Medtronic

Billing and coding guide

CD Horizon™ Solera™

5.5/6.0mm Fenestrated Screw Set

Device description

The CD Horizon™ Solera™ 5.5/6.0mm fenestrated screw set consists of a variety of cannulated multi-axial screws (MAS) with fenestrations. The CD Horizon™ Solera™ fenestrated screws are specifically designed to connect to 5.5mm and 6.0mm diameter rods and associated connecting components contained within the CD Horizon™ spinal system. The screws contain six fenestrations near the distal tip of the screw which provides a controlled means to deliver a small amount of polymethylmethacrylate (PMMA) bone cement into a targeted vertebral body.

Indications for use

When used without cement, the CD Horizon™ fenestrated screw (with or without Sextant™ or Longitude™ instrumentation) are intended for posterior, non-cervical fixation as an adjunct to fusion for the following indications: degenerative disc disease (defined as back pain of discogenic origin with degeneration of the disc confirmed by history and radiographic studies), spondylolisthesis, tumor and/or trauma (i.e., fracture or dislocation), spinal stenosis, curvatures (i.e., scoliosis, kyphosis, or lordosis), pseudarthrosis, and/or failed previous fusion.

When used in conjunction with Kyphon™ HV-R™ bone cement or Kyphon™ Xpede™ bone cement, the CD Horizon™ fenestrated screw are intended to restore the integrity of the spinal column even in the absence of fusion for a limited time period in patients with advanced stage tumors involving the thoracic and lumbar spine in whom life expectancy is of insufficient duration to permit achievement of fusion. CD Horizon™ fenestrated screw augmented with either Kyphon™ HV-R™ bone cement or Kyphon™ HV-R™ bone cement are for use at spinal levels where the structural integrity of the spine is not severely compromised.

Physician 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 (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 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.

Because CD Horizon™ Solera™ fenestrated screws are designed to restore spinal integrity in patients whose life expectancy is of insufficient duration to permit achievement of fusion, the screws will frequently be inserted without a concurrent fusion procedure. However, spinal instrumentation CPT codes are designated as "add-on codes" which by definition cannot be reported as stand-alone codes. Because of this reason, the following unlisted CPT code may be appropriate to report for insertion of CD Horizon™ fenestrated screws without a primary procedure like fusion:

CPT Code	Description	Medicare Payment
22899	Unlisted procedure, spine	By Report

Source: See references.

In some cases, CD Horizon™ Solera™ fenestrated screws may be inserted as part of a traditional fusion procedure. In these cases, it may be appropriate to report one of the following CPT codes for insertion of the screws in addition to the appropriate fusion code:

CPT Code	Description	RVUs	Medicare Payment
+22840	Posterior non-segmental instrumentation (eg, Harrington Rod Technique, Pedicle Fixation across 1 interspace, Atlantoaxial Transarticular Screw Fixation, Sublaminar Wiring at C1, Facet Screw Fixation) (list separately in addition to code for primary procedure)	22.60	$739.92
+22842	Posterior segmental instrumentation (eg, Pedicle Fixation, Dual Rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (list separately in addition to code for primary procedure)	22.81	$746.80

Source: See references.

If posterior segmental spinal instrumentation is inserted at more than 6 segments, use the appropriate CPT code (22843-22844).

Some have suggested that insertion of PMMA bone cement into the vertebral body through the fenestrated screw may be similar enough to a vertebroplasty procedure to justify reporting vertebroplasty CPT codes 22510-22512. However, a vertebroplasty involves use of a needle to inject cement in order to reinforce a fractured or collapsed vertebra, which is a fundamentally different procedure from use of the CD Horizon™ Solera™ fenestrated screw set. Hence, we do not believe it is appropriate to report vertebroplasty CPT codes in these cases.

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-CM and 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 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-10-PCS

Hospitals use ICD-10-PCS codes to report inpatient services. An insertion code with a 6th character device value for "internal fixation device" may be appropriate for the implantation of CD Horizon™ Solera™ fenestrated screws connected with rods and associated connecting components within the CD Horizon™ Spinal System in the absence of a fusion procedure. When used as an adjunct to spinal fusion, this device is not reported separately from the fusion ICD-10-PCS code. Fixation (rods, plates, screws) is included in the fusion and no additional code is assigned." -AHA Coding Clinic for ICD-10-CM and ICD-10-PCS 3rd Quarter 2014.

