

FAQs

Where can the Medicare physician fee schedule be found?

The physician fee schedule can be found at CMS.gov.

Does Medtronic offer webinars on coding for spinal procedures?

Yes. It's no longer necessary to travel to a classroom to stay abreast of changes in the industry. Now it's possible to go online and learn about the latest developments in the business of spine care, coding changes, regulations, and documentation requirements. Medtronic provides live webinars, free of charge throughout the year. For more information, visit [Medtronic.com/SpineLine](https://www.medtronic.com/SpineLine).

What is the appropriate code for Cornerstone, Tangent, Precision and other tricortical allografts?

Per the February 2005 edition of CPT Assistant, all structural allograft bone used for spine surgery should be coded as 20931. Threaded bone dowels and machined allograft are coded as 20931.

How many times per encounter can an allograft for spine surgery be reported?

CPT Assistant guidelines state each allograft for spine surgery code can be reported once per operative session regardless of the spinal levels to which the allograft is placed. January 2004 CPT Assistant states, "Each type of bone graft code (20930-20938) may be reported one time for a spinal procedure, regardless of the number of vertebral levels being surgically fused."

What code should be reported for a cervical laminoplasty procedure?

CPT code 63050 or 63051 is appropriate depending on whether there is reconstruction of the posterior bone elements.

Can codes 22630 and 63047 be reported together?

According to the National Correct Coding Initiative Policy Manual for Medicare Services "CMS payment policy does not allow separate payment for CPT codes 63042 (laminotomy...; lumbar) or 63047 (laminectomy...; lumbar) with CPT codes 22630 or 22633 (arthrodesis; lumbar) when performed at the same

interspace. If the two procedures are performed at different interspaces, the two codes of an edit pair may be reported with modifier 59 appended to CPT code 63042 or 63047.”

Do I use +63052 for a laminectomy/facetectomy/foraminotomy performed at the same space as a posterior/posterolateral fusion (22612)?

No. This new code is appropriate in conjunction with posterior lumbar interbody fusion procedures (22630, +22632, 22633, +22634).

Do +63052 and +63053 replace the already established laminectomy/foraminotomy codes +63047 and +63048?

No. For decompressions performed on the same vertebral segment[s] and/or interspace[s] as posterior lumbar interbody fusions see +63052, +63053. However, if the decompression procedure is performed by itself or without a posterior interbody fusion, the existing laminectomy codes (eg, 63040-+63048) may be used to report the service.

Can you explain when code 22551 should be reported?

This code combines both the anterior cervical fusion procedure and the anterior cervical discectomy (including decompression) procedure. For traditional anterior cervical discectomy and fusion (ACDF) cases, code 22551 should now be reported instead of 22554 and 63075.

Per CPT, codes 22554 and 63075 should not be reported together even if the procedures are performed by separate surgeons. Code 22551 should be reported if the anterior cervical fusion and anterior cervical discectomy are performed at the same level during the same session.

How is a lumbar discectomy procedure coded when it's performed with the METRX system?

CPT code 63030 may be appropriate for an open procedure when there is continuous direct visualization through the surgical opening. Code 63035 would be assigned in addition to the primary procedure for each additional interspace. 62380 may be appropriate for an endoscopic decompression when there is continuous direct visualization through an endoscope. For a bilateral procedure, report with modifier 50. CPT guidelines define direct visualization as “Light-based visualization; can be performed by eye, or with surgical loupes, microscope, or endoscope.” For percutaneous decompression performed with indirect visualization without the use of any device that allows visualization through a surgical incision, see 62287, 0275T. Code 62287 is used to report percutaneous decompression of the nucleus pulposus using needle-based technique.

How is a direct lateral interbody fusion (DLIF) or an oblique lateral interbody fusion (OLIF) coded?

22558. Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar.

Which CPT code is appropriate for the Rialto SI fusion system, 27280 or 27279?

CPT code 27279 is appropriate for the Rialto SI Fusion System: Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device (For bilateral procedure, report 27279 with modifier 50). Code 27280 is used to report open arthrodesis of the sacroiliac joint. There are clinical examples of 27279 & 27280 published in CPT Changes 2015 that may also help distinguish the difference between these two codes.

What is the Medicare National Correct Coding Initiative?

The Medicare National Correct Coding Initiative (NCCI) (also known as CCI) was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

In addition to code pair edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UoS) allowable under most circumstances for a single Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a date of service for a single beneficiary.

Who can I contact with additional questions?

You can contact the Reimbursement Support Center at RS.CSTreimbursementssupport@medtronic.com.

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