Medtronic

Engineering the extraordinary

2025 Billing and Coding Guide

Spinal procedures

Overview

New for 2025

Coding & Reimbursement

Resources

Overview

This guide is intended to aid providers in appropriate procedure code selection for spinal related procedures. The document reflects applicable and commonly billed procedure codes as well as the unadjusted national Medicare average rates assigned to the CPT®[1] code.

Instructions for use:

- New tools and updates can be found in the New for 2025 section
- Code descriptions and details of code reporting requirements and/or guidance, as well as Physician, Hospital Outpatient, and/or Ambulatory Surgery Center (ASC) rates, can be found in the Coding & Reimbursement section.
- Details surrounding specialized coding and reimbursement information can be found in FAQ and resources section.
- This document is not all-inclusive, nor does it replace advice from your coding and compliance departments and/or CPT® coding manuals.

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

New for 2025

C-code Finder

New MS-DRGs

2025 Spinal MS-DRGs

Beginning October 1, 2024, CMS released several new revisions to the spinal Medicare Severity-Diagnosis Related Groups (MS-DRGs.)

The 2025 revisions reflect a more detailed classification of spinal fusion procedures, particularly distinguishing between single and multiple level fusions.

For more detailed information, see the section, Coding and Reimbursement.

New Sites

Medtronic Reimbursement resources

We offer comprehensive, professional services to secure and maintain coverage and payment. See below to find educational programs, reimbursement guides, and other resources to assist with coding, coverage, and reimbursement for our products and therapies. Or contact our reimbursement specialists with questions.

www.medtronic.com/us-en/healthcare-professionals/reimbursement.html

Medicare provides C-codes, a type of HCPCS[3] II code, for hospital use in billing Medicare for some medical devices and supplies in the hospital outpatient setting. The C-code finder can be accessed at www.medtronic.com/c-code or by using the C-code button.

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

TOC

This section provides Medicare unadjusted national average allowable rates for physician, hospital outpatient, ambulatory surgery, and hospital inpatient settings. The coding information in this section does not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. All diagnosis and procedure codes must be supported by clear documentation within the medical record.

Providers may choose to perform multiple procedures during the same encounter. When this occurs, providers must report all procedures, and the payment may be subject to packaging rules or multiple procedure reductions.

- Medicare payment systems
- HCPCS[3] II codes
- CPT®[1] procedure codes & Physician[4], Hospital outpatient[2] and Ambulatory surgery center[2] reimbursement rates
- Inpatient[6] national unadjusted reimbursement rates and ICD-10-PCS[7] codes

Medtronic

Coding & reimbursement

Medicare payment systems

Payment system	Place of service	Basis of payment	Types of services included
Inpatient Prospective Payment System[6] (IPPS)	Hospital Inpatient	MS-DRGs[6] (DRGs)	• Inpatient admissions that require hospital stays • Procedures excluded from coverage in the outpatient setting
Hospital Outpatient Prospective Payment System[2] (OPPS)	Hospital Outpatient	Ambulatory Payment Classification System[2] (APCs)	• Less invasive surgical procedures that do not require hospital stay
Ambulatory Surgery Center Prospective Payment System[2] (ASC)	ASC	Scaled APC payment[2]	• Specific surgeries and procedures approved for use in the ASC setting • Not all surgeries are allowed in the ASC
Medicare Physician Fee Schedule[4] (MPFS)	Physician Office and some other types of free-standing centers	Relative Value Units[4] (RVUs)	• Physician office visits and services • Payment to HCP when performing services in the facility setting (HCP payment for the procedures performed)

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

C-code Finder

HCPCS[3] II codes

Level II HCPCS[3] codes are primarily used to report supplies, drugs and implants that are not reported by a CPT®[1] code. HCPCS codes are reported by the physician, hospital or DME provider that purchased the item, device, or supply. Different payers have different payment methods for these items.

C-codes are a series of HCPCS codes that facilities reimbursed under the Medicare Outpatient Prospective Payment System (OPPS) are required to report for eligible items and services. Medicare assigns C-codes to specific devices eligible for pass-through payment. Every year, in the OPPS rule, Medicare publishes a list of CPT®1 and HCPCS codes that are designated as device-intensive procedures. When reporting procedures on this list, facilities should capture both the CPT®1 code representing the procedure performed and the C-code representing the device used. Although C-codes only affect Medicare outpatient reimbursement, facilities may also want to report C-codes on inpatient claims if the device is not used exclusively for inpatient procedures. Medicare tracks this information and uses it in its rate-setting process. Non-OPPS facilities may report C-codes at their discretion.

The following list provides some HCPCS II codes that may be applicable.

