payment rates, though the impact is not expected to be seen until 2013.

The standardized payment amounts for FY 2009 include a 3.6% inflation update for hospitals reporting quality data, a -0.9% coding and documentation adjustment to account for the hospital incentive under the new MS-DRG system to increase aggregate payments through better coding and documentation, and annual budget neutrality factors. Payment rates to the more than 3,500 acute care hospitals will thus increase by nearly \$4.75 billion for FY 2009.

Spine fusion and dynamic stabilization DRGs are projected to experience a 5.8% increase, which is greater than the market-basket increase set aside by Medicare. The tables on page 3 and 4 provide synopses and 5-year trend data for the MS-DRGs associated with Medtronic's Spinal and Biologics products. ■

New CPT Codes Implemented for Spinal Procedures

The American Medical Association (AMA) recently published the new CPT codes effective January 1, 2009. Six new codes were created for spinal procedures.

Cervical arthroplasty received 3 new Category I CPT codes to report the initial insertion (22856), revision/replacement (22861) and removal of the artificial disc (22864). The new initial arthroplasty code is all-inclusive, so a decompressive discectomy code would not be reported separately. The codes to report cervical arthroplasty on additional levels remain category III codes.

A new code was also created for the percutaneous aspiration within the nucleus pulposus, disc or paravertebral tissue (62267). This code should only be used for diagnostic purposes and is typically performed when an infection is suspected.

Lastly, two new Category III codes were developed for pre-sacral arthrodesis. This procedure is commonly known as AxiaLIF by Trans1.

For more information, please contact Medtronic's coding and reimbursement support line, SpineLine®, at 1-877-690-5353. ■

Code	Description	RVU*	Medicare FY09 Reimbursement**
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical	43.15	\$1,556
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	52.24	\$1,884
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	48.51	\$1,750
62267	Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes	6.61	\$238
0195T	Arthrodesis, pre-sacral interbody technique, including instrumentation, imaging (when performed), and discectomy to prepare the interspace, lumbar; single interspace	0.00	Carrier determines
0196T	each additional interspace (List separately in addition to code for primary procedure)	0.00	Carrier determines

*RVUs published in the Medicare Physician Fee Schedule. Federal Register, November 19, 2008

**Calculated for 2009: RVU (no geographic adjustment) x conversion factor



www.sofamordanek.com

Medtronic
Spinal and Biologics Business
Worldwide Headquarters

2600 Sofamor Danek Drive
Memphis, TN 38132

1800 Pyramid Place
Memphis, TN 38132

(901) 396-3133
(800) 876-3133
Customer Service: (800) 933-2635

For more information go to
www.myspinetools.com

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