CPT* CODE	PROCEDURE DESCRIPTION	ICD-10 Codes Supporting Medical Necessity	PHYSICIAN			AMBULATORY SURGERY CENTER	HOSPITAL		TOOLS	BILLING GUIDELINES
			Work RVUs	TOTAL RVUs	PAYMENT RATE** OFFICE & FACILITY		OUTPATIENT APC	PAYMENT RATE		
62380	***Endoscopic*** decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, ***lumbar***	G54.X, G55, G57.XX, G90.5XX, G95.9, Q76.XX, T81.40XX, M19.90, M43.XX, M45.X, M46.XX, M47.X, M48.XX, M51.X, M53.XX, M54.XX, M72.9, M96.1, M99.3X, M99.49, M99.6X, M99.7X, M99.83	0.0	0.0	$0 (carrier-priced)	$3,393	5114	$6,823	DiscFX or Endoscopic Set	For bilateral procedures, report with modifier 50. Multiple procedure rule (100%/50%/50%/25%) applies. MUE***: 2. Global Period: 90 days.
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, ***cervical***	G54.1, M43.XX, M45.X, M47.XXX, M48.XXXX, M51.XX, M53.XX, M54.XX, M99.XX, Q76.2, Q76.415, T81.40XA, T81.40XD, T81.40XS	14.91	33.40	$1,093.85	$3,393	5114	$6,823	DiscFX or Endoscopic Set	Report 1 unit per level. For facilities, a case rate payment applies regardless of the number of levels treated. MUE: 1. Global Period: 90 days.
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, **lumbar**		12.00	27.85	$912.09					
+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** (List separately in addition to code for primary procedure)		3.86	6.98	$228.60	$0 (bundled)	n/a	$0 (bundled) ****		
63045	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***	G54.1, M43.XX, M45.X, M47.XXX, M48.XXXX, M51.XX, M53.XX, M54.XX, M99.XX, Q76.2, Q76.415, T81.40XA, T81.40XD, T81.40XS	17.95	39.21	$1,284.13	$3,393	5114	$6,823	Endoscopic Set	Report 1 unit per level. For facilities, a case rate payment applies regardless of the number of levels treated. MUE: 1. Global Period: 90 days.
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**		17.25	37.40	$1,224.85					
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**		15.37	33.61	$1,100.73					
+63048	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 vertebral segment, cervical, thoracic, or lumbar** (List separately in addition to code for primary procedure)		3.47	6.30	$206.33	$0 (bundled)	n/a	$0 (bundled)		
63055	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; ***thoracic***	M43.XX, M45.X, M47.XXX, M48.XXXX, M51.XX, M53.2X7, M99.XX, Q76.415, T81.40XA, T81.40XD, T81.48S, M54.XX	23.55	49.38	$1,617.20	$3,393	5114	$6,823	DiscFX or Endoscopic Set	Report 1 unit per level. For facilities, a case rate payment applies regardless of the number of levels treated. MUE: 1. Global Period: 90 days.
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)		21.86	45.18	$1,479.65					
+63057	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** (List separately in addition to code for primary procedure)		5.25	9.62	$315.06	$0 (bundled)	n/a	$0 (bundled)		
64772	Transection or avulsion of other spinal nerve, extradural	G54.6, G54.7, G56.40, G56.41, G56.42, G56.43, M12.551, M12.552, M12.559, M54.10, M54.18, M79.2	7.84	16.93	$554.46	$898	5431	$1,842	Endoscopic Set or DART	Report 1 unit per level. Multiple procedure rule (100%/50%/50%/25%) applies. MUE: 2. Global Period: 90 days.
22100	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for bony lesion, single vertebral segment; ***cervical***	A18.1, C41.2, C79.5X, D16.6, D48.0, D49.2, M25.78, M45.X, M46.XX, M47.XXX, M48.XX, M48.45X, M48.9X, M51.XX, Q76.XX, T81.40XX, M84.XXXX, M85.XX, M86.XX, M87.XX, M90.8X, M96.8X, M99.5X, M99.7X	11.00	28.97	$948.70	n/a (hospital only)	5114	$6,823	Edoscopic Set + Burr	Report 1 unit per level. For facilities, a case rate payment applies regardless of the number of levels treated. MUE: 1. Global Period: 90 days.
22101	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; **thoracic**		11.08	26.72	$875.02					
22102	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; **lumbar**		11.08	23.36	$764.98	$3,393				
+22103	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; **each additional segment** (List separately in addition to code for primary procedure)		2.34	4.01	$131.32	$0 (bundled)	n/a	$0 (bundled)		
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed; ***lumbar***	M46.XX, M47.XX, M51.XX, M5.XX, M96.1, M99.5X, S33.XXA, S33.XD	9.03	18.09	$592.45	$898	5431	$1,842	DiscFX	Report 1 unit per level. Multiple procedure rule (100%/50%/50%/25%) applies. MUE: 1. Global Period: 90 days.

*Current Procedural Terminology (CPT) Copyright American Medical Association (AMA) 2023

**CMS CY 2024 Conversion Factor: $32.7476

***Medically Unlikely Edit. An MUE is the maximum units of service that a provider would report under most cicumstances for a single beneficiary on a single date of service. Not all CPT codes have an MUE.

**** $0 payment (bundled); Per Medicare, no additional payment is issued to the facility for additional procedure(s) and/or levels performed that map to the same APC.

+ Denotes Add-On Code. Add-On codes are NOT subjected to the multiple procedure discount rule. 100% of the published fee schedule is reimbursed.

Sources: CMS 2024 Physician Fee Schedule, HOPPS Final Rule, ASC Final Rule, Federal Register; November 1, 2023

Payor Prior-Authorization

Coverage may vary by payor, or even by individual benefit plan within a particular payor. To determine coverage for a particular patient and procedure, a benefit verification should be conducted and the payor policy should be reviewed. Coverage is typically based on medical necessity and may require a pre-authorization or pre-determination. Once a patient is identified, the practice or the facility should allow enough time to complete these steps prior to scheduling a patient for surgery.

Traditional Medicare does not require a prior authorization for these procedures. Other health plans, however, may require a prior-authorization as a condition of coverage and payment. Prior-authorization requests to the payor generally include the following: All relevant clinical documentation and chart notes that support individual patient medical necessity. This is likely to include diagnostic testing results, timely imaging, previously tried and failed treatment(s)/procedure(s), clinical reason(s) for the proposed treatment/procedure, and a letter of medical necessity describing the patient's specific clinical need. NOTE: If a payor responds to a prior-authorization request with 'No Prior-Authorization Required', it is not advisable to perform the procedure as the physician and facility are afforded no level of protection. At the least, consider requesting a 'Benefit Coverage Determination' in this situation.

For Coding, Billing and Prior-Authorization Support, Please Contact Reimbursement@elliquence.com (it will go to Bob Bargenquast)

Disclaimer: The information contained in this document has been prepared by reimbursement and coding professionals to assist health care professionals in understanding the reimbursement process. It is intended to assist providers in accurately obtaining reimbursement for health care services. It is not intended to increase or maximize reimbursement by any payor. We strongly suggest that you consult your payor organizations regarding local reimbursement policies. The information contained in this document is provided for informational purposes only and represents no statement, promise, or guarantee concerning levels of reimbursement, payment, charge, or guarantee that these codes will be appropriate in every scenario, or that third-party reimbursement will be forthcoming.