Medtronic spinal & biologic devices:

HCPCS[3] code	Description
C1713	**Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)** ***e.g., screws, plates, wiring, pins*** Implantable pins and/or screws that are used to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone. Screws oppose tissues via drilling as follows: soft tissue- to-bone, tendon-to-bone, or bone-to-bone fixation. Pins are inserted or drilled into bone, principally with the intent to facilitate stabilization or oppose bone-to-bone. This may include orthopedic plates with accompanying washers and nuts. This category also applies to synthetic bone substitutes that may be used to fill bony void or gaps (i.e., bone substitute implanted into a bony defect created from trauma or surgery).
C1776	**Joint device (implantable)** An artificial joint that is implanted in a patient. Typically, a joint device functions as a substitute to its natural counterpart and is not used (as are anchors) to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone.
C1889	Implantable/insertable device for device intensive procedure, not otherwise classified ***e.g., interbody cages, distraction devices***

Medtronic cerebral spinal fluid products:

HCPCS[3] code	Description
C1729	**Catheter, draining (for the ventricular or lumbar catheter used in external cerebrospinal fluid drainage)** Intended to be used for percutaneous drainage of fluids. NOTE: This category does NOT include Foley catheters or suprapubic catheters.
C1781	**Mesh (implantable) (for mesh used in cranial plating)** A mesh implant or synthetic patch composed of absorbable or non-absorbable material that is used to repair hernias, support weakened or attenuated tissue, cover tissue defects, etc.

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Common spinal procedures

		Physician[4]		Hospital Outpatient[2]			Ambulatory Surgery Center[2]	
CPT®[1] code	Description	Work RVU	Facility rate	Status indicator	APC	Rate	Payment indicator	Rate
Posterior fusion								
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)	20.64	$1,508	C	n/a	n/a	n/a	n/a
22600	Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment	17.40	$1,293	C	n/a	n/a	n/a	n/a
22610	Arthrodesis, posterior or posterolateral technique, single interspace; thoracic (with lateral transverse technique, when performed)	17.28	$1,273	C	n/a	n/a	n/a	n/a
22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)	23.53	$1,554	J1	5116	$18,390	J8	$14,037
+22614	Arthrodesis, posterior or posterolateral technique, single interspace; each additional interspace (List separately in addition to code for primary procedure)	6.43	$380	N	n/a	n/a	N1	n/a
PLIF or TLIF								
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	22.09	$1,544	J1	5116	$18,390	n/a	n/a
+22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (list separately in addition to code for primary procedure)	5.22	$312	N	n/a	n/a	n/a	n/a

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Common spinal procedures

		Physician[4]		Hospital Outpatient[2]			Ambulatory Surgery Center[2]	
CPT®[1] code	Description	Work RVU	Facility rate	Status indicator	APC	Rate	Payment indicator	Rate
Anterior fusion								
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	25.00	$1,674	J1	5115	$12,867	J8	$9,069
+22552	each additional interspace (List separately in addition to code for separate procedure)	6.50	$385	N	n/a	n/a	N1	n/a
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	17.69	$1,247	J1	5115	$12,867	J8	$8,976
22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	24.70	$1,660	C	n/a	n/a	n/a	n/a
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar ***e.g., DLIF/XLIF/LLIF/OLIF***	23.53	$1,498	C	n/a	n/a	n/a	n/a
+22585	each additional interspace (List separately in addition to code for primary procedure)	5.52	$314	N	n/a	n/a	N1	n/a
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1	28.12	$2,015	C	n/a	n/a	n/a	n/a

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Common spinal procedures

		Physician[4]		Hospital Outpatient[2]			Ambulatory Surgery Center[2]	
CPT®[1] code	Description	Work RVU	Facility rate	Status indicator	APC	Rate	Payment indicator	Rate
Combined fusion								
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique, including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression); single interspace and segment, lumbar (do not report with 22612 or 22630 at the same level)	26.80	$1,781	J1	5116	$18,390	n/a	n/a
+22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique, including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression); each additional interspace, lumbar (do not report with 22612 or 22630 at the same level) (list separately in addition to code for primary procedure)	7.96	$471	N	n/a	n/a	n/a	n/a
Arthroplasty								
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical	24.05	$1,597	J1	5116	$18,390	J8	$14,005
+22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (list separately in addition to code for primary procedure)	8.40	$493	N	n/a	n/a	N1	n/a
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar	27.13	$1,709	C	n/a	n/a	n/a	n/a
+22860	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)	6.88	$400	C	n/a	n/a	n/a	n/a
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	33.36	$2,291	C	n/a	n/a	n/a	n/a

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Common spinal procedures

		Physician[4]		Hospital Outpatient[2]			Ambulatory Surgery Center[2]	
CPT®[1] code	Description	Work RVU	Facility rate	Status indicator	APC	Rate	Payment indicator	Rate
Biomechanical devices								
+22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (list separately in addition to code for primary procedure)	4.25	$250	N	n/a	n/a	N1	n/a
+22854	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (list separately in addition to code for primary procedure)	5.50	$326	N	n/a	n/a	N1	n/a
+22859	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh, methyl methacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (list separately in addition to code for primary procedure)	5.50	$326	N	n/a	n/a	N1	n/a
Posterior instrumentation								
+22840	Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (list separately in addition to code for primary procedure)	12.52	$732	N	n/a	n/a	N1	n/a
+22841	Internal spinal fixation by wiring of spinous processes (list separately in addition to code for primary procedure)	0.00	$0.00	C	n/a	n/a	n/a	n/a
+22842	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); three to six vertebral segments (list separately in addition to code for primary procedure)	12.56	$741	N	n/a	n/a	N1	n/a
+22843	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (list separately in addition to code for primary procedure)	13.44	$795	C	n/a	n/a	n/a	n/a
+22844	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (list separately in addition to code for primary procedure)	16.42	$958	C	n/a	n/a	n/a	n/a
0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar	0.00	$0.00	J1	5114	$7,144	n/a	n/a

