Spinal Fusion Surgery Reimbursement Guide

2023

CERAPEDICS

Enhancing the Science of Bone Repair

TABLE OF CONTENTS

INTRODUCTION

This reimbursement guide has been developed to help physicians and facilities ("providers") with accurate coding for spinal fusion surgeries. It is the provider's responsibility to determine and submit appropriate codes, charges, and modifiers for the products and services rendered. Payers may have additional or different coding and reimbursement requirements. Therefore, before filing any claim, providers should verify these requirements in writing with payers.

HOW TO USE THIS GUIDE

This reimbursement guide is organized by type of provider (physician, hospital inpatient, hospital outpatient, and ambulatory surgical center). For each type of provider, the type of spinal fusion surgery (e.g., decompression procedures, spine arthrodesis and arthroplasty procedures, grafting and instrumentation procedures) is used to group similar procedures together.

For each procedure, relevant codes (e.g., CPT, MS-DRG) along with descriptions are provided.
For example, if a hospital outpatient department wants to get reimbursed for an anterior cervical discectomy and fusion (ACDF) procedure they furnish, they can follow the following steps to identify appropriate coding.

1. Go to "Outpatient and ASC Facility" Section
2. Go to "Spine Arthrodesis and Arthroplasty Procedure Codes" and "Grafting and Instrumentation Procedure Codes" Sections
3. Identify most relevant codes for the ACDF procedure based on the procedure descriptions
   A. Primary surgery coding: 22551 (one level) | 22551 & 22552 (multiple levels)
   B. Bone graft coding: 20930 (Allograft, morselized) | 20931 (Allograft, structural)
   C. Instrumentation: 22845

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. Most CPT codes are assigned relative value units (RVUs) to represent the physician work, malpractice costs, and practice expenses. Medicare annually revises a dollar conversion factor that, when multiplied by the code's RVUs, results in the national Medicare reimbursement for that procedure.

CPT Code	Description	2023 Total RVUs
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc; one interspace, lumbar	N/A
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), one or two vertebral segments; cervical	36.69
63003	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), one or two vertebral segments; thoracic	36.68
63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), one or two vertebral segments; lumbar, except for spondylolisthesis	35.61
63015	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; cervical	43.97
63016	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; thoracic	45.32
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	37.55
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; one interspace, cervical	34.45
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; one interspace, lumbar	29.00
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	5.64

Decompression Procedure Codes (continued)

CPT Code	Description	2023 Total RVUs
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	41.04
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	38.44
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	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	N/A
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [e.g., spinal or lateral recess stenosis]), single vertebral segment; cervical	38.28
63046	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; thoracic	36.48
63047	Laminectomy, facetectomy and foraminotomy, (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar	32.84
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar	6.21
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	7.62
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	5.70
63055	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; thoracic	48.26

Decompression Procedure Codes (continued)

CPT Code	Description	2023 Total RVUs
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; lumbar (including transfacet or lateral extraforaminal approach) (e.g., far lateral herniated intervertebral disc)	44.32
63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar	9.47
63064	Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., herniated intervertebral disc), thoracic; single segment	52.82
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	40.37
63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace	7.18
63077	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace	44.58
63078	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, each additional interspace	6.10
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment	52.17
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	7.81
63085	Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment	57.17
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	5.62
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	71.29

Decompression Procedure Codes (continued)

CPT Code	Description	2023 Total RVUs
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	7.56
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	58.06
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	5.23

Spine Arthrodesis and Arthroplasty Procedure Codes

Type	CPT Code	Description	2023 Total RVUs
Anterior Fusion	**22551**	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy, and decompression of spinal cord and/or nerve root(s); cervical below C2	50.50
	22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (list separately in addition to code for separate procedure)	11.69
	22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	37.38
	22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	49.41
	22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	45.34
	22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace	9.60

Spine Arthrodesis and Arthroplasty Procedure Codes (continued)

Type	CPT Code	Description	2023 Total RVUs
Posterior Fusion	**22595**	Arthrodesis, posterior technique, atlas-axis (C1–C2)	45.03
	22600	Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment	38.60
	22610	Arthrodesis, posterior or posterolateral technique, single interspace; thoracic (with lateral transverse technique, when performed)	37.93
	22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)	47.06
	22614	Each additional interspace	11.53
PLIF & TLIF	**22630**	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	46.96
	22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace	9.46
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)	54.89
	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 and segment, lumbar (do not report with 22612 or 22630 at the same level)	14.64
Artificial Disc Replacement	**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	48.36
	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	14.93
	22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	68.78
	22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	61.42

Grafting and Instrumentation Procedure Codes

Type	CPT Code	Description	2023 Total RVUs
Allograft & Autograft	**20930**	Allograft, morselized, or placement of osteopromotive material, for spine surgery only	0.00
	20931	Allograft, structural, for spine surgery only	3.26
	20936	Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process or laminar fragments) obtained from same incision	0.00
	20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision)	4.92
	20938	Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (list separately in addition to code for primary procedure)	5.43
	20939	One marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision	2.05
Posterior Instrument-ation	**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	N/A
	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)	22.38
	22841	Internal spinal fixation by wiring of spinous processes	0.0
	22842	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); three to six vertebral segments	22.50
	22843	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments	24.06
	22844	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments	29.02

Grafting and Instrumentation Procedure Codes (continued)

