i-FACTOR® REIMBURSEMENT GUIDE

Physician Services

When physicians bill for services performed, payers require physicians to assign a CPT code to classify or identify the procedure performed. These codes are uniformly accepted by all payers. Medicare and most insurance companies use a fee schedule to pay physicians for their professional services, assigning a payment amount to each CPT code.

Hospital Outpatient & Ambulatory Surgical Center (ASC)

Medicare reimburses outpatient hospital and ASC services under the Outpatient Prospective Payment System (OPPS), which bases payment on Ambulatory Payment Classifications (APCs). The payment to ASCs are set based on the OPPS rates.

Type of Surgery	CPT Code	Description	APC Code
Primary Surgery	22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	5115
Bone Graft	20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only; (List separately in addition to code for primary procedure)	Bundled with APC 5115
Instrumentation	22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)	

Hospital Inpatient

Medicare reimburses inpatient hospital services under the Inpatient Prospective Payment System (IPPS), which bases payment on MS-DRGs (Medicare Severity Diagnosis Related Groups). 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 group has a flat payment rate, which bundles the reimbursement for all services and devices the patient received during the inpatient stay.

MS-DRGs	Description
471	Cervical spinal fusion with MCC*
472	Cervical spinal fusion with CC**
473	Cervical spinal fusion without CC/MCC

*MCC: Major Complication or Comorbidity **CC: Complication or Comorbidity

ICD-10-PCS

For patient admissions involving procedures, hospitals must also report ICD-10-PCS procedure codes for surgeries and other procedures as well as ICD-10-CM diagnosis codes. The example of codes may be appropriate for the performance of an anterior cervical discectomy and fusion surgery, using i-FACTOR®.

ICD-10-PCS	Description
0RG10K0	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG13K0	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG14K0	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG10A0	Fusion of Cervical Vertebral Joint with Interbody Fusion Device, Anterior Approach, Anterior Column, Open Approach
0RG13A0	Fusion of Cervical Vertebral Joint with Interbody Fusion Device, Anterior Approach, Anterior Column, Percutaneous Approach
0RG14A0	Fusion of Cervical Vertebral Joint with Interbody Fusion Device, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach

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Glossary

Ambulatory Payment Classification (APC): A system for grouping outpatient services provided by hospitals based on similarity of costs and clinical indications; used by the Centers for Medicare and Medicaid Services to set the rates at which it will reimburse hospitals for outpatient care.

Ambulatory Surgical Center (ASC): A facility that focus on providing same-day surgical care, including diagnostic and preventive procedures.

Current Procedural Terminology (CPT): CPT codes offer health care professionals a uniform language for coding medical services and procedures to streamline reporting. These CPT codes are created and maintained by the American Medical Association (AMA) and are reviewed and revised on an annual basis.

Healthcare Common Procedure Coding System (HCPCS): HCPCS is a standardized coding system used to process claims for insurance payments by CMS. It has two main categories: Level 1 codes are CPT codes, describing medical, surgical, and diagnostic services performed; Level 2 codes are developed by CMS to identify products, supplies, and services not included in Level 1 codes (e.g., ambulance services, drugs, devices, DME).

Hospital Inpatient Prospective Payment System (HIPPS): This system categorizes cases into diagnoses-related groups (DRGs) that are then weighted based on resources used to treat Medicare beneficiaries in those groups.

Hospital Outpatient Prospective Payment System (HOPPS): The system through which Medicare decides how much money a hospital or community mental health center will get for outpatient care provided to patients with Medicare.

ICD-10-CM: A statistical classification system created by the Center for Disease Control and Prevention Act, which arranges diseases and injuries into groups according to predetermined criteria.

ICD-10-PCS: A classification system, which is used for coding procedures and services provided in the inpatient setting only.

Important Information:

This document is intended solely for the use of healthcare professionals. Reimbursement, coding, coverage, and payment information is provided for general information only and is not intended to provide coverage, coding, payment, medical treatment or legal advice. Cerapedics does not warrant, promise, guarantee, or make any statement that the codes supplied in this guide are appropriate for any individual patient or that the use of this information will result in coverage or payment for treatment using any Cerapedics products or that any payment received will reimburse a provider's costs. The information is not intended to guarantee or increase payment by any payor. Laws, regulations, and policies concerning reimbursement are complex, subject to change and updated regularly.

Cerapedics does not assume any responsibility for coding decisions, nor does it recommend codes for specific patients' procedures. The provider is solely responsible for reporting the codes that accurately describe the services furnished to a particular patient as well as the patient's medical condition. It is the provider's responsibility to determine and document that the services provided are medically necessary and that the site of service is appropriate. It is the health care provider's responsibility to report the patient diagnosis, the procedures performed, and the products used, consistent with the specific payer's guidelines.

There is no requirement that any patient or healthcare provider uses i-FACTOR® in exchange for this information and a physician must always rely on his or her own professional clinical judgment when deciding whether to use a particular product when treating a particular patient.

For Reimbursement assistance and support, contact us:

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ML-1216-1