Overview
New for 2025
Coding & Reimbursement
Resources

Medtronic

Coding & reimbursement

Common spinal procedures

		Physician[4]		Hospital Outpatient[2]			Ambulatory Surgery Center[2]	
CPT®[1] code	Description	Work RVU	Facility rate	Status indicator	APC	Rate	Payment indicator	Rate
Anterior instrumentation								
+22845	Anterior instrumentation; two to three vertebral segments (list separately in addition to code for primary procedure)	11.94	$705	N	n/a	n/a	N1	n/a
+22846	Anterior instrumentation; four to seven vertebral segments (list separately in addition to code for primary procedure)	12.40	$735	C	n/a	n/a	n/a	n/a
+22847	Anterior instrumentation; eight or more vertebral segments (list separately in addition to code for primary procedure)	13.78	$772	C	n/a	n/a	n/a	n/a
Bone graft								
+20930	Allograft (morselized) e.g., bone chips, bone graft	0.00	$0.00	N	n/a	n/a	N1	n/a
+20931	Allograft (structural) e.g., bone dowel	1.81	$108	N	n/a	n/a	N1	n/a
+20936	Autograft (rib/lamina/spinous process, same incision) e.g., bone from laminectomy via same incision as fusion	0.00	$0.00	N	n/a	n/a	N1	n/a
+20937	Autograft (morselized, separate incision) e.g., crushed bone harvested from iliac crest	2.79	$162	N	n/a	n/a	N1	n/a
+20938	Autograft (structural, separate incision) e.g., bone cortex graft from iliac crest	3.02	$178	N	n/a	n/a	N1	n/a
+20939	Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (list separately in addition to code for primary procedure)	1.16	$68	N	n/a	n/a	N1	n/a

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Common spinal procedures

		Physician[4]		Hospital Outpatient[2]			Ambulatory Surgery Center[2]	
CPT®[1] code	Description	Work RVU	Facility rate	Status indicator	APC	Rate	Payment indicator	Rate
Navigation								
+61783	Stereotactic computer-assisted (navigational) procedure; *spinal* (List separately in addition to code for primary procedure)	3.75	$225	N	n/a	n/a	N1	n/a
Decompression procedures								
62267	Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes	3.00	$148	T	5071	$704	G2	$378
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle-based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar	9.03	$587	J1	5431	$1,953	A2	$925
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar	0.00	$0.00	J1	5114	$7,144	G2	$3,511
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; cervical	17.61	$1,221	J1	5114	$7,144	G2	$3,511
63003	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; thoracic	17.74	$1,227	J1	5114	$7,144	G2	$3,511
63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis	16.43	$1,196	J1	5114	$7,144	G2	$3,511

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Common spinal procedures

		Physician[4]		Hospital Outpatient[2]			Ambulatory Surgery Center[2]	
CPT®[1] code	Description	Work RVU	Facility rate	Status indicator	APC	Rate	Payment indicator	Rate
Decompression procedures								
63011	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; sacral	15.91	$1,074	J1	5114	$7,144	n/a	n/a
63012	Laminectomy with removal of abnormal facets and/or pars interarticularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (gill type procedure)	16.85	$1,181	J1	5114	$7,144	n/a	n/a
63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; cervical	20.85	$1,470	J1	5114	$7,144	n/a	n/a
63016	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; thoracic	22.03	$1,508	J1	5114	$7,144	n/a	n/a
63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than two vertebral segments; lumbar	17.33	$1,257	J1	5114	$7,144	n/a	n/a
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	14.91	$1,091	J1	5114	$7,144	G2	$3,511
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	12.00	$908	J1	5114	$7,144	G2	$3,511
+63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (list separately in addition to code for primary procedure)	3.86	$226	N	n/a	n/a	n/a	n/a

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Common spinal procedures

		Physician[4]		Hospital Outpatient[2]			Ambulatory Surgery Center[2]	
CPT®[1] code	Description	Work RVU	Facility rate	Status indicator	APC	Rate	Payment indicator	Rate
Decompression procedures								
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; cervical	20.31	$1,357	J1	5114	$7,144	n/a	n/a
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; lumbar	18.76	$1,277	J1	5114	$7,144	G2	$3,511
+63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; each additional cervical interspace (list separately in addition to code for primary procedure)	0.00	$0.00	N	n/a	n/a	n/a	n/a
+63044	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; each additional lumbar interspace (list separately in addition to code for primary procedure)	0.00	$0.00	N	n/a	n/a	N1	n/a
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical	17.95	$1,275	J1	5114	$7,144	G2	$3,511
63046	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic	17.25	$1,217	J1	5114	$7,144	G2	$3,511
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar	15.37	$1,095	J1	5114	$7,144	G2	$3,511
+63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (list separately in addition to code for primary procedure)	3.47	$205	N	n/a	n/a	n/a	n/a

