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.

Physician Reimbursement	CPT Code	Description	Total RVUs	Medicare National Average Payment*
Primary Surgery	22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	47.74	$1,544.22
Bone Graft	20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only; (List separately in addition to code for primary procedure)	0.00**	$0
Instrumentation	22842	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); three to six vertebral segments	22.64	$732.32
	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	7.74	$250.36

*Conversion Factor: $33.2875

**CPT 20930 is considered a packaged service with the primary procedure

Hospital Outpatient

Medicare reimburses hospital outpatient services under the Outpatient Prospective Payment System (OPPS), which bases payment on Ambulatory Payment Classifications (APCs). CMS considers Transforaminal Lumbar Interbody Fusion (TLIF) performed in an Ambulatory Surgical Center (ASC) place of service non-reimbursable.

Outpatient Hospital Reimbursement	APC Code	Description	Medicare National Average Payment*
Primary Surgery	5116	Level 6 Musculoskeletal Procedure	$18,390.05
Bone Graft	Bundled with APC 5116		
Instrumentation			

*Conversion Factor: $87.382

Hospital Inpatient

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-DRG Code	Description	Medicare National Average Payment*
450	Spinal fusion, except cervical, with MCC**	$ 36,754
451	Spinal fusion, except cervical, without MCC**	$ 22,023

*National Base Operating Rate: $7,002.00

ICD-10-PCS

For patient admissions involving procedures, hospitals must also report ICD-10-PCS procedure codes for surgeries and other procedures as well as ICD-10-CM diagnosis codes. The example of codes may be appropriate for the performance of a transforaminal lumbar interbody fusion surgery, using PearlMatrix®.

ICD-10-PCS	Description
0SG00AJ	Fusion of Lumbar Vertebral Joint with Interbody Fusion Device, Posterior Approach, Anterior Column, Open Approach
0SG03AJ	Fusion of Lumbar Vertebral Joint with Interbody Fusion Device, Posterior Approach, Anterior Column, Percutaneous Approach
0SG04AJ	Fusion of Lumbar Vertebral Joint with Interbody Fusion Device, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach

For Reimbursement assistance and support, contact us:

reimbursement@cerapedics.com **(303) 974-6275, press 7** **info.cerapedics.com/reimbursement**

References

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3. FY 2025 IPPS Final Rule | CMS - 1785F, 1785CN. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page. Accessed August 19, 2025.
4. Centers for Medicare & Medicaid Services. International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) https://www.cms.gov/medicare/coding-billing/icd-10-codes/2024-icd-10-pcs. Accessed August 19, 2025.