2023 Comprehensive Reimbursement Resource Guide

Prepared by Musculoskeletal Clinical Regulatory Advisers, LLC. Version January 2023.

prodisc® L

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Reimbursement Disclaimer: This information is for educational/informational purposes only and should not be construed as authoritative. The information presented here is current as of January 2023 and is based upon publicly available source information. Codes and values are subject to frequent change without notice. The entity billing Medicare and/or third-party payers is solely responsible for the accuracy of the codes assigned to the services or items in the medical record. When making coding decisions, we encourage you to seek input from the American Medical Association (AMA), relevant medical societies, Centers for Medicare & Medicaid Services (CMS), your local Medicare Administrative Contractor, (MAC) and other health plans to which you submit claims. Items and services that are billed to payers must be medically necessary and supported by appropriate documentation. It is important to remember that while a code may exist describing certain procedures and/or technologies, it does not guarantee payment by payers. The decision as to how to complete a reimbursement form, including the amount to bill, is exclusively the responsibility of the provider.

PRODUCT TECHNOLOGY OVERVIEW

TECHNOLOGY DESCRIPTION

The pro**disc** L device is composed of three components – two cobalt chrome alloy (CoCrMo) endplates and an ultra-high molecular weight polyethylene (UHMWPE) inlay.

FDA INFORMATION ON PRODISC L FOR 1 AND 2 LEVELS

The FDA cleared the pro**disc** L for 1 level indication on August 14, 2006 (P050010) [i].

The FDA expanded the indication to include treatment of two adjacent levels of the lumbar spine on April 4th, 2020. (P050010/S020)[ii]

INDICATIONS FOR USE

The pro**disc** L Total Disc Replacement is indicated for spinal arthroplasty in skeletally mature patients with degenerative disc disease (DDD) at one or two adjacent vertebral level(s) from L3-S1. DDD is defined as discogenic back pain with degeneration of the disc confirmed by patient history and radiographic studies. These DDD patients should have no more than Grade 1 spondylolisthesis at the involved level(s). Patients receiving the pro**disc** L Total Disc Replacement should have failed at least six months of conservative treatment prior to implantation of the pro**disc** L Total Disc Replacement.

CONTRAINDICATIONS

- Active systemic infection or infection localized to the site of implantation
- Osteopenia or osteoporosis as defined as DEXA bone density measured T-score < -1.0
- Bony lumbar spinal stenosis
- Allergy or sensitivity to implant materials (cobalt, chromium, molybdenum, polyethylene, titanium)
- Isolated radicular compression syndromes, especially due to disc herniation
- Pars defect
- Involved vertebral end plate dimensionally smaller than 34.5 mm in the medial-lateral and/or 27 mm in the anterior-posterior directions
- Clinically compromised vertebral bodies at affected level due to current or past trauma
- Lytic spondylolisthesis or degenerative spondylolisthesis of grade > 1

MEDICARE COVERAGE DETERMINATIONS (NCD/LCD)

Currently, there is a National Coverage Determination (NCD) related to the pro**disc** L that does not cover over 60 years of age. Check with your local Medicare Administrative Contractor (MAC) regarding any Local Coverage Determinations (LCDs) related to the pro**disc** L. Medicare may cover the pro**disc** L on a case-by-case basis, with evidence of medical necessity. While traditional Medicare does not require or allow prior authorization or prior approval for procedures, Medicare Advantage plans are managed by commercial payers who may require prior authorization for Medicare Advantage patients. Check with your plan administrator for any prior authorization requirements.

PRIVATE PAYER COVERAGE DETERMINATIONS

Commercial insurance coverage policies vary, and many require prior authorization for any procedure. We encourage health care professionals (HCPs) to contact payer(s) directly with questions regarding coverage policies or guidelines for the pro**disc** L.

MEDICARE PHYSICIAN CODING AND 2023 MEDICARE PAYMENT

CPT CODE[iii]	DESCRIPTION	2023 RVU	2023 MEDICARE NATIONAL AVERAGE PHYSICIAN PAYMENT[iv]
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	52.73	$1,786.87
22860	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)	N/A	Carrier Priced
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	69.88	$2,367.70
22865	Removal of total disc arthroplasty (artificial disc) anterior approach, single interspace; lumbar	68.21	$2,311.45

MEDICARE BILLING AND PAYMENT

For hospital inpatient and outpatient procedures, device category HCPCS codes (i.e. C-codes) for implantable devices, along with the associated charge for the device may be reported. Complete and accurate reporting of implantable devices and the associated HCPCS codes assures accurate payment and provides necessary data for the reimbursement system.