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Common spinal procedures

		Physician[4]		Hospital Outpatient[2]			Ambulatory Surgery Center[2]	
CPT®[1] code	Description	Work RVU	Facility rate	Status indicator	APC	Rate	Payment indicator	Rate
Decompression procedures								
63050	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments	22.01	$1,464	C	n/a	n/a	n/a	n/a
63051	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [eg, wire, suture, mini-plates], when performed)	25.51	$1,663	C	n/a	n/a	n/a	n/a
+63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	4.25	$251	N	n/a	n/a	n/a	n/a
+63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure). *Use 63053 in conjunction with 63052*	3.78	$223	N	n/a	n/a	n/a	n/a
63055	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic	23.55	$1,604	J1	5114	$7,144	G2	$3,511
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)	21.86	$1,466	J1	5114	$7,144	G2	$3,511
+63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (list separately in addition to code for primary procedure)	5.25	$313	N	n/a	n/a	n/a	n/a
63064	Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; single segment	26.22	$1,738	J1	5114	$7,144	n/a	n/a

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Common spinal procedures

		Physician[4]		Hospital Outpatient[2]			Ambulatory Surgery Center[2]	
CPT®[1] code	Description	Work RVU	Facility rate	Status indicator	APC	Rate	Payment indicator	Rate
Decompression procedures								
+63066	Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; each additional segment (list separately in addition to code for primary procedure)	3.26	$201	N	n/a	n/a	n/a	n/a
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	19.60	$1,336	J1	5114	$7,144	n/a	n/a
+63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (list separately in addition to code for primary procedure)	4.04	$237	N	n/a	n/a	n/a	n/a
63077	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace	22.88	$1,431	C	n/a	n/a	n/a	n/a
+63078	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, each additional interspace (list separately in addition to code for primary procedure)	3.28	$202	C	n/a	n/a	n/a	n/a
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment	26.10	$1,736	C	n/a	n/a	n/a	n/a
+63082	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)	4.36	$258	C	n/a	n/a	n/a	n/a
63085	Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment	29.47	$1,896	C	n/a	n/a	n/a	n/a
+63086	Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, each additional segment (List separately in addition to code for primary procedure)	3.19	$185	C	n/a	n/a	n/a	n/a

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Common spinal procedures

		Physician[4]		Hospital Outpatient[2]			Ambulatory Surgery Center[2]	
CPT®[1] code	Description	Work RVU	Facility rate	Status indicator	APC	Rate	Payment indicator	Rate
Decompression procedures								
63087	Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment	37.53	$2,382	C	n/a	n/a	n/a	n/a
+63088	Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; each additional segment (List separately in addition to code for primary procedure)	4.32	$251	C	n/a	n/a	n/a	n/a
63090	Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment	30.93	$1,903	C	n/a	n/a	n/a	n/a
+63091	Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; each additional segment (List separately in addition to code for primary procedure)	3.03	$170	C	n/a	n/a	n/a	n/a
SI fusion using Rialto™								
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	12.13	$790	J1	5116	$18,390	J8	$15,177

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Modifiers

Modifiers are used to supplement the information or adjust the care description to provide extra details concerning a procedure or service. Modifiers help further describe a procedure code without changing its definition. Modifiers are appended to CPT®[1] codes. A list of modifiers can be found in the CPT®[1] book.[2]

Modifier	Description
22	**Increased Procedural Service** Used to alert payers to unusual circumstances or complications encountered during a procedure, when the services provided are greater than usually required.
26	**Professional Component** Used to denote the professional component of a CPT code.
50	**Bilateral Procedure** A bilateral procedure is defined as the same procedure being performed on both sides of the body in the same operative session.
51	**Multiple Procedures** Used to denote more than one medical/surgical procedure being performed by the same physician on the same day and during the same operative session.
52	**Reduced Services** Used when the physician reduces or eliminates a portion of the procedure as described within a CPT© code.
53	**Discontinued Procedure** Used when a surgical procedure may have been started but is discontinued due to extenuating circumstances or those that threaten the well-being of the patient.
54	**Surgical Care Only** Used when one physician provides surgical services, and another provides pre-operative and/or postoperative care.
58	**Staged or Related Procedure/Service by the Same Physician During the Postoperative Period** Used when a procedure is performed during the postoperative period by the same surgeon.
59	**Distinct Procedural Service** Used when a procedure is performed during the postoperative period by the same surgeon to indicate that a procedure/service was distinct or independent from the first procedure. Documentation must support a different session, different procedure or surgery, different site or organ. system, separate incision/excision, separate lesion, or separate injury.
62	**Two Surgeons (Different Specialties)** Used when two surgeons work together as primary surgeons who are performing distinct part(s) of a procedure. The -62 modifier should only be appended to a single definitive primary procedure code and any associated add-on codes(s), as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the same procedure code with the co-surgery modifier.

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Status/payment indicators

Each HCPCS code in the Outpatient Prospective Payment System and Ambulatory Surgery Center System is assigned a status or payment indicator to signify whether a discount (payment reduction) applies to the respective payment.