Possible Medicare Severity-Diagnosis Related Groups

MS-DRG	Description*	MDC	Relative Weight†	Medicare Payment†
028	Spinal Procedures with MCC	01	6.0261	$42,192
029	Spinal Procedures with CC or Spinal Neurostimulator	01	3.4282	$24,003
030	Spinal Procedures without CC/MCC	01	2.319	$16,237
453	Combined Anterior/Posterior Spinal Fusion with MCC	08	8.8614	$62,044
454	Combined Anterior/Posterior Spinal Fusion with CC	08	6.1163	$42,824
455	Combined Anterior/Posterior Spinal Fusion without CC/MCC	08	4.6056	$32,247
456	Spinal Fusion except Cervical with Spinal Curvature/Malignancy/Infection or Extensive Fusions with MCC	08	8.4294	$59,019
457	Spinal Fusion except Cervical with Spinal Curvature/Malignancy/Infection or Extensive Fusions with CC	08	6.0753	$42,537
458	Spinal Fusion except Cervical with Spinal Curvature/Malignancy/Infection or Extensive Fusions without CC/MCC	08	4.531	$31,724
459	Spinal Fusion Except Cervical with MCC	08	6.6323	$46,437
460	Spinal Fusion Except Cervical without MCC	08	3.6579	$25,611
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC	08	3.1615	$22,136
516	Other Musculoskeletal System and Connective Tissue O.R. Procedures with CC	08	2.0408	$14,289
517	Other Musculoskeletal System and Connective Tissue O.R. Procedures without CC/MCC	08	1.4944	$10,463

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; and MS-DRGs 981, 982, 983.

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

†Source: See references.

Outpatient Reimbursement

Under Medicare's methodology for hospital outpatient payment, each CPT 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 percentage of charges mechanism, depending on their contract with the hospital.

HCPCS Code	Description	APC	Status Indicator	Medicare Payment
22899	Unlisted procedure, spine	5111	T	$224.92
+22840	Posterior non-segmental instrumentation (eg, Harrington Rod Technique, Pedicle Fixation across 1 interspace, Atlantoaxial Transarticular Screw Fixation, Sublaminar Wiring at C1, Facet Screw Fixation) (list separately in addition to code for primary procedure)	N/A	N	N/A
+22842	Posterior segmental instrumentation (eg, Pedicle Fixation, Dual Rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (list separately in addition to code for primary procedure)	N/A	N	N/A

Source: See references.

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:

T Procedure or Service, Multiple Procedure Reduction Applies. Paid under OPPS; separate APC payment.
N Items and services packaged into APC rates, no separate payment.
APC 5115: $12,539.82

Ambulatory Surgery Centers

Ambulatory Surgery Centers (ASCs) use CPT and HCPCS codes to report their services. Medicare's payment methodology is based on the hospital outpatient APCs, but using payments unique to ASCs. Many payers use a similar type of fee schedule to reimburse ASCs, while other payers use alternate mechanisms depending on their contracts with the ASC.

CPT Code	Description	Payment Indicator	Medicare Payment
22899	Unlisted procedure, spine	N/A	Excluded
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	N1	N/A
22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)	N1	N/A

Source: See references..

Payment Indicators:
Each code in the ASC Payment System is assigned a payment indicator to signify certain payment rules. The following status indicator is represented in this procedure:

N1 Packaged service/item; no separate payment made.

Medical necessity

Prior authorization

Assistance with a prior authorization or denial may be available from Medtronic for patients whose medical needs are consistent with FDA approved/cleared indications or are otherwise in accordance with payer policies. Prior authorization requests may require the following items:

- Progress notes
- X-ray and/or MRI reports
- Medicare or other coverage policies
- Clinical literature (available from Medtronic upon request)

Site of service

Medical necessity will dictate site of service for each individual patient. Physicians should confirm inpatient or outpatient admission criteria before selecting site of service.

Documentation

- Medical record documentation is key to communicating essential information for making a decision as to whether a procedure was reasonable and necessary for a particular patient.
- At minimum, the medical record should convey information about a patient's medical condition, the rationale for why the service was needed, and the outcome of the procedure.
- Medical record documentation should include a detailed history and physical, which enables billing personnel to verify that a claim is coded specifically and accurately. For example, some payers require documentation that conservative care has been tried and has failed.

See payer policy for specific documentation and clinical coverage criteria.

Coding and reimbursement assistance

SpineLine™

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

Email: RS.CSTreimbursementsupport@medtronic.com

Web: medtronic.com/SpineLine

References

CPT Changes 2017, American Medical Association. Source: 2024 Medicare Fee Schedule, Final Rule, Federal Register. No geographic adjustments. Check bundling edits before applying and submitting codes for payment. 2/24

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Please see the package insert for the complete list of indications, warnings, precautions, and other important medical information.

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