MEDICARE HOPSITAL OUTPATIENT/ASC CODING AND 2023 MEDICARE PAYMENT

CPT CODE	DESCRIPTION	SI	APC	2023 MEDICARE NATIONAL AVERAGE PAYMENT HOPD[v]	SI	PI	2023 MEDICARE NATIONAL AVERAGE PAYMENT ASC[vi]
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	N/A	N/A	Not allowed in the HOPD Setting of care for Medicare	N/A	N/A	Not allowed in the ASC Setting of care for Medicare
22860	Total disc arthroplasty (artificial						

	disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)	N/A	N/A	Not allowed in the HOPD Setting of care for Medicare	N/A	N/A	Not allowed in the ASC Setting of care for Medicare
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	N/A	N/A	Not allowed in the HOPD Setting of care for Medicare	N/A	N/A	Not allowed in the ASC Setting of care for Medicare
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	N/A	N/A	Not allowed in the HOPD Setting of care for Medicare	N/A	N/A	Not allowed in the ASC Setting of care for Medicare

Private Payers may allow for this procedure to be done in the HOPD/ASC settings of care

HOSPITAL INPATIENT CODING AND 2023 MEDICARE PAYMENT

The ICD-PCS (procedure) code and possible MS-DRG assignments are provided below along with the 2023 Medicare national average payment rates.

LEVEL 1 & LEVEL 2

CLINICAL DIAGNOSIS NAME	ICD-10-CM CODE	ICD-10-PCS CODE	MS-DRG[vii]	MS-DRG DESCRIPTION	2023 MEDICARE PAYMENT
Total Disc Arthroplasty	M51.36 M51.37 M43.16 M43.17	0SR20JZ Lumbar 0SR40JZ Lumbosacral	518	Back and Neck procedures Except Spinal Fusion with MCC or Disc Device/Neurostimulator	$25,570.16
Total Disc Arthroplasty Replacement	M96.69 T84.216A T84.226A** T84.296A T84.418A T84.428A T84.498A T84.63XA T84.7XXA	0SR20JZ Lumbar		Replacement of Lumbar Vertebral Disc with Synthetic Substitute, Open Approach	
		0SR40JZ Lumbosacral		Replacement of Lumbosacral Disc with Synthetic Substitute, Open Approach	
Total Disc Arthroplasty Revision	T84.81XA T84.82XA T84.83XA T84.84XA T84.85XA T84.86XA T84.89XA T84.9XXA Z47.2**	0SW20JZ Lumbar	520	Revision of Synthetic Substitute in Lumbar Vertebral Disc, Open Approach	$10,150.69
		0SW40JZ lumbosacral		Revision of Synthetic Substitute in Lumbosacral Disc, Open Approach	

HCPCS CODES

HCPCS Code(s)[viii]	HCPCS Code Description
C1889	Implantable/insertable device, not otherwise classified

POSSIBLE ICD-10-CM (DIAGNOSIS) CODES (This is not a complete list)

ICD-10-CM DIAGNOSIS CODES

M51.36 Other intervertebral disc degeneration, lumbar region M51.37 Other intervertebral disc degeneration, lumbosacral region M43.16 Spondylolisthesis, lumbar region grade1
M43.17 Spondylolisthesis, lumbosacral region grade 1

ICD-10-CM CODES FOR REMOVAL & REPLACEMENT/REVISION

M96.69	Fracture of other bone following insertion of orthopedic implant, joint prosthesis, or bone plate
T84.216A	Breakdown (mechanical) of internal fixation device of vertebrae, initial encounter
T84.226A	**Displacement of internal fixation device of vertebrae, initial encounter **
T84.296A	Other mechanical complication of internal fixation device of vertebrae, initial encounter
T84.418A	Breakdown (mechanical) of other internal orthopedic devices, implants and grafts, initial encounter
T84.428A	Displacement of other internal orthopedic devices, implants and grafts, initial encounter
T84.498A	Other mechanical complication of other internal orthopedic devices, implants and grafts, initial encounter
T84.63XA	Infection and inflammatory reaction due to internal fixation device of spine, initial encounter
T84.7XXA	Infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts, initial encounter
T84.81XA	Embolism due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
T84.82XA	Fibrosis due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
T84.83XA	Hemorrhage due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
T84.84XA	Pain due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
T84.85XA	Stenosis due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
T84.86XA	Thrombosis due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
T84.89XA	Other specified complication of internal orthopedic prosthetic devices, implants and grafts, initial encounter
T84.9XXA	Unspecified complication of internal orthopedic prosthetic device, implant and graft, initial encounter
Z47.2	Encounter for removal of internal fixation device

REFERENCES

[i] https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P050010

[i] https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P050010S020

[ii] https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P050010

[ii] https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P050010S020

[iii] CPT 2023 Professional Edition, ©2022 American Medical Association (AMA); CPT is a trademark of the AMA.

[iv] https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1770-f

[v] https://www.cms.gov/files/document/cy2023-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-final-rule.pdf Addenda A&B

[vi] https://www.cms.gov/license/ama?file=/files/zip/2023-nfrm-addendum-aa-bb-dd1-dd2-ee-and-ff.zip ASC Addendum AA, BB, DD1, DD2, EE, and FF

[vii] https://www.cms.gov/files/zip/fy2023-ipps-fr-impact-file.zip Table 5 MS-DRGs, Relative Weighting Factors and Geometric and Arithmetic Mean Length of Stay 2023 MS- DRG IPPS Final Rule CMS-1771-F

[viii] https://www.cms.gov/medicare/coding/hcpcsreleasecodesets/hcpcs-quarterly-update