Indicator	Description
C	Inpatient-only procedure (not paid under OPPS)
J1	Hospital part B services paid through a comprehensive APC
J8	Device-intensive procedure; paid at adjusted rate
N	Items and services packaged into APC rates, no separate payment
N1	Packaged service/item, no separate payment
T	Significant Procedure, multiple procedure reduction applies

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Medicare Severity-Diagnosis Related Groups

Medicare reimburses inpatient hospital services under the Inpatient Prospective Payment System (IPPS) which bases payment on Medicare Severity Diagnosis-Related Groups (MS-DRGs). The MS-DRG payment system groups similar diagnoses into a single payment level according to the extent of resources typically required to treat patients with similar diagnoses undergoing similar treatments. Each inpatient stay is assigned to a single MS-DRG, primarily on the basis of patient diagnoses (reported with ICD-10-CM codes) and procedures performed (reported with ICD-10-PCS codes). All services and supplies provided during the inpatient admission are bundled into a single MS-DRG payment, regardless of the length of the inpatient stay, the intensity of treatments, or the number of procedures performed for the specific individual.

- In the inpatient setting, MCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities, MCC. MS-DRGs with MCC have at least one major secondary complication or comorbidity. Similarly, with CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities. MS-DRGs with CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs without CC/MCC have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise.

- Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were POA, present on admission, and do not count as CCs or MCCs when the conditions were acquired in the hospital during the stay.

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Complication and comorbidity designation

Secondary Diagnosis

MS-DRG groups are further differentiated by assigning a CC, MCC, or without CC/MCC. For more information on these designations, see the MS-DRG Manual.

MCC

Major Complications and Comorbidities

CC

Complications and Comorbidities

w/o CC/MCC

Without (Major) Complication or Comorbidities

Medtronic

Coding & reimbursement

Inpatient[6] national unadjusted reimbursement rates

Under Medicare's MS-DRG[6] methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 750 diagnosis-related groups, based on the ICD-10 codes assigned to the diagnoses and procedures. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Surgical supplies and implanted devices are typically included in the flat payment and are not paid separately. Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed.

MS-DRG	Description	2025 Rate
Spinal Procedures with a Neurologic Diagnosis (MDC 1)		
Procedures that are accompanied with a neurological diagnosis		
28	Spinal procedures with MCC	$43,387
29	Spinal procedures with CC or spinal neurostimulators	$23,955
30	Spinal procedures without CC/MCC	$15,882
Spinal Fusion (Except Cervical) with Spinal Curvature, Malignancy, Infection, or Extensive Fusions (MDC 8)		
Complex lumbar or thoracic fusions (curvatures, deformity, malignancy, infection, or extensive fusions)		
456	Spinal fusion except cervical with spinal curvature, malignancy, infection or extensive fusions with MCC	$60,441
457	Spinal fusion except cervical with spinal curvature, malignancy, infection or extensive fusions with CC	$40,959
458	Spinal fusion except cervical with spinal curvature, malignancy, infection or extensive fusions without CC/MCC	$30,816
Cervical Fusion (MDC 8)		
Cervical fusions, unless your diagnosis is neurological, in which case use DRG 28-30; ex. ACDF		
471	Cervical spinal fusion with MCC	$34,664
472	Cervical spinal fusion with CC	$20,676
473	Cervical spinal fusion without CC/MCC	$16,895

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Inpatient[6] national unadjusted reimbursement rates

MS-DRG	Description	2025 Rate
Spinal Procedures with a Neurologic Diagnosis (MDC 1)		
Procedures that are accompanied with a neurological diagnosis		
28	Spinal procedures with MCC	$43,387
29	Spinal procedures with CC or spinal neurostimulators	$23,955
30	Spinal procedures without CC/MCC	$15,882
Spinal Fusion (Except Cervical) with Spinal Curvature, Malignancy, Infection, or Extensive Fusions (MDC 8)		
Complex lumbar or thoracic fusions (curvatures, deformity, malignancy, infection, or extensive fusions)		
456	Spinal fusion except cervical with spinal curvature, malignancy, infection or extensive fusions with MCC	$60,441
457	Spinal fusion except cervical with spinal curvature, malignancy, infection or extensive fusions with CC	$40,959
458	Spinal fusion except cervical with spinal curvature, malignancy, infection or extensive fusions without CC/MCC	$30,816
Cervical Fusion (MDC 8)		
Cervical fusions, unless your diagnosis is neurological, in which case use DRG 28-30; ex. ACDF		
471	Cervical spinal fusion with MCC	$34,664
472	Cervical spinal fusion with CC	$20,676
473	Cervical spinal fusion without CC/MCC	$16,895

Medtronic

Coding & reimbursement

Inpatient[6] national unadjusted reimbursement rates

MS-DRG	Description	2025 Rate
Other Spinal Procedures (MDC 8)		
Laminectomy, laminotomy, discectomy; (peripheral nervous system procedures) ex. nerve decompression		
515	Other musculoskeletal system and connective tissue O.R. Procedures with MCC	$22,069
516	Other musculoskeletal system and connective tissue O.R. Procedures with CC	$14,357
517	Other musculoskeletal system and connective tissue O.R. Procedures without CC/MCC	$10,653
Back and Neck Procedures Except Spinal Fusion (Including Artificial Disc, X-Stop, and Fenestrated Screws) (MDC 8)		
Laminectomy, discectomy; (central nervous system procedures) or artificial disc procedures; ex. spinal cord decompression		
518	Back and neck procedures except spinal fusion with MCC or disc device or neurostimulator	$25,577
519	Back and neck procedures except spinal fusion with CC	$14,073
520	Back and neck procedures except spinal fusion without CC/MCC	$10,228
Tibia Fracture Indication for rhBMP^{-2} (MDC 8)		
rhBMP^{2} for the treatment of open tibial fractures		
492	Lower extremity and humerus procedures except hip, foot and femur with MCC	$25,343
493	Lower extremity and humerus procedures except hip, foot and femur with CC	$17,135
494	Lower extremity and humerus procedures except hip, foot and femur without CC/MCC	$13,455

