

2012 Spine Reimbursement Fact Sheet

SURGEON CPT CODE ¹	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT ²
Traditional Open Procedure		
22856	Total disc arthroscopy (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression) cervical, single interspace	\$1,675
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, single interspace	1,664
22861	Revision of total disc arthroplasty, anterior approach cervical, single interspace	2,009
22862	Revision including replacement of total disc arthroplasty (artificial disc) anterior approach, lumbar, single interspace	2,107
22864	Removal of total disc arthroplasty, anterior approach cervical, single interspace	1,931
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, lumbar, single interspace	2,065
22899	Unlisted procedure, spine	Carrier Priced
0092T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyctomy for nerve root or spinal cord decompression and microdissection), each additional interspace, cervical (List separately in addition to code for primary procedure)	Carrier Priced
0095T	Removal of total disc arthroplasty, anterior approach; each additional interspace cervical (List separately in addition to code for primary procedure)	Carrier Priced
0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach; each additional interspace, cervical (List separately in addition to code for primary procedure)	Carrier Priced
0163T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, each additional interspace	Carrier Priced
0164T	Removal of total disc arthroplasty, anterior approach, lumbar; each additional interspace	Carrier Priced
0165T	Revision of total disc arthroplasty, anterior approach, lumbar; each additional interspace	Carrier Priced

NOTE: Spinal arthroplasty procedures are not covered by Medicare in the Hospital Outpatient or Ambulatory Surgical sites of service

OUTPATIENT FACILITY

Hospital Outpatient Department

APC	APC DESCRIPTION	MEDICARE PAYMENT ³
0050	Level II Musculoskeletal Procedures Except Hand and Foot (CPT code: 22899)	\$2,267

INPATIENT FACILITY

ICD-9 CODE ⁵	DESCRIPTION
84.65	Insertion of total spinal disc prosthesis, lumbosacral
84.68	Revision or replacement of artificial spinal disc prosthesis, lumbosacral
84.69	Revision or replacement of artificial spinal disc prosthesis, not otherwise specified

NOTE: ICD-9 codes are grouped into Diagnoses Related Groups (DRGs) for Medicare reimbursement using a patient's diagnoses, procedures performed, age, sex and discharge status. One DRG is assigned to each inpatient stay.

DRG	DESCRIPTION	AVERAGE LENGTH OF STAY (DAYS) ⁶	NATIONAL AVERAGE DRG PAYMENT ⁴
028	Spinal procedures with MCC	13.0	\$31,803
029	Spinal procedures with CC or spinal neurostimulator	6.2	15,941
030	Spinal procedures without CC/MCC	3.1	9,530
490	Back and neck procedures except spinal fusion with CC/MCC or disc device/neurostimulator	4.2	10,129
491	Back and neck procedures except spinal fusion without CC/MCC	2.1	5,669
907	Other O.R. Procedures for injuries with MCC	11.3	22,334
908	Other O.R. Procedures for injuries with CC	6.0	10,867
909	Other O.R. Procedures for injuries without CC/MCC	3.3	6,539
957	Other O.R. Procedures for multiple significant trauma with MCC	14.5	37,175
958	Other O.R. Procedures for multiple significant trauma with CC	9.2	21,112
959	Other O.R. Procedures for multiple significant trauma without CC/MCC	5.7	13,915



¹ All Current Procedural Terminology (CPT) five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines and other material are copyright 2011 American Medical Association. All Rights Reserved.

² Federal Register, Vol. 76, No. 228, Monday, November 28, 2011/ Rules and Regulations. The 2012 Final Physician Reimbursement Conversion Factor = \$34.0376.

³ Hospital ICD-9-CM 2010 Volumes 1, 2 & 3, 9th Revision-Clinical Modification, American Medical Association. Copyright © 2011 Saunders, an imprint of Elsevier, Inc.

⁴ Federal Register, Vol. 76, No. 160, Thursday, August 18, 2011/ Rules and Regulations; Final National Average DRG Payment.

Physicians should refer to their provider Carrier Manual for their geographic payments.

The information contained in this document is provided to help you understand the reimbursement process. It is not intended to increase or maximize reimbursement by any payor. We strongly recommend that providers consult their payor organization with regard to local reimbursement policies. The information contained in this document is provided for information purposes only and represents no statement, promise or guarantee by Ethicon Endo-Surgery, Inc. concerning levels of reimbursement, payment or charge. Similarly, all CPT, HCPCS and ICD-9 codes are supplied for information purposes only and represent no statement, promise or guarantee by Ethicon Endo-Surgery, Inc. that these codes will be appropriate or that reimbursement will be made. ICD-9 is based on the official version of the World Health Organization's Ninth Revision, International Classification of Diseases. CPT codes and descriptions only are copyright 2011 American Medical Association. All Rights Reserved. CPT does not include fee schedules, relative values or related listings. The source for this information is the Centers for Medicare and Medicaid Services and various commercial payors. The content provided by the Centers for Medicare and Medicaid Services is updated frequently. It is the responsibility of the health services provider to confirm the appropriate coding required by their local Medicare carriers, fiscal intermediaries and commercial payors.