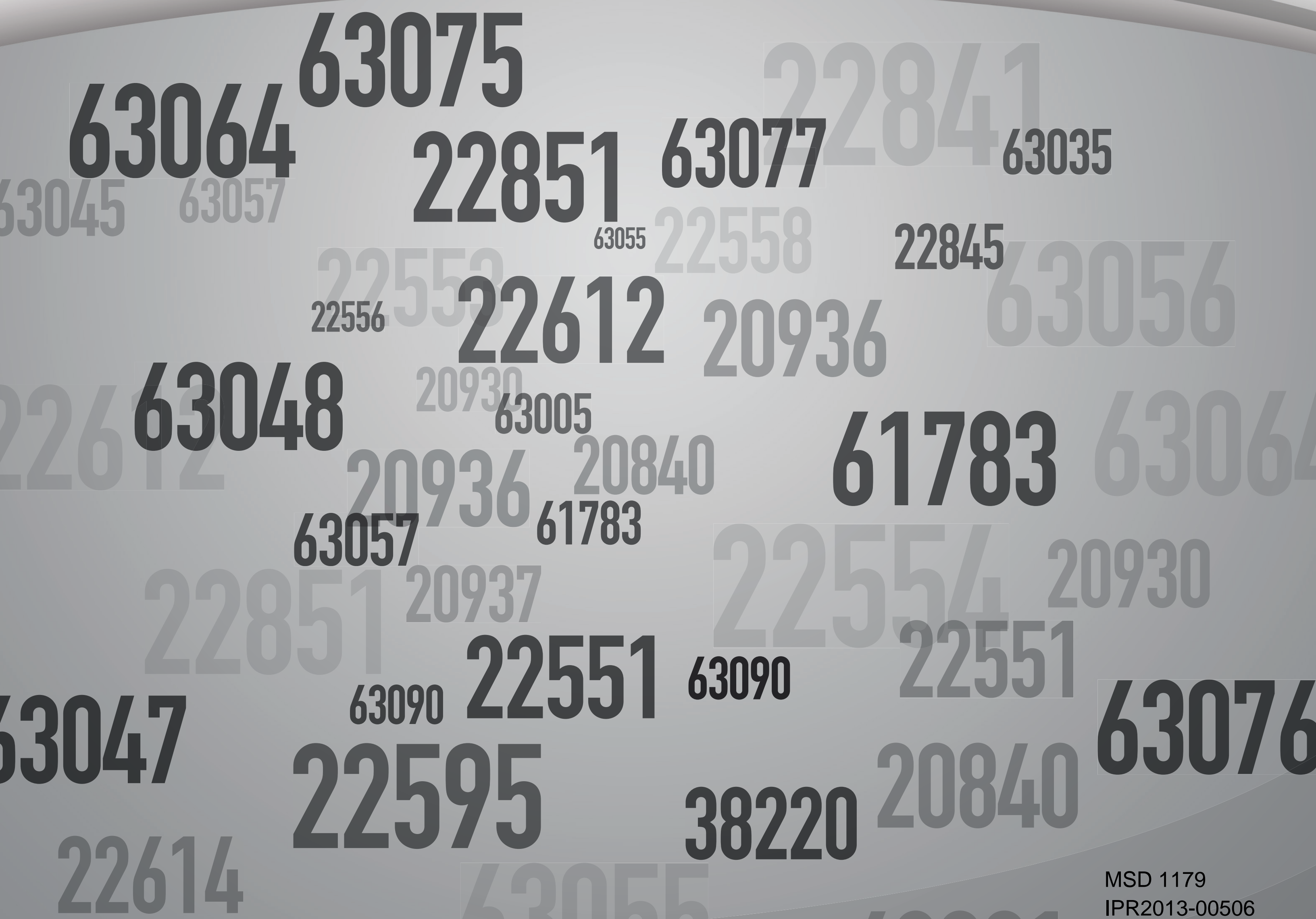
NUVASIVE
Speed of Innovation®

2014
Reimbursement Guide



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2014 Reimbursement Guide

I. INTRODUCTION

This Reimbursement Guide has been prepared to assist physicians and facilities ("providers") in accurately billing for NuVasive® implants and instrumentation systems. The NuVasive corporate headquarters houses a state-of-the-art education center and cadaver operating lab, designed to provide training and education to physicians on these technologies.

This information details our general understanding of the application of certain codes to NuVasive products. It is the provider's responsibility to determine and submit appropriate codes, charges, and modifiers for the products and services rendered. Payors may have additional or different coding and reimbursement requirements. Therefore, before filing any claim, providers should verify these requirements in writing with local payors. For more information, visit **www.nuvasive.com**.

Spine Reimbursement Support

800-211-0713 or **reimbursement@nuvasive.com**

Working with professional medical societies and legislators, NuVasive has taken an active role regarding reimbursement for spine products and procedures. To assist providers with coding and denial issues, NuVasive established Spine Reimbursement Support assistance, available at **800-211-0713** or **reimbursement@nuvasive.com**. Please use this resource for reimbursement questions regarding any of the NuVasive products and associated procedures.

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II. PHYSICIAN CODING AND PAYMENT

When physicians bill for services performed, payors require the physician to assign a Current Procedural Terminology (or CPT®) code to classify or identify the procedure performed. These CPT codes are created and maintained by the American Medical Association (AMA) and are reviewed and revised on an annual basis. The most commonly used CPT codes are referred to as Category I codes and are five-digit codes accompanied by narrative descriptions.

The AMA assigns a number of relative value units (or RVUs) to most CPT codes to represent the physician work, malpractice costs, and practice expenses associated with a given procedure or service. Medicare annually revises a dollar conversion factor that, when multiplied by the code's RVUs, results in the national Medicare reimbursement for that procedure. Most private payors also consider a code's RVUs when establishing physician fee schedules.

Industrial or work-related injury cases are usually paid according to state-established fee schedules or percentage of billed charges. A state-appointed agency or private third party payors handle administration of workers' compensation benefits and claims.

1. FUSION FACILITATING TECHNOLOGIES

The following CPT codes are generally used to report a decompression and/or arthrodesis procedures. The codes listed here are examples only, not an exhaustive listing. It is always the physician's responsibility to determine and submit appropriate codes, charges, and modifiers for the services that were rendered.

CPT CODING FOR ARTHRODESIS USING THE NUVASIVE® MAXCESS® SYSTEM

NASS provided coding guidance for physicians when performing a fusion through an anterolateral approach. During an XLIF® lateral approach procedure, the patient is typically positioned laterally in order to spread the abdominal muscles to approach the lumber spine via a retroperitoneal exposure. The iliopsoas muscle is either split or mobilized to access the anterior spine from the lateral approach. The target of this approach is the vertebral body and anterior interspace. The physician is therefore performing an anterior fusion through an anterolateral approach. For this reason, NASS recommended the use of the anterior arthrodesis CPT code 22558, as well as the applicable instrumentation code(s) to describe the procedure.

When obtaining preauthorization for this procedure, please keep the following key points in mind:

- Include trade names of the devices to ensure appropriate review by payors. Payors may establish coverage criteria based on the specific devices/approach. In addition, utilize recognized correct coding nomenclature.
- Medical necessity for the fusion must be established through relevant patient diagnosis codes.
- Preauthorization should be requested for all relevant procedure codes for the case (e.g., anterior arthrodesis, posterior arthrodesis, instrumentation, graft material, nerve monitoring, etc.).

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