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Inpatient[6] national unadjusted reimbursement rates

MS-DRG	Description	2025 Rates
Lumbar or Thoracic Fusion (MDC 8)		
Standard lumbar or thoracic fusions due to degeneration; ex. ALIF, DLIF, OLIF, PLIF, TLIF, SI Fusion		
447	Multiple level spinal fusion except cervical with MCC or custom-made anatomically designed interbody fusion device	$47,848
448	Multiple level spinal fusion except cervical without MCC	$29,142
450	Single level spinal fusion except cervical with MCC or custom-made anatomically designed interbody fusion device	$36,754
451	Single level spinal fusion except cervical without MCC	$22,023
Combined Anterior and Posterior Fusion (MDC 8)		
Combination anterior and posterior fusions; ex. PLF/PLIF		
402	Single level combined anterior and posterior spinal fusion except cervical	$27,920
426	Multiple level combined anterior and posterior spinal fusion except cervical with MCC or custom-made anatomically designed interbody fusion device	$74,758
427	Multiple level combined anterior and posterior spinal fusion except cervical with CC	$50,689
428	Multiple level combined anterior and posterior spinal fusion except cervical without CC/MCC	$39,280
429	Combined anterior and posterior cervical spinal fusion with MCC	$59,523
430	Combined anterior and posterior cervical spinal fusion without MCC	$39,040

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

ICD-10-PCS[7]

ICD-10-PCS[7] procedure codes are used by hospitals to report surgeries and procedures performed in the inpatient setting. Below are commonly used ICD-10-PCS procedure codes, however codes listed below are not exhaustive as other codes may apply.

ICD-10-PCS[7] code	Description
0SG00A0	Fusion of Lumbar Vertebral Joint with Interbody Fusion Device, Anterior Approach, Anterior Column, Open Approach
0SB20ZZ	Excision of Lumbar Vertebral Disc, Open Approach
0RR30JZ	Replacement of cervical disc with synthetic substitute, open approach
0RP30JZ	Removal of synthetic substitute from cervical disc, open approach
0RW30JZ	Revision of synthetic substitute in cervical disc, open approach
0SG734Z	Fusion of right sacroiliac joint, with internal fixation device, percutaneous approach
0SG834Z	Fusion of left sacroiliac joint, with internal fixation device, percutaneous approach
0SG00A0	Fusion of Lumbar Vertebral Joint with Interbody Fusion Device, Anterior Approach, Anterior Column, Open Approach
0SG10A0	Fusion of 2 or more Lumbar Vertebral Joints with Interbody Fusion Device, Anterior Approach, Anterior Column, Open Approach
0SG30A0	Fusion of Lumbosacral Joint with Interbody Fusion Device, Anterior Approach, Anterior Column, Open Approach
0SG04A0	Fusion of Lumbar Vertebral Joint with Interbody Fusion Device, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG14A0	Fusion of 2 or more Lumbar Vertebral Joints with Interbody Fusion Device, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34A0	Fusion of Lumbosacral Joint with Interbody Fusion Device, Anterior Approach Column, Percutaneous Endoscopic Approach

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Coding & reimbursement

Site of service

The table below reflects common spinal procedures by site of service. **Green** highlight reflects revised DRGs.

2025	Anterior Cervical Disc Replacement	Anterior Cervical Discectomy and Fusion	Lumbar Interbody Fusion ALIF/DLIF/OLIF	PLF/PLIF Lumbar Fusion	PLIF/TLIF Lumbar Fusion	Posterolateral Lumbar Fusion	SI Fusion	Lumbar Discectomy
DRG[6]	518	471-473	447-448 450-451	402, 426-430	447-448 450-451	447-448 450-451	447-448 450-451	515-517
APC	5116	5115	-----	5116	5116	5116	5116	5114
CPT[1]	22856	22551	22558	22633	22630	22612	27279	63047/63030
Inpatient[6]	$25,577	$34,664– $16,895	$47,848– $22,023	$27,920, $74,758-$39,040	$47,848– $22,023	$47,848– $22,023	$47,848– $22,023	$22,069- $10,653
Outpatient[2]	$18,390	$12,867	IP Only	$18,390	$18,390	$18,390	$18,390	$7,144
ASC[2]	$14,005	$9,069	IP Only	IP and OP Only	IP and OP Only	$14,037	$15,177	$3,511
Physician[4]	$1,597	$1,674	$1,498	$1,781	$1,544	$1,554	$790	$1,100/ $912

Under the MS-DRG system, cases are assigned based on individual patient diagnosis and presence, or absence of additional surgical procedures performed.

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Frequently asked questions

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, or email rs.CSTUSReimbursementSupport@medtronic.com.

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.

