

INTREPID™ Spinal System

Reimbursement Guide



The INTREPID™ Spinal System is indicated for use with autogenous bone graft in patients with degenerative disc disease (DDD) at one or two contiguous levels from L2 to S1. These DDD patients may also have up to Grade I spondylolisthesis or retrolisthesis at the involved levels. DDD is defined as discogenic back pain with degeneration of the disc confirmed by history and radiographic studies. These patients should be skeletally mature and have had six months of nonoperative treatment. These implants may be implanted via a laparoscopic or an open anterior approach. The INTREPID™ Spinal System device is intended to be used with the three titanium alloy screws that accompany the implant. If the physician chooses to use fewer than three, or none of the provided screws, then additional supplemental fixation, which has been cleared by the FDA for use in the lumbar spine, must be used to augment stability.

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 lumbar interbody fusion (ALIF) using the INTREPID™ Spinal System:

CPT Code	Description	RVUs	2008 Medicare Payment
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	38.86	\$1,374
22851	Application of intervertebral biomechanical device(s) (e.g., synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace	11.14	\$394
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or facial incision)	4.59	\$162
<i>Codes that may be appropriate for additional levels:</i>			
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)	9.20	\$325
22851-59	Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace	11.14	\$394

Calculated for 2008: Budget Neutrality Adjusted RVU (no geographic adjustment) × \$38.0870 (Medicare Conversion Factor for 1st half 2008)

Check bundling edits before applying and submitting codes for payment.

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Coding of Anterior Instrumentation

There is some controversy over the coding for combination devices such as the INTREPID™ Spinal System. 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 lumbar interbody fusion (ALIF) using the INTREPID™ Spinal System:

Code	Description
81.06	Lumbar and lumbosacral 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'08 Medicare Payment
028	Spinal Procedures with MCC	1	4.2339	\$22,934
029	Spinal Procedures with CC or Spinal Neurostimulator	1	2.8356	\$15,360
030	Spinal Procedures without CC/MCC	1	1.7617	\$9,543
453	Combined Anterior/Posterior Spinal Fusion with MCC	8	8.4313	\$45,670
454	Combined Anterior/Posterior Spinal Fusion with CC	8	6.5810	\$35,648
455	Combined Anterior/Posterior Spinal Fusion without CC/MCC	8	5.7023	\$30,888
456	Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/Infection or 9+ Fusions with MCC	8	6.7669	\$36,655
457	Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/Infection or 9+ Fusions with CC	8	5.4650	\$29,603
458	Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/Infection or 9+ Fusions without CC/MCC	8	4.9437	\$26,779
459	Spinal Fusion Except Cervical with MCC	8	4.8679	\$26,368
460	Spinal Fusion Except Cervical without MCC	8	3.4870	\$18,888
907	Other O.R. Procedures for Injuries with MCC	21	3.1030	\$16,808
908	Other O.R. Procedures for Injuries with CC	21	2.1865	\$11,844
909	Other O.R. Procedures for Injuries without CC/MCC	21	1.4112	\$7,644
957	Other O.R. Procedures for Multiple Significant Trauma with MCC	24	5.7960	\$31,395
958	Other O.R. Procedures for Multiple Significant Trauma with CC	24	4.4786	\$24,259
959	Other O.R. Procedures for Multiple Significant Trauma without CC/MCC	24	3.6988	\$20,035

* 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 2008 Medicare Hospital Inpatient Prospective Payment System, Final Rule. Federal Register, August 22, 2007. Updated rates published in the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates. Federal Register, November 27, 2007.

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.

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HCPCS Code	Description	APC	Status Indicator	Relative Weight	CY'08 Medicare Payment
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	—	C	—	—
22851	Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace	0049	T	21.2689	\$1,355
<i>Codes that may be appropriate for additional levels:</i>					
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)	—	C	—	—
22851-59	Application of intervertebral biomechanical device(s) (e.g., synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace	0049	T	21.2689	\$1,355

Source: CY 2008 Medicare Hospital Outpatient Prospective Payment System, Final Rule. Federal Register, November 27, 2007.

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

SPINELINE®

Spine Coding and Reimbursement Support

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

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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.

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