Type	CPT Code	Description	2023 Total RVUs
Anterior Instrumentation	22845	Anterior instrumentation; two to three vertebral segments	21.46
	22846	Allograft, structural, for spine surgery only Anterior instrumentation; four to seven vertebral segments	22.31
	22847	Anterior instrumentation; eight or more vertebral segments	23.61
Bio-Mechanical 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	7.61
	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	9.88
	22859	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect	9.82

INPATIENT FACILITY

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

MS-DRGs	Description	2023 Relative Weight
453	Combined Anterior/Posterior Spinal Fusion with MCC*	9.19
454	Combined Anterior/Posterior Spinal Fusion with CC**	6.09
455	Combined Anterior/Posterior Spinal Fusion without CC/MCC	4.78
456	Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/ Infection or Extensive Fusions with MCC	8.60
457	Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/ Infection or Extensive Fusions with CC	6.50
458	Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/ Infection or Extensive Fusions without CC/MCC	5.01
459	Spinal Fusion Except Cervical with MCC	6.73
460	Spinal Fusion Except Cervical without MCC	3.93
471	Cervical Spinal Fusion with MCC	5.02
472	Cervical Spinal Fusion with CC	3.05
473	Cervical Spinal Fusion without CC/MCC	2.54
518	Back and neck procedure except spinal fusion with MCC or disc device/ neurostimulator	3.59
519	Back and neck procedure except spinal fusion with CC	1.96
520	Back and neck procedure except spinal fusion without CC/MCC	1.42

OUTPATIENT & ASC FACILITY

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.

Decompression Procedure Codes

CPT Code	APC	Description
63040	**5114**	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
63042		Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar
63043	**N/A**	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
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
63045	**5114**	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
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
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
63048	**N/A**	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
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
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

Decompression Procedure Codes (continued)

CPT Code	APC	Description
63040	**5114**	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
63042		Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar
63043	**N/A**	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
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
63045	**5114**	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
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
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
63048	**N/A**	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
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
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

Decompression Procedure Codes (continued)

CPT Code	APC	Description
63055	5114	Transpedicular approach with decompression of spinal cord, equina and/ or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic
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)
63057	N/A	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
63064	5114	Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; single segment
63066	N/A	Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; each additional segment
63075	5114	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
63076	N/A	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace

Spine Arthrodesis and Arthroplasty Procedure Codes

CPT Code	APC	Description
22551	5114	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
22552	N/A	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace
22554	5114	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2

Spine Arthrodesis and Arthroplasty Procedure Codes (continued)

CPT Code	APC	Description
22585	**N/A**	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace
22612	**5115**	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)
22614	**N/A**	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment
22630	**5116**	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
22633	**5115**	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)
22634	**N/A**	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 and segment, lumbar (do not report with 22612 or 22630 at the same level)
22840		Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)
22842		Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments
22845		Anterior instrumentation; 2 to 3 vertebral segments
22853		Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace

Spine Arthrodesis and Arthroplasty Procedure Codes (continued)

CPT Code	APC	Description
22854	**N/A**	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect
22856	**5116**	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
22858	**N/A**	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
0221T	**5114**	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
20930	**5116**	Allograft, morselized, or placement of osteopromotive material, for spine surgery only
20931	**N/A**	Allograft, structural, for spine surgery only
20936		Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process or laminar fragments) obtained from same incision
20937		Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision)
20938		Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (list separately in addition to code for primary procedure)

Spine Arthrodesis and Arthroplasty Procedure Codes (continued)

CPT Code	APC	Description
20939	**N/A**	One marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision
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)
22842		Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); three to six vertebral segments
22845		Anterior instrumentation; two to three vertebral segments
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
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
22859		Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect

MODIFIERS

Medical modifiers are additional codes that can be used with CPT and HCPCS codes to provide additional information so that providers get paid correctly for treatments performed. In addition, modifiers also show treatments performed more than once or treatments that were administered unusually. Lastly, modifiers are also used when the services in a bundle are not performed.

Modifiers	Description
22	Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.
50	Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code.
51	Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes (see Appendix D).
52	Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).
53	Discontinued Procedure: Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

Modifiers (continued)

Modifiers	Description
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period: It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.
59	Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/ excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.
62	Two Surgeons: When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.
76	Repeat Procedure or Service by the Same Physician or Other Healthcare Professional: It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.
77	Repeat Procedure by Another Physician or Other Qualified Healthcare Professional: It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Healthcare Professional Following Initial Procedure for a Related Procedure During the Postoperative Period: It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

Modifiers (continued)

Modifiers	Description
79	Unrelated Procedure or Service by the Same Physician During the Postoperative Period: The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)
80	Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).
81	Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number
82	Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).

For additional questions or assistance on approval of i-FACTOR, please contact reimbursement@cerapedics.com

References
1. FY 2023 Medicare Physician Fee Schedule | CMS-1770-F. https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1770-f. Accessed December 19, 2022.
2. FY 2023 Hospital Outpatient PPS | CMS-1772-FC. https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1772-fc. Accessed December 19, 2022.
3. FY 2023 IPPS Final Rule | CMS - 1771F, 1771F2, 1771CN, 1772FC. https://www.cms.gov/medicare/acute-inpatient-pps/fy-2023-ipps-final-rule-home-page. Accessed December 19, 2022.
4. Centers for Medicare & Medicaid Services. International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) https://www.cms.gov/medicare/icd-10/2021-icd-10-pcs. Accessed December 19, 2022

Corporate Headquarters
11025 Dover Street, Suite 1600
Westminster, CO 80021 USA

www.cerapedics.com

CERAPEDICS
Enhancing the Science of Bone Repair

ML-0794 2.3.2023