Medtronic

Frequently asked questions

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.CSTUSReimbursementSupport@medtronic.com

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Appendix

Team	Footnote	Definition
Add-on CPT®[1] codes	+	An Add-on Code (AOC) is a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) code that describes a service that is performed in conjunction with the primary service by the same practitioner. An AOC is rarely eligible for payment if it's the only procedure reported by a practitioner.
Carrier priced		Carrier priced codes are not assigned a rate on a national level. Local contractors will determine the reimbursement amount on a case-by-case basis.
Complexity adjustment		The complexity adjustments were implemented by CMS to provide for a payment adjustment when two or more high-cost procedures are performed and paid under Medicare's Hospital Outpatient Comprehensive APC system. To qualify, claims with certain code combinations must meet specific thresholds for both cost and frequency. When these thresholds are met, the code combinations qualify for reassignment to the next highest paying APC.
Comprehensive APC	†	Under its comprehensive APC (C-APC) policy, CMS makes payment for certain costly primary services and all other items and services reported on the hospital outpatient department claim, which CMS considers integral, ancillary, supportive, dependent, and adjunctive to the primary service and representing components of a complete comprehensive service.
Device intensive[11]	¶	Definition/symbol - The "device intensive" status is assigned to all surgical procedures with an individual HCPCS code-level device offset of greater than 40%. Device intensive procedures are identified in Addendum AA with a payment indicator of J8.
Inpatient only (IPO) list	C	CMS can define procedures and services for which payment under the outpatient prospective payment system (OPPS) is inappropriate. These codes have a status indicator of "C". Services designated as "inpatient only" are not appropriate to be furnished in a hospital outpatient department. Generally, inpatient only procedures are surgical services that require inpatient care because of the nature of the procedure.
Modifiers[12]	‖	Modifiers are used to supplement the information or adjust the care description to provide extra details concerning a procedure or service. Modifiers help further describe a procedure code without changing its definition. Modifiers are appended to CPT®1 codes. List of modifiers can be found in the CPT®1 book.
Multiple procedure discount[14]	††	When multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, Medicare will pay 100 percent of the highest paying surgical procedure on the claim, plus 50 percent of the applicable payment rate(s) for the other ASC covered surgical procedures.
Packaged payment	§	Under OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items is included in the APC payment for the service of which they are an integral part. For example, routine supplies, anesthesia, recovery room and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure.
Payment indicator		CMS uses payment indicators to identify each covered service that is eligible for ASC payment and the payment methodology by which the payment amount is calculated. The payment indicators also indicate which services' costs are packaged into the payment for other services and which surgical procedures are excluded from Medicare payment (72 FR 67189-67190).
Status indicator		In the Hospital Outpatient, Status Indicator (SI) shows how a code is handled for payment purposes: C= Inpatient procedures, not paid under OPPS; J1 = paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; S = procedure or service not discounted when multiple procedure; Additional details can be found in Addendum D1 of the OPPS rule.
Unlisted codes		Unlisted codes do not have established RVUs under Medicare's Physician Payment System and are typically priced by the contractor after review and individual consideration. Unlisted CPT®[1] codes do not carry a rate assignment from Medicare in the physician office setting. Payment may be available on a case-by-case basis with submission of medical records.
Work relative value unit (RVU)		The Work RVU is a unit of measure that describes the work associated with a physician's procedural services and is factored into the total physician payment. Work RVU is one of three total components on which physician payment is based: physician work RVU, practice expense RVU, and medical malpractice RVU.7.
w/MCC, w/CC or w/o CC/MCC		In the inpatient setting, w/MCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs w/MCC have at least one major secondary complication or comorbidity. Similarly, w/CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities, and MS-DRGs w/CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs w/o CC/MCC have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise. Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were present on admission, and do not count as CCs or MCCs when the conditions were acquired in the hospital during the stay.

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic

Medtronic SpineLine™

Medtronic.com/SpineLine

- Billing and coding guides
- CPT/HCPCS codes
- Reimbursement rates
- Coding tips
- Modifiers
- FAQs

SpineLine™ Learning Series

AAPC approved for 1.5 CEUs each

1. Advanced Spine Coding
2. Anatomy
3. Beginner's Spine Coding
4. Bone Grafting
5. Cervical and Lumbar Spinal Procedures
6. Demystifying Reimbursement
7. Spine Procedures in the ASC

