Medtronic

Billing and coding guide

Mazor™

Robotic Guidance Platform

Description

The Medtronic surgical instruments are specifically designed for use in spinal procedures with Mazor™ robotic guidance platform. Medtronic surgical instruments can be navigated or non-navigated manual instruments that may or may not be guided through the Mazor™ robotic guidance platform arm guide.

Indication

Medtronic surgical instruments are intended to be used during the preparation and placement of Medtronic implants during spinal surgery to assist the surgeon in precisely locating anatomical structures in either open, or minimally invasive, procedures. Medtronic surgical instruments are specifically designed for use with the Mazor™ robotic guidance platform, which is indicated for any medical condition in which the use of stereotactic surgery may be appropriate, and where reference to a rigid anatomical structure, such as a skull, a long bone, or vertebra can be identified relative to a CT or MR-based model, fluoroscopy images, or digitized landmarks of the anatomy.

Medtronic surgical instruments can be navigated or non-navigated manual instruments that may or may not be guided through the Mazor™ robotic guidance platform arm guide.

Physician reimbursement

Physicians use Current Procedural Terminology (CPT®) codes to report 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 Relative Value Units (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 of 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 CPT code listed below is appropriate computer assisted surgical navigation in spinal surgery.

CPT	Description	RVU	Medicare Payment
+61783	Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)	6.93	$226.89

Source: See references.

There are no separate CPT codes specific for robotic assistance in spinal surgery. Physicians should report CPT codes for the procedure(s) performed.

HCPCS Level II

There is a temporary national (Non-Medicare) HCPCS Level II S code for surgical techniques requiring the use of a robotic surgical system. S codes are used by the Blue Cross/Blue Shield Association (BCBSA) and the Health Insurance Association of America (HIAA) to report drugs, services, and supplies for which there are no national codes but for which codes are needed by the private sector to implement policies, programs, or claims processing. They are for the purpose of meeting the particular needs of the private sector. These codes are also used by the Medicaid program, but they are not payable by Medicare. S2900 – Surgical techniques requiring use of robotic surgical system (List separately in addition to code for primary procedure).

Providers should refer to each payor's policy regarding robotic assisted procedures to confirm their coverage position. Many policies indicate that robotic technology is integral to the procedure and not eligible for separate reimbursement.

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 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 (i.e., 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. The following ICD-10-PCS codes may be appropriate for computer and robotic assisted procedures.

Code	Description
8E0**B*	Computer-assisted procedure
8E0**CZ	Robotic-assisted procedure

Diagnosis-Related Groups (DRGs)

Thoracic/Lumbar spinal fusions are typically grouped to the following MS-DRGs:

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

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.

Hospital Outpatient & ASC 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 percentage of charges mechanism, depending on their contract with the hospital. Medicare's ASC payment methodology is based on the hospital outpatient APCs but using payments unique to ASCs.

CPT Code	Description	Status/ Payment Indicator	Medicare Payment
+61783	Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)	N/N1	N/A

Source: See references.

Status Indicators:
The following status/payment indicators are represented in this procedure:

N — Items and Services Packaged into APC Rates, no separate payment in the hospital outpatient setting

N1 — Packaged service/item; no separate payment made in the ASC setting

Coding and reimbursement assistance

SpineLine™

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

E-mail: RS.CSTreimbursementsupport@medtronic.com

Web: medtronic.com/SpineLine

References

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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For additional reimbursement information contact the SpineLine™ Reimbursement Support Center at (877) 690-5353.

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

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.

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

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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.

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