Oblique Lateral Interbody Fusion

The Oblique Lateral Interbody Fusion (OLIF) procedure allows for minimally invasive retroperitoneal access to the lumbar spine for surgeons who want to address degenerative pathologies.

**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 conversion factor to determine the physician payment. Many other payers use Medicare’s RBRVS fee schedule or a variation on it.

Industrial or workrelated 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 code may be appropriate for the performance of an OLIF:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>RVUs</th>
<th>2018 Medicare Payment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>22558</td>
<td>Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar</td>
<td>44.54</td>
<td>$1,603.42</td>
</tr>
<tr>
<td>+22585</td>
<td>Each additional interspace (List separately in addition to the code for primary procedure).</td>
<td>9.58</td>
<td>$344.88</td>
</tr>
</tbody>
</table>

*Check bundling edits before applying and submitting codes for payment

FACILITY 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 payment group, based on the ICD-10-PCS codes assigned to the major diagnoses and procedures. Each DRG 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-10-PCS Procedure Codes

Hospitals use ICD-10-PCS procedure codes to report inpatient services. In ICD-10-PCS insertion of interbody devices is included in the 6th character device value of the primary procedure code, and not coded separately. The following ICD-10-PCS codes may be appropriate for the performance of a OLIF with an interbody fusion device:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0SG00A0</td>
<td>Fusion of Lumbar Vertebral Joint with Interbody Fusion Device, Anterior Approach, Anterior Column, Open Approach</td>
</tr>
<tr>
<td>0SG10A0</td>
<td>Fusion of 2 or more Lumbar Vertebral Joints with Interbody Fusion Device, Anterior Approach, Anterior Column, Open Approach</td>
</tr>
<tr>
<td>0SG30A0</td>
<td>Fusion of Lumbosacral Vertebral Joint with Interbody Fusion Device, Anterior Approach, Anterior Column, Open Approach</td>
</tr>
</tbody>
</table>

Diagnosis-Related Groups (DRGs)

FY2018 Medicare Severity—Diagnosis Related Group (MS-DRG) Assignment

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Description</th>
<th>MDC</th>
<th>Relative Weight*</th>
<th>Payment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>028</td>
<td>Spinal procedures with MCC</td>
<td>01</td>
<td>5.5586</td>
<td>$33,498.79</td>
</tr>
<tr>
<td>029</td>
<td>Spinal procedures with CC or spinal neurostimulator</td>
<td>01</td>
<td>3.2737</td>
<td>$19,728.89</td>
</tr>
<tr>
<td>030</td>
<td>Spinal procedures without CC/MCC</td>
<td>01</td>
<td>2.1333</td>
<td>$12,856.29</td>
</tr>
<tr>
<td>453</td>
<td>Combined anterior/posterior spinal fusion with MCC</td>
<td>08</td>
<td>9.7411</td>
<td>$58,704.54</td>
</tr>
<tr>
<td>454</td>
<td>Combined anterior/posterior spinal fusion with CC</td>
<td>08</td>
<td>6.4968</td>
<td>$39,152.84</td>
</tr>
<tr>
<td>455</td>
<td>Combined anterior/posterior spinal fusion without CC/MCC</td>
<td>08</td>
<td>5.0782</td>
<td>$30,603.67</td>
</tr>
<tr>
<td>456</td>
<td>Spinal fusion except cervical with spinal curvature/malignancy/ infection or extensive fusions with MCC</td>
<td>08</td>
<td>9.2044</td>
<td>$55,470.13</td>
</tr>
<tr>
<td>457</td>
<td>Spinal fusion except cervical with spinal curvature/malignancy/ infection or extensive fusions with CC</td>
<td>08</td>
<td>6.8062</td>
<td>$41,017.43</td>
</tr>
<tr>
<td>458</td>
<td>Spinal fusion except cervical with spinal curvature/malignancy/ infection or extensive fusions without CC/MCC</td>
<td>08</td>
<td>5.3657</td>
<td>$32,336.28</td>
</tr>
<tr>
<td>459</td>
<td>Spinal fusion except cervical with MCC</td>
<td>08</td>
<td>6.0381</td>
<td>$36,388.49</td>
</tr>
<tr>
<td>460</td>
<td>Spinal fusion except cervical without MCC</td>
<td>08</td>
<td>4.0149</td>
<td>$24,195.71</td>
</tr>
</tbody>
</table>

Under the MS-DRG system, cases may be assigned to a number of other MS-DRGs, based on individual patient diagnosis and presence or absence of additional surgical procedures performed. Additional MS-DRGs include but are not limited to: MS-DRGs 907, 908, 909; MS-DRGs 957, 958, 959; MS-DRGs 981, 982, 983.

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

Source: FY2018 Medicare Hospital Inpatient Prospective Payment System, Final Rule. Federal Register, August 14, 2017. Updated with Correction Notice dated October 4, 2017. Assumes payment for a hospital with wage index and geographic adjustment factor of 1.000 and submitted quality data and is a meaningful EHR user.
Outpatient Reimbursement

Hospitals use the Healthcare Common Procedure Coding System (HCPCS) to report outpatient services. Under Medicare’s methodology for hospital outpatient payment, each HCPCS code is assigned to one Ambulatory Payment Classification (APC). Each APC has a relative weight which is multiplied by a 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 lumbar interbody 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.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>APC</th>
<th>Status Indicator</th>
<th>Relative Weight</th>
<th>CY ‘18 Medicare Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>22558</td>
<td>Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar</td>
<td></td>
<td>C</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Status Indicators:

Each HCPCS 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 indicator is represented in this procedure:

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

CODING AND REIMBURSEMENT ASSISTANCE

SpineLine®

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

Phone: 877-690-5353

E-mail: (Physician) spinalcodingmd@medtronic.com
        (Hospital) spinalcodinghospital@medtronic.com

Internet: www.medtronicspinal.com/spineline
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 here. The responsibility for coding correctly lies with the healthcare 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.

Consult instructions for use at this website www.medtronic.com/manuals.

Note: Manuals can be viewed using a current version of any major internet browser. For best results, use Adobe Acrobat® Reader with the browser.