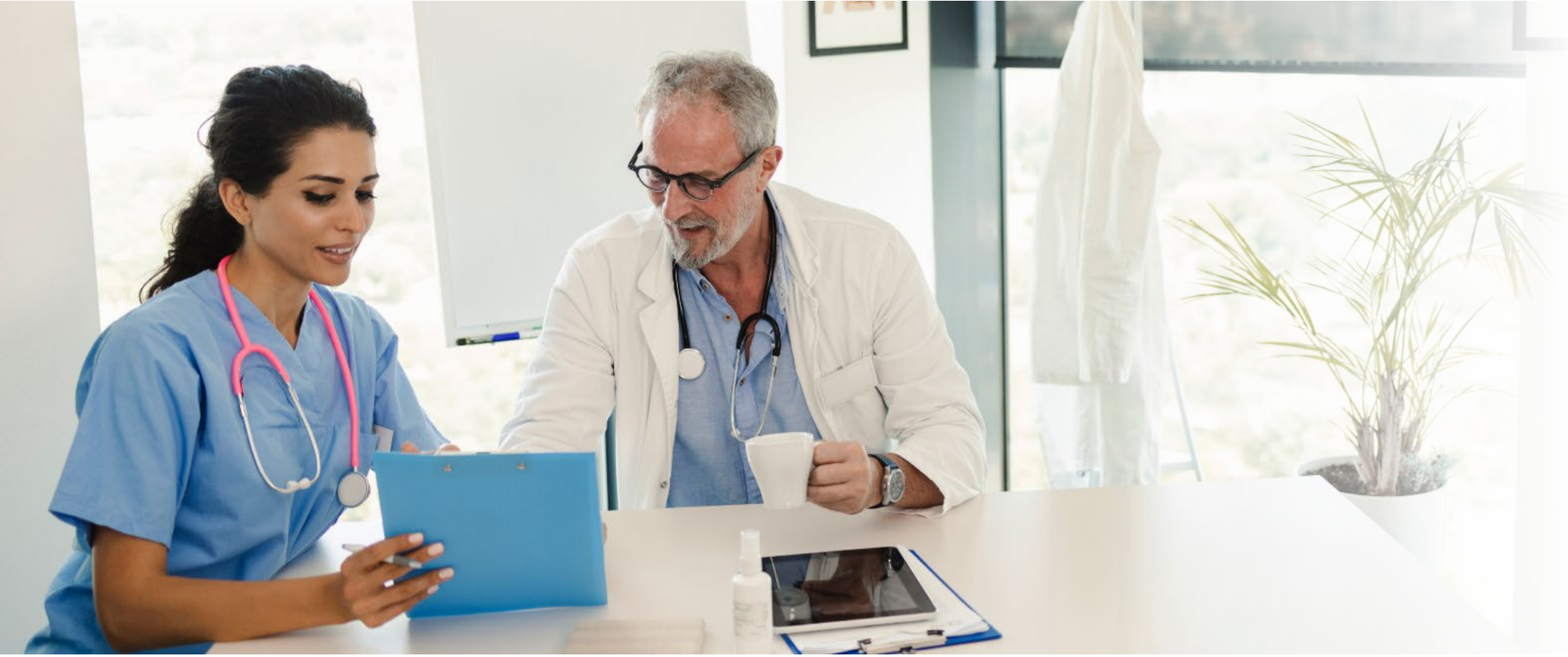
Medtronic

Resources

Reimbursement Support Center

rs.CSTUSReimbursementSupport@medtronic.com

- Coding, coverage & payment
- Customer education & training
- Resources & assistance



CST | HEPR

Medtronic SpineLine™

Healthcare Economics (HE)

For inquiries regarding reimbursement and coding, economic value evidence (including translation, application, and generation), health reform updates, payer coverage, or general support for physicians and hospitals through education, information, documentation, and training, please contact:

Anqi Lu, anqi.lu@medtronic.com or

Joshua Nance, joshua.nance@medtronic.com

Resources

Medtronic SpineLine™ offers resources, education, and training to help physicians, hospitals, and coding professionals navigate reimbursement and coding for our spine and biologics products and therapies.

Medtronic.com/SpineLine

Medtronic

References

1. CPT copyright 2024 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
2. Centers for Medicare and Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Final Rule, Federal Register (88 Fed. Reg. No. 224 81540-82185), https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf. Published November 2024. January 2025 ASC Approved HCPCS Code and Payment Rates. https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment/11_addenda_updates. Published December 2024.
3. Centers for Medicare and Medicaid Services. Healthcare Common Procedure Coding System (HCPCS) Quarterly Update. https://www.cms.gov/medicare/coding/hcpcsreleasecodesets/hcpcs-quarterly-update. Accessed January 2025.
4. Centers for Medicare and Medicaid Services. Medicare Program; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Federal Register (88 Fed. Reg. No. 220 78818-80047) https://www.govinfo.gov/content/pkg/FR-2023-11-16/pdf/2023-24184.pdf. 2025 National Physician Fee Schedule Relative Value File January Release https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files/rvu24a. Published Jan 2025.
5. Centers for Medicare and Medicaid Services. Outreach and Education: AMA Notices, Definitions, Terms, & Conditions. https://edit.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How_to_MPFS_Booklet_ICN901344.pdf. Accessed January 2025.
6. Centers for Medicare and Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2022 Rates; Final Rule, Federal Register (88 Fed. Reg. No. 165 58640-59438), https://www.govinfo.gov/content/pkg/FR-2023-08-28/pdf/2023-16252.pdf. Published August 2024.
7. Centers for Medicare and Medicaid Services. International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS). https://www.cms.gov/medicare/coding-billing/icd-10-codes/2025-icd-10-pcs. Accessed January 2025.
8. American Medical Association. CPT 2025 Professional Edition. 2024.
9. Centers for Medicare and Medicaid Services; Medicare NCCI Policy Manual. https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare/medicare-ncci-policy-manual. Accessed January 2025.
10. AHA Coding Clinic for ICD-10-CM
11. CPT Changes 2017, American Medical Association.
12. CPT Assistant July 2011, American Medical Association.
13. AHA Coding Clinic for ICD-10-PCS First Quarter 2018
14. Centers for Medicare and Medicaid Services; Medicare NCCI Policy Manual. https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare/medicare-ncci-policy-manual. Accessed January 2025.

Overview

New for 2025

Coding & Reimbursement

Resources

Medtronic