



HOSPITAL CODING OPTIONS

| CPT ¹ Code | Code Description |
|-----------------------|--|
| 22612** | Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique) |
| 22614** | each additional vertebral segment (list separately in addition to code for primary procedure) |
| 22630 | Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar |
| 22632 | each additional interspace (list separately in addition to code for primary procedure) |
| 22558 | Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar |
| 22585 | each additional interspace (list separately in addition to code for primary procedure) |
| 22849 | Reinsertion of spinal fixation device |
| 63047 | Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equine and/or nerve root(s), (e.g., spinal or lateral recess stenosis), single vertebral segment; lumbar |
| 63048 | each additional segment, cervical, thoracic, or lumbar (list separately in addition to code for primary procedure) |
| 63030** | Laminotomy with decompression, including partial facetectomy, foraminotomy and/or excision of herniated disc |
| 63035** | each additional interspace, cervical or lumbar (list separately in addition to code for primary procedure) |
| 22840 | Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, face screw fixation) |
| 22842 | Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks or sublaminar wires); 3-6 segments |
| 22850 | Removal of posterior segmental non-segmental instrumentation |
| 22852 | Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) |

**Status indication "T" - Subject to multiple procedure reductions.
Status indication "C" - In Patient only and not subject to OPPS.

| COMMON ICD9 ² | Diagnosis Description |
|--------------------------|---|
| 721.42 | Spondylosis with myelopathy, lumbar region |
| 722.10 | Displacement of lumbar intervertebral disc without myelopathy |
| 722.52 | Degeneration of lumbar spine or lumbosacral intervertebral disc |
| 722.73 | Intervertebral lumbar disc disorder with myelopathy, lumbar region |
| 724.02 | Spinal stenosis of lumbar region |
| 731.00 | Osteitis deformans without mention of bone tumor |
| 756.11 | Spondylolysis, lumbosacral region |
| 756.12 | Spondylolisthesis |
| 805.50 | Open fracture of lumbar vertebra without mention of spinal cord injury |
| 839.20 | Closed dislocation, lumbar vertebra |
| 839.30 | Open dislocation, lumbar vertebra |
| 996.40 | Unspecified mechanical complication of internal orthopedic device, implant, and graft (use additional code to identify prosthetic joint with mechanical complication) |

HOSPITAL CODING OPTIONS FOR 2011

DSS® SYSTEM



| COMMON ICD9 | Diagnosis Description |
|-------------|--|
| 996.67 | Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft (use additional code to identify specified infections) |
| 996.78 | Other complications due to other internal orthopedic device, implant, or graft (use additional code to identify complication) |

| ICD-9 | ICD-9 Procedure |
|-------|--|
| 03.09 | Other exploration and decompression of spinal canal |
| 78.59 | Internal fixation of other bone, except facial bones, without fracture reduction |
| 80.51 | Excision of intervertebral disc |
| 81.07 | Lumbar and lumbosacral fusion, lateral transverse process technique |
| 81.08 | Lumbar and lumbosacral fusion, posterior technique |
| 81.37 | Refusion of lumbar and lumbosacral spine, lateral transverse process technique |
| 81.38 | Refusion of lumbar and lumbosacral spine, posterior technique |
| 84.51 | Insertion of interbody spinal fusion device |

| APC | APC Description | 2011 Medicare Average Allowable Rate ³ |
|------|--------------------------------|---|
| 0208 | Laminotomies and Laminectomies | \$ 3,535.92 |

| Revenue | Revenue Description |
|---------|-----------------------------|
| 278 | Medical device and implants |

| MS-DRGs ⁴ | MS-DRG Description | 2011 Medicare Average Allowable Rate ⁵ |
|----------------------|---|---|
| 028 | Spinal procedures with MCC | \$29,209.40 |
| 459 | Spinal fusion except cervical with MCC | \$36,333.08 |
| 460 | Spinal fusion except cervical without MCC | \$21,617.80 |

Rates and RVUs are for 2011 - Physician, ASC and Outpatient effective 1/1/11; Inpatient effective 10/1/10
Codes denoted above are recommendations only. Codes and values are subject to frequent change without notice.
Manufacturer of device assumes no responsibility for coding. Therefore health care providers must use great care and validate coding requirements ascribed by payors with whom they work.

- 1) CPT 2011 Professional Edition 2010 American Medical Association;
- 2) 2011 Expert ICD-9-CM for Hospitals – Volumes 1,2 & 3, 2010
- 3) 2011 Medicare ASC Payment Rate 11/01/2010
- 4) 2011 DRG Expert, American Medical Association, 2010
- 5) 2011 www.cms.gov Medicare average payment will